U.S. Department of Justice v. The State of Ohio

Civil Action No: 2:08-cv-475

Monitor's First Report on the Amended Stipulation dated June 28, 2011

Kelly Dedel, Ph.D., Lead Monitor
Daphne Glindmeyer, M.D., Subject Matter Expert
Michelle Staples-Horne, M.D., Subject Matter Expert

One in 37 Research, Inc.
1608 NW Riverscape Street
Portland, OR 97209
(503)799-0915
kdedel@comcast.net

Draft Submitted December 2, 2011
Final Submitted January 23, 2012

TABLE OF CONTENTS

INTRODUCTION

On June 4, 2008, The United States Department of Justice (DOJ) and the State of Ohio (the State) signed a stipulation for injunctive relief (the Stipulation) concerning conditions at the Scioto Juvenile Correctional Facility (Scioto) and the Marion Juvenile Correctional Facility (Marion; which was closed shortly after the Stipulation was signed). Fred Cohen, the Lead Monitor of the concurrent conditions of confinement lawsuit, *S.H. v Stickrath et al*., served as the monitor for the Stipulation until late 2009. At that point, Mr. Cohen resigned and the DOJ assumed the role of Monitor, with Dr. Kelly Dedel, Dr. Daphne Glindmeyer, and Dr. Michelle Staples-Horne serving as subject matter experts.

As the original stipulation expired, the Parties recognized that the State had not yet reached substantial compliance with several key portions of the Stipulation. Thus, the Stipulation was renegotiated to include a subset of the original provisions. The Amended Stipulation terminates when the State has achieved substantial compliance with each provision and has maintained substantial compliance for two reporting periods (i.e., 12 months). The Parties also agreed that the Amended Stipulation is subject to the termination provisions of the Prison Litigation Reform Act.

The Monitor for the Amended Stipulation is Dr. Kelly Dedel, who evaluates the State's progress in the areas of Protection From Harm, Grievances, Programming and Special Education. She is assisted by two Subject Matter Experts, Dr. Daphne Glindmeyer, who evaluates the State's progress on provisions related to Mental Health Services, and Dr. Michelle Staples-Horne, who evaluates the State's progress on provisions related to Medical Care.

As the Monitor, Dr. Dedel is the primary liaison between the Monitoring Team and the Parties and she compiles the Monitor's Report. To do so, she combines Drs. Glindmeyer's and Staples-Horne's reports with her own to form a coherent whole, but does not change the substance of the reports by either of the Subject Matter Experts, who are responsible for forming their own opinions about the level of compliance for each provision in their areas of expertise.

This is the Monitor's first report on the State's progress toward the reforms required by the Amended Stipulation. The monitoring period is June 4, 2011 through October 31, 2011. Progress reports will be issued approximately every six months hereafter.

EXECUTIVE SUMMARY

The Amended Stipulation includes 33 provisions related to Protection From Harm (n=3); Grievances (n=2); Programming (n=2); Mental Health Care (n=18) and Documentation (n=2); Medical Care (n=3); and Special Education (n=3). Each provision is listed in the table below, along with the Monitor's or Subject Matter Expert's compliance rating.

The following compliance ratings are used throughout this report:

- Substantial Compliance means that the facility has drafted relevant policies and procedures; has trained the staff responsible for implementation; has sufficient staff to implement the required reform; has demonstrated the ability to properly implement the procedures during the majority of the monitoring period; and has ascertained that the procedures accomplish the outcome envisioned by the provision. Non-compliance with mere technicalities or a temporary failure to comply (due to staff vacancy or illness, facility disruptions, or other short-term events) during an otherwise sustained period of compliance do not constitute a failure to achieve or maintain substantial compliance. Conversely, temporary compliance during a period of sustained non-compliance does not constitute substantial compliance.

- Non-Compliance means that the facility has not drafted relevant policies and procedures; and/or has not trained the staff responsible for implementation; and/or does not have sufficient staff to implement the required reform; and/or has not implemented the procedures over a significant period of time; and/or has not yet ascertained whether the procedures accomplish the outcome envisioned by the provision.

Table 1. Compliance Ratings for Each Provision		
No	Provision	Rating
Protection From Harm		
III.A. 1	General Protection From Harm	NC
III.A.3	Seclusion	NC
III.A.5	Investigation of Serious Incidents	SC
III.D.1	Grievances	NC
III.D.2	Grievances Explained to Youth	NC
III.F.1	Structured Programming	NC
III.F.2	Orientation	NC

Mental Health Services		
III.B.1	Mental Health Screening	NC
III.B.2	Immediate Referral to QMHP	NC
III.B.3	Identification of Previously Unidentified Youth	NC
III.B.4	Mental Health Assessment	NC
III.B.5	Adequate Care and Treatment	NC
III.B.6	Treatment Planning	NC
III.B.7	Treatment Teams	NC
III.B.8	Integrated Treatment Plans	NC
III.B.9	Access to QMHP	NC
III.B.10	Mental Health Involvement in Housing and Plcmt	NC
III.B.11	Staffing	NC
III.B.12	Medication Notice	NC
III.B.13	Mental Health Medications	NC
III.B.14	MH/DD Training for Direct Care Staff	NC
III.B.15	Staff Mental Health Training	NC
III.B.16	Suicide Prevention	NC
III.B.17	Transition Planning	NC
III.B.18	Oversight of Mental Health	NC
III.G.1	Progress Notes	NC
III.G.2	Accessibility of Information	NC
Medical Services		
III.C.1	General Medical Care	SC
III.C.2	Health Records	SC
III.C.5	Access to Health Services	SC
Special Education Services		
III.E.1	Provision of Special Education	NC
III.E.7	Individual Education Plans	NC
III.E.8	Vocational Education	NC

Overall, the State is in substantial compliance with 4 of the 33 provisions (15%). Compliance ratings for each section and key issues to be addressed are highlighted below.

Protection from Harm (includes Grievances and Programming)

The facility is in substantial compliance with 1 of the 7 provisions (14%) related to protecting youth from harm. Two provisions, those related to the Grievance process, require only very minor actions to reach substantial compliance. More significant concerns plague the other provisions and the following actions should be prioritized:

- Determine the underlying causes of youth violence and enact targeted violence prevention strategies to reduce youth-on-youth and youth-on-staff assaults.
- Address the pattern of perceptions by female residents that some staff speak or behave in sexually inappropriate ways. Expand the dialog among administrators, girls and staff about this issue to ensure that the facility is aware of and addresses all such perceptions.
- Decrease the reliance on regular seclusion to respond to mid-level, non-violent misconduct.
- Address staff shortages to ensure sufficient personnel are available to provide youth with safe access to a full range of programming.
- Improve the quality of internal investigations.
- Expand the PROGRESS Unit's program design to ensure treatment plans and treatment team meetings are focused around realistic, measurable goals and that data are routinely captured to assess youth progress and readiness to transition to the general population.
- Ensure that youth admitted to the PROGRESS Unit receive a timely, comprehensive Orientation.
- Ensure youth have access to a full range of structured programming so that idle time is kept to a minimum, particularly among youth who have graduated from high school or obtained a GED.

Mental Health Services

The facility is not in substantial compliance with any (0%) of the 18 provisions related to mental health services. The following actions are required:

- Review and revise policies and procedures, as needed, to ensure they are compatible with the facility's new mission as a long-term placement.
- Adequately staff the facility with qualified social workers, clinicians, psychiatrists and psychiatric nurses so that mental health treatment can be implemented to meet the needs of all youth. Increase psychiatry clinical resources.
- Develop an organized training schedule for mental health staff.
- Train direct care staff and mental health staff to understand the behavior and needs of youth with mental illnesses and developmental disabilities and recognize and respond to signs and symptoms of serious mental illness.

- Train mental health staff to develop high-quality case conceptualizations that integrate the information generated by the multiple assessments administered to youth upon admission.
- Train, coach and adequately supervise direct care staff and mental health staff to implement the Phoenix New Freedom curriculum, particularly in skills for leading group therapy sessions to ensure the interactions and documentation reflect generally accepted practices for mental health care.
- Ensure all screenings are completed within 24 hours of the youth's admission.
- Provide a written rationale for all placement decisions by the Behavior Review Panel.
- Develop procedures to ensure, and to document, that youth are assessed by a qualified mental health professional within 12 hours when a serious risk to the youth's safety is identified.
- Ensure mental health staff assesses youth on suicide precautions, those in seclusion, and those on the Progress Units every 24 hours.
- Ensure youth with acute mental illnesses requiring extensive mental health treatment have access to more appropriate placements.
- Ensure treatment plans are individualized including measurable goals and targeted interventions to address the goals. Update treatment plans regularly and monitor youth's progress toward achieving treatment goals. Adapt treatment plans for youth who are not progressing.
- Ensure Interdisciplinary Treatment Team meetings include representatives from the major sectors of the facility including social workers, direct care staff and psychiatrists and that Treatment Teams are focused on treatment issues and the youth's progress toward treatment goals.
- Ensure youth on the Progress Units are appropriate for the secure setting and receive appropriate treatment. Conduct thorough assessments of all youth currently housed on the Progress Units and those proposed for placement in the future.
- Ensure youth receive proper laboratory examinations and side-effect monitoring commensurate with the psychotropic medications prescribed and reflecting generally accepted practices.
- Beginning at admission, hold structured discussions in Treatment Team meetings about discharge needs and appropriate community services. Ensure aftercare appointments and linkages are set up prior to youths' release from Scioto.
- Develop a coherent, coordinated quality assurance process that provides a cogent review of social work, psychological and psychiatric services at the facility.

Medical Services

The facility is in substantial compliance with all 3 (100%) of the provisions related to medical services. The following suggestions are offered in the spirit of continually improving those services, and are discussed in greater detail under the relevant provision:

- Expand the immunization program to Include Hepatitis A and HPV vaccinations of youth.

- Develop protocols for decontamination and medical assessment of youth after exposure to OC spray.
- Provide AEDs (Automated External Defibrillators) on site, train staff in its use and include them in the Emergency Medical Response and Services Policy.
- Improve completeness of youth Problem List in health record to include all chronic diagnoses, including mental health, substance abuse and acute diagnoses such as headache, shoulder pain, etc.
- Improve Quality Assurance (QA) activities by considering a review at least annually by a source external to ODYS Health Services. ODYS should also consider expansion of the QA process to include some additional quality indicators.
- Continue to improve process for sharing of health information between medical and mental health to include psychologists. Consider implementation of electronic health record or if not possible now, allow medical staff to access to the Mental Health database.
- Continue to review and update policies and procedures annually. Reduce length of policies and procedures and attempt to consolidate some.
- Encourage youth to complete Health Call forms in non-emergency situations in order to fully document medical responses to youth requests.

Special Education

The facility is not in substantial compliance with any of the 3 education-related provisions (0%). The following actions should be prioritized:

- Improve the documentation of Unit Instruction and ascertain whether youth receive the required education services while serving time in disciplinary seclusion.
- Increase attendance rates among youth on the PROGRESS units.
- Improve the quality of IEP progress reporting to ensure reports are grounded in data that are responsive to a set of realistic, measurable IEP goals.
- Develop sufficient vocational opportunities to meet the needs of the population of Scioto students and graduates.

The facility has undergone a massive transformation since the Stipulation was amended. Originally, Scioto was the central reception facility for all DYS facilities. In the summer of 2011, DYS began to de-centralize its reception process to convert Scioto to a long-term facility that houses medium and close custody boys. Scioto remains the reception center for girls and also operates a long-term girls' program and a mental health unit for girls. The facility has struggled mightily with these changes which is disheartening given the significant progress toward compliance with the Stipulation Scioto had made as a reception center. With the change in target population came a set of new problems, with different dynamics, and different solutions than the challenges that had been conquered in the past. Facility administrators and staff are commended for their adaptability and encouraged to apply the same level of problem solving and commitment to the new challenges they face.

PROTECTION FROM HARM

III.A.1 General Protection From Harm. The State shall, at all times, provide youth in the facilities with safe living conditions. As part of this requirement, the State shall take appropriate measures to ensure that youth are protected from abuse and neglect, use of excessive force, undue seclusion, undue restraint, and over-familiarization.	
Compliance Rating	Non-Compliance
Self Assessment	The State provided an array of data to illustrate the trends in youth violence, restraints, seclusion, and allegations of employee misconduct, along with an interpretation of the trends and the underlying causes of recent increases. While the interpretation of these data leads to significant concern for the safety of youth and staff at Scioto, the fact that the facility continues to be able to collect and analyze an array of data related to key indicators of youth safety is very positive. Without this capacity, the facility would be unable to craft new violence prevention initiatives to address the underlying causes of the youths' behavior. When the facility's target population changed, so did the factors that contribute to youth violence. In the past, the facility clearly demonstrated its ability to analyze and respond to youth violence in its reception population. It must employ these same skills to its new population of long-term residents. Trends in youth violence, restraints, and allegations of over-familiarization are discussed here, while detailed discussions about the use of seclusion and staff misconduct can be found in III.A.3 and III.A.5 respectively. *Youth Violence* Early in the monitoring period, youth violence was concentrated in two units: Jefferson (younger boys' reception) and Buckeye (boys' intensive mental health program). The State enacted a variety of violence prevention strategies and achieved significant reductions in the rates of youth violence by July 2011. As noted in the Introduction, in late Summer 2011, Scioto converted from a reception center and boys' mental health unit to a long-term program. Scioto's boys' program now includes general population housing for medium and close custody boys and a maximum-security segregation unit. Scioto's girls' program continues to include reception, general population and an intensive mental health program. With this conversion came rather immediate and significant increases in the rates of youth violence. In contrast to the previous eight months where the average rate of youth violence was .34, the

	rate of youth violence in September 2011 increased 60% to .54. Nearly all of this increase can be attributed to a increase in gang recruitment activity, in which initiation rites required youth to assault staff. In contrast to the previous eight months where the average number of assaults on staff was 12, in September 2011, the number increased nearly 400% to 45 assaults on staff. *Restraints* Compared to the previous eight months, the rates of physical restraint and use of handcuffs more than doubled in September 2011. These increases are commensurate with the increases in acts of violence, discussed above. Over the past six months, Scioto investigated 17 allegations of excessive or inappropriate uses of force. Six of these (35%) were substantiated. As discussed in more detail in Provision III.A.5, most of the substantiated cases were for relatively minor violations of the use of force policy. Further, while the number of excessive use of force allegations seems high in comparison to other facilities of a similar size, the facility's well-developed use of force review and its vigilance surrounding adherence to policy and procedure may translate to a higher number of referrals, but also to greater protection from harm by staff. Thus, with the change in the facility's mission came a rather immediate spike in youth violence and restraints. The extent to which these increases will be short-lived or will persist over time will depend on the State's success in identifying the underlying causes (e.g., gang activity) and to enact evidence-based solutions that respond to these dynamics.
Steps Taken to Assess Compliance	In addition to reviewing the data presented by the State in its self-assessment, the Monitor also reviewed information gathered by the DOJ related to allegations of over-familiarization by staff and the circumstances surrounding a major tactical operation that occurred in September 2011. *Over-Familiarization* While on site in October 2011, the DOJ interviewed several female youth who alleged that some staff speak to them and behave in sexually inappropriate ways. The allegations included inappropriate touching on the buttocks, sexual propositions and language, comments about the girls' bodies, and sexual relationships between staff and youth. The DOJ has received similar allegations during each of its prior visits to the facility and has made the facility aware of some of the details of each allegation. However, wanting their

	conversations with youth to remain confidential, the DOJ has chosen not to reveal the names of the youth making the allegations. Further, in some cases, the alleged victims did not know or want to report the name of the staff member who was alleged to have been inappropriate with them. DOJ reported the most recent allegations to the State in a letter dated November 2, 2011. The State responded with a letter of its own, dated November 30, 2011, contesting that the lack of detail provided by the DOJ was not conducive to reasonable and effective investigations. While the Monitor agrees that without knowing the identity of the alleged victim, the State's ability to investigate the specific allegations heard by DOJ is very limited. However, given that the DOJ hears such allegations every time it interviews youth at Scioto, the persistence of the youth's perceptions that some staff are sexually inappropriate is concerning and needs to be addressed. While the State receives a few similar allegations through its grievance process, the frequency and seriousness of the allegations does not mirror those noted by the DOJ. In an effort to reconcile the two positions, the Monitor recommends that the State launch a proactive initiative to expand the discussion about this topic with both youth and staff. The youth initiative could include an Ombudsman (or another individual who is trusted by youth and is skilled at talking with youth about sensitive issues) who holds on-going group and individual meetings with girls to hear their complaints or concerns about sexually inappropriate behavior or language from staff. The staff part of the initiative could include training (e.g., short sessions during shift briefing or at all-staff meetings) discussing the prohibitions on sexualized language and behavior with youth and also how to recognize and respond to over-familiarization issues when working with youth. Again, the State is indeed limited in its ability to investigate specific allegations absent identifying information; however, given the pattern of such allegations received by the DOJ, the State needs to be proactive in its efforts to expand the conversation around this issue with both youth and staff. *Operation Safety First* In response to the increasing violence at Scioto and also at DYS' Circleville facility, the Department launched Operation Safety First. This operation targeted a set of highly aggressive youth and entrenched gang leaders for transfer to a maximum-security segregation unit at Scioto. The heightened security features of the unit were designed to decrease the youth's access to potential victims. The DYS utilized a tactical team from Ohio's adult prison system (the DRC's STAR team) to effect the transfer of youth.

	Although by policy DYS staff are not permitted to use Oleoresin Capsicum (OC) spray, the DYS' agreement with the DRC permitted the STAR team to use the spray when deemed necessary. During the transfer, one youth was sprayed for resisting transport. Three other Scioto youth who were not part of the transfer were also OC sprayed in response to disruptive behavior. A review of incident reports related to the events and interviews with each of the four Scioto youth who were sprayed suggest that OC spray was used in situations when the youth did not present an immediate threat of serious bodily harm to staff or other youth. Although the youth involved had a history of assaultive behavior, their refusal to follow staff instructions and the level disruption to the operation of the facility was not overly aggressive nor did it present an immediate risk of serious harm to other youth or staff. In fact, one youth was sprayed while he was in handcuffs and several other youth were sprayed through the cuff ports of their cell doors when they posed no danger at all to staff or youth. If they are to be used, generally accepted practices for juvenile correctional facilities limit the use of chemical restraints to only those situations in which less restrictive measures have failed and only when an immediate risk of harm is present. The use of OC spray during Operation Safety First appears to have been unnecessary to maintain control of the youth involved and therefore is of concern to the Monitor.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue to utilize aggregate data on youth violence, restraints and seclusion to identify trends that threaten youth and staff safety. 2. Identify the underlying causes of the increases in youth violence and develop targeted violence prevention strategies to address the factors that contribute to assaultive behavior among youth. 3. Launch a proactive initiative to expand the conversation surrounding the perception of female residents that some staff engage in sexually inappropriate talk and behavior. Reinforce the prohibition against this type of behavior with staff and ensure staff know how to recognize and respond to such behavior. 4. Ensure that all restraint practices are aligned with DYS policy, limiting the use of force to only what is necessary to control the immediate risk posed by youth.
Sources of	• Self-assessment data and oral presentation of its

Information	interpretation for III.A.1, prepared at my request • Incident reports and youth interviews regarding Operation Safety First, conducted in early October 2011 • Interviews with n=29 youth housed on the PROGRESS units, conducted by the Monitor and the DOJ attorney during two site visits in October 2011

III.A.3 Seclusion. The State shall develop and implement policies, procedures and practices so that staff use seclusion only in accordance with policy and in an appropriate manner and so that staff document fully the use and administrative review of any imposition of seclusion, including the placing of youth in their rooms outside normal sleeping hours.	
Compliance Rating	Non-Compliance
Self Assessment	The State presented data on the use of seclusion across the previous nine months. *Regular Seclusion* Data on the use of regular seclusion (a period of isolation imposed by direct care staff in response to mid-level, non-violent misconduct) showed significant increases in both its use and duration beginning in August 2011. The average number of seclusions from January to July was 71. In August, the number of seclusions tripled to 205, and then doubled again to 430 in September 2011. These data reflect the high level of non-violent (yet still concerning) behavior that accompanied the influx of long-term, medium and close custody boys. Further, the duration of seclusion increased significantly. In the first seven months of 2011, approximately 85% of seclusions were 4 hours or less. In August and September, only about half were 4 hours or less, with the remainder anywhere between 4 and 72 hours. *Pre-Hearing Seclusion* Data on the use of pre-hearing seclusion (PHS; a period of isolation imposed following an act of violence, pending a disciplinary hearing) showed significant increases in the use of PHS in September 2011, concurrent with the increase in youth-on-staff assaults discussed in III.A.1. Whereas the average number of PHSs in the preceding eight months was 55, there were 91 PHSs in September 2011. Over one-third of these lasted 56 hours or more (which makes sense given the high proportion of staff assaults after which, according to the IRAV policy, youth are not eligible for release from PHS pending the disciplinary hearing). In prior months, only about 15% of youth who committed an act of violence were in PHS longer than 56 hours. *Intervention Seclusion* Intervention hearings are held to determine whether youth are culpable for serious misconduct and whether additional time in seclusion is warranted. Sometimes, youth are suspected of taking part in an act of group violence, but the subsequent investigation shows they were not involved. The hearing officer may also decide that a treatment-related sanction, combined with the time already spent in PHS, is sufficient to address the youth's behavior. In these cases, intervention seclusion is not used. The self-assessment showed that

	the proportion of youth receiving intervention seclusion is lower than that witnessed in previous months. In August and September, an average of 35% of youth in PHS received intervention seclusion, compared to an average of 57% in the previous seven months. This decrease reflects the dynamics of the disciplinary process, particularly for a group of youth who are relatively unfamiliar to staff. Overall, the total number of hours of seclusion utilized in the day-to-day operation of the facility has increased significantly in recent months. In contrast to June and July 2011, when the facility had begun to get a handle on the violent behavior of youth in the reception units, the total number of seclusion hours nearly doubled in August and September 2011 (5,428 total hours in June and July versus 10,074 total hours in August and September).
Steps Taken to Assess Compliance	The data presented for the self-assessment suggest that the use of seclusion has become a more central feature in the facility's response to youth misconduct. The use of regular, pre-hearing and intervention seclusion all increased significantly at the end of the monitoring period. In large part, these increases reflect the increase in youth violence at the facility and may have been an appropriate response in a crisis situation. Moving forward, as the staff become more familiar with the youth involved and the dynamics among groups of youth, staff should become able to respond to misconduct in a more productive, less punitive manner. In the past, a major concern related to the use of seclusion was the extent to which staff followed required procedures to mitigate the risk of self-harm posed by youth confined to their rooms for disciplinary reasons. For several years, the administrative team has conducted random reviews of videotape footage to ensure that staff conduct the required safety and welfare checks. Over the past seven months, 45 reviews were conducted (about 6 per month). In about 20% of these reviews, staff were cited for their failure to follow some aspect of the policy. In contrast to previous reviews, the severity of these policy violations has decreased with staff missing a very small number of checks during a shift, rather than failing to conduct safety checks during an entire shift. The facility's continued vigilance and quality assurance efforts in this area offer a solid mechanism for protecting youth from self-harm. However, compared to previous visits to Scioto, two recent situations have caused youth to spend more time in isolation behind their locked doors. First, Scioto has experienced significant staff shortages in the past few months. Of the 170 Youth Specialists, 27 staff (16%) were on extended leave due to work-related injury or FMLA and 8

	positions are vacant (5%). Staff and youth reported and unit logbooks confirmed that over the past couple months, several units were locked down, mostly during 1st shift, because sufficient staff were not available to operate the program safely. When confined to their cells, youth are denied access to the normal range of programming and their risk of becoming frustrated, anxious and self-injurious increases accordingly. Second, some of the youth confined in the maximum-security segregation units (i.e., Cedar and Sycamore; the PROGRESS Units) appear to be spending excessive amounts of time locked in their rooms. The program design includes two phases (Phase I and II) with different levels of restrictiveness. Phase I youth are permitted out of their cells for school, one hour of large muscle activity, treatment, and showers. Meals and leisure time are spent in-cell. Once promoted to Phase II, youth may also spend their leisure time out-of-cell. While youth in both Phases should be out of their rooms during the school day, during Intersession, PROGRESS youth were in their rooms throughout most of the day because Intersession activities had not been planned for them. Even once school was back in session in mid-October 2011, attendance records revealed high levels of chronic absenteeism. If not attending school, or if they have graduated, youth on the PROGRESS units spend most of their day locked in their cells. The facility's ability to identify and address this problem is hampered by the lack of valid data. The PROGRESS Unit's logbooks have a form for recording the location of each youth, each hour of the day. If filled in properly, the facility would have a record of precisely how much time each PROGRESS youth spends in his cell. However, staff do not exercise adequate care in completing this form. Most often, they simply place an "X" in each box, indicating that the youth is on the unit, but without distinguishing whether the youth is in his room, the dayroom, the group room, etc. These records should be maintained more conscientiously. Further, the PROGRESS units have only been operating for a couple months, and the program design has not been fully developed. In particular, the requirements around treatment planning, articulating treatment goals, and conducting treatment teams have not been fully explicated. A review of treatment team notes for nine PROGRESS youth indicated pervasive problems conceptualizing specific, measurable goals for the youth on these units. Even when youth have goals that could be measured, updates on the youth's progress at weekly interdisciplinary team meetings (IDT meetings) do not include data that reflect youth progress on their goals. Most often the "Outcomes" section of the IDT report is completely blank. As a result,

	youth are not moving through Phase I, to Phase II, to Transition as quickly as they would if the program were better orchestrated. As a result, youth are held in highly restrictive settings without a clear pathway for a return to the general population. In addition, facility staff were confused about the process for phase promotion and demotion on the PROGRESS Units. As noted above, by design, the PROGRESS Unit behavior management program has two phases. Once youth complete goals for Phase I, they should be promoted to Phase II. If a Phase II youth engages in an act of violence, he should be demoted to Phase I. However, in practice, this process became blurred with the SBBMS, where youth were not demoted but their Phase was "frozen" for a period of time. While the end result may have been the same (youth lose status and thus spend more time in their room than a Phase II youth), the reason for demotion and the consequent seclusion must be accurately described and implemented so that the youth understand the workings of the system. In summary, the increased levels of misconduct and violence among youth who were not well known to staff, staffing shortages, and early implementation issues on the PROGRESS units have resulted in the increased use and duration of seclusion at Scioto. Not only is seclusion one of the least effective tools for managing youth behavior, it also decreases youth's access to needed treatment programs and increases their risk of self-harm. As a result, its use should be minimized.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue to track data on the use of seclusion to ensure that it is used only in response to the most serious misconduct and is only of the duration necessary to ensure the safety of the facility. Continue to review videotaped footage to ensure that staff conduct required safety checks when youth are confined to their rooms. 2. Address the underlying causes of mid-level misconduct resulting in regular seclusion and expand the use of alternative sanctions (i.e., non-seclusion) for these behaviors. 3. Address staff shortages to ensure that sufficient staff are available to operate the program without confining youth to their rooms during non-sleeping hours. [The remedy to this problem involves systemic reforms that are currently being undertaken by the *S.H.* Monitoring Team.] 4. Improve the quality of record keeping on the PROGRESS units so that the precise number of hours youth spend locked inside

	their rooms can be ascertained. 5. Expand the development of the PROGRESS Unit program design to address the issues of treatment planning, articulating treatment goals and conducting treatment teams to facilitate the youth's transition to the general population as quickly as possible. Ensure that PROGRESS Unit youth are not confined to their rooms, except as articulated in the original program design (e.g., all youth are out of their rooms for school, recreation, treatment and showers; Phase II youth are also out of their rooms for leisure time).
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.3, prepared at my request • Interviews with 29 youth on the PROGRESS Units conducted by the Monitor and DOJ attorney in October 2011, plus information from interviews with 20 general population youth conducted by the DOJ attorney in late October 2011 • SOP 303.01.07 "PROGRESS Unit", draft dated 10/20/11 • Draft "PROGRESS Unit Handbook" and "Transition Unit Manual", received October 26, 2011 • "Unit PROGRESS and Transition Training," PowerPoint presentation slides, received October 26, 2011 • Treatment plans and IDT minutes for n=9 youth from the Cedar and Sycamore units • Attendance records for the Cedar and Sycamore units, October 18-31, 2011 • Unit logbooks for the Cedar and Sycamore units, October 2011

III.A.5 Investigation of Serious Incidents. The State shall develop and implement policies, procedures and practices so that appropriate investigations are conducted of all incidents of: use of force; staff-on-youth violence; serious youth-on-youth violence; inappropriate relationships with youth; sexual misconduct between youth; and abusive institutional practices. Investigations shall be conducted by persons who do not have direct or immediate indirect responsibility for the employee being investigated.	
Compliance Rating	Substantial Compliance
Self Assessment	The State submitted a log of all investigations related to excessive uses of force, allegations of abuse, allegations of verbal abuse, and inappropriate relationships. More serious allegations (n=22) were investigated by the Chief Inspector's Office (CIO), while less serious allegations (n=29) were investigated by facility-based investigators. Training for facility-based investigators by the CIO is planned for November 2011. Between January and August 2011, the facility completed 51 investigations related to the topics covered by this provision. [The facility also conducted approximately 60 investigations of time and attendance issues during this same time period.] Across the 51 investigations, 20 were substantiated (39%), the vast majority for violating the use of force policy. The CIO conducts quarterly audits of the investigations to ensure they are high quality and completed within required timelines. A number of deficits in investigative technique were noted in the Q1 audit, and most of these had been rectified by the Q2 audit. The facility's Administrative Reviews of all investigations likely contributed to these improvements.
Steps Taken to Assess Compliance	*Rate of Substantiated Allegations* Of the 51 investigations completed, 20 allegations were substantiated (39%). Approximately 12 of these were for improper uses of force. More specifically: • failing to submit an incident report or witness statement (5 of 20); • using an unauthorized restraint technique (e.g., headlock, arm lock, grabbing a youth's collar; 4 of 20); • pushing a youth (3 of 20); • excessive force (e.g., lifting a youth off the ground and slamming him to the ground; throwing a punch at a youth; pinning a youth's arms to his side and taking him to the floor; 3 of 20); • restraining a youth who did not pose an immediate threat (2 of 20);

	• inappropriate relationships with youth via FaceBook (2 of 20); and • verbal abuse (1 of 20). For the most part, these data mirror the youth's perceptions of their treatment by staff. The 12 substantiated allegations were among approximately 1,150 physical restraints during that time period (or, approximately 1%). By and large, youth reported that staff do not physically abuse them or treat them heavy-handedly during restraints. As discussed in Provision I.A.1, above, the DOJ has consistently received a larger number of allegations of inappropriate comments, touching and sexual/inappropriate relationships when interviewing youth than is reflected in the facility's investigation log. The reasons for this disparity are unknown, but the State is encouraged to broaden its inquiry about these types of concerns among the girls to determine whether the difference in frequency can be attributed the DOJ's proactive inquiry (see I.A.1 for a more detailed discussion of this issue). *Quality of Investigations* A random sample of 15 investigations of alleged physical abuse or excessive uses of force were selected for in-depth review. These investigations were completed by the CIO and were particularly well done. They featured comprehensive interviews with all key witnesses, and pursued tangential issues that emerged during the course of the initial inquiry. Across the sample, the findings appeared to be reasonable and the basis for the conclusion was clearly identified among the evidence. In order to examine the State's response to allegations of verbal mistreatment, all 14 investigations of this type were selected for review. [Only 11 of the 14 investigations could be reviewed because three of the electronic files were mismarked.] Scioto supervisory staff conduct investigations of alleged verbal abuse. While most of the internal investigations were at least adequate, a small number (36%; 4 of the 11) were poorly done: • 5501110021 failed to substantiate the alleged inappropriate conduct, even though the subject of the investigation admitted that she made the statement alleged by the youth. The reason that the comment was judged by the investigator to be appropriate was not explained; • 550110025 is very convoluted in its presentation of the facts. It is not clear how the facility became aware of the incident or

	why it took over one month to assign the investigation. Further, the investigator did not interview the alleged victim until two months after the incident occurred. Finally, a youth witness corroborated the youth's allegation, and the reason for discounting this evidence was not explained; • 5500110070 noted that 4 youth witnesses corroborated the youth's allegation but did not explain why this evidence was discounted. • 5500110085 does not pursue a full investigation, apparently because the youth indicated that he did not want to pursue the allegation. The summary of the interview with the accused staff said only that the staff "denied" making the comments and "said there were no witnesses." The investigator never describes the situation in which the comments were alleged to have occurred and the paucity of this contextual information makes it appear that the inquiry was dropped simply because the youth did not want to pursue it. Unfortunately, these shoddy investigations cluster around an issue of significant concern—inappropriate comments or antagonizing language by staff. While not the overwhelming sentiment across youth, a significant minority of youth reported that some staff treat them disrespectfully and the youth believe that these staff are not held accountable for their behavior. As discussed in Provision III.D.1, the State has not yet developed procedures to inform youth of the outcome of grievances that are referred for investigation. The shoddy quality of some of these investigations may contribute to the perception that staff are not held accountable for their verbal mistreatment of youth. *Timeliness of Investigations* Across the 51 investigations submitted for review, a significant proportion (42%) were not completed before their due dates. Often, the assigned investigator experienced a delay of between 4 and 7 days while awaiting approval from the Ohio State Patrol (the law enforcement agency with jurisdiction to bring criminal charges) to pursue the internal investigation. Compared to other jurisdictions, the investigation timelines in Ohio are relatively short (particularly the 14 days allocated for use of force investigations). The DYS may want to reconsider the timelines required by policy so that they remain both speedy and reasonable, but so that the vast majority of investigations could be completed on time. This would highlight those investigations experiencing unusual delays.
Recommendations	The State is in substantial compliance with this provision. However, in

	order to maintain substantial compliance, the State must improve the quality of its internal investigations to ensure they are promptly assigned, thoroughly and properly investigated.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.5, prepared at my request • Log, "Investigations of Serious Incidents, January-August, 2011" • Random sample of n=15 CIO investigations completed since February 2011 • Review of n=11 internal investigations of alleged verbal abuse completed since February 2011 • Communication with DOJ attorney regarding the allegations of verbal mistreatment made by youth on the girls' units, October 2011

III.D.1 Grievances. The State shall develop and implement policies, procedures and practices to ensure that the facility has an adequate grievance system including: no formal or informal preconditions to the completion and submission of a grievance; review of grievances by the Chief Inspector; timely initiation and resolution of grievances; appropriate corrective action; and written notification provided to the youth of the final resolution of the grievance.	
Compliance Rating	Non-Compliance
Self Assessment	The Grievance Officer reported that the process is unchanged from previous visits and continues to meet the requirements of this provision: no preconditions; review by Chief Inspector; timely initiation and resolution; appropriate corrective action; and written notification to youth of the final resolution of the grievance. Between February and September 2011, Scioto youth filed over 300 grievances. The Chief Inspector's Office's Q1 and Q2 audits found that all grievances were resolved in a timely manner. Scioto also had a lower rate of grievances per youth than the other DYS facilities. Each month, the Grievance Officer drafts a monthly report showing the number and type of grievances coming from each housing unit. The report also describes the major dynamics in the facility. Reading the past nine months' summaries in succession illuminates the challenges that have faced the facility during its conversion to a long-term program. Staff training in this area admonishes staff not to impede the grievance process in any way, e.g., by refusing access to necessary supplies or by threatening or intimidating youth who choose to file a grievance.
Steps Taken to Assess Compliance	Between February and September 2011, a total of 321 grievances were submitted. The most frequent types of concerns were complaints about unfair treatment by staff (32%); living conditions (9%); medical care (7%) and verbal abuse by staff (4%). Together, these four categories accounted for over half (52%) of all grievances. Of the 321 grievances received, 24 (7%) were closed and forwarded for investigation. [Although the data were not presented this way, the Monitor suspects these 24 referrals included the complaints about verbal abuse (n=13) and physical abuse/excessive force (n=10).] As the facility converted from a reception to a long-term program, the number and content of grievances changed noticeably. During the first half of 2011, the facility averaged about 35 grievances per month. In September, once the facility had completely switched over to a long-term program, 70 grievances were submitted. Many of

	these reflected youth's attempts to become familiar with a new facility with slightly different rules and to ensure that possessions and privileges from their previous facility were transferred to Scioto. Some of the grievances also highlighted staff's lack of familiarity with procedures for the long-term program (e.g., certain features of the SBBMS; Phase Freeze; commissary). The Grievance Officer has exhibited tremendous compassion towards both youth and staff as they attempt to adapt to the transition. Youth at Scioto continue to have dependable access to a grievance process that is timely, thorough and responsive to their concerns. When interviewed, youth continue to have positive reviews of the Grievance Officer and the process for handling most of their concerns. However, as discussed in previous reports, the Grievance Process has not yet been adapted to provide sufficient feedback to youth regarding their allegations of staff misconduct that are forwarded for investigation. Youth are told that their complaint was referred for investigation and the grievance response includes the assigned investigation number; however, youth are not informed when the investigation has been concluded and whether the allegation was substantiated. For this reason, youth tend to believe that the issue was dropped and that staff are never held accountable. The Grievance Officer reported that policy revisions toward this end are underway. The Monitor would like to review the policy revisions prior to the policy being finalized. When the process is fully implemented and youth are informed of the outcomes of investigations of their allegations, the facility will be in substantial compliance with this provision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop procedures and practices to inform youth that investigations of staff misconduct have been completed and whether the allegation was substantiated or not.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.1, prepared at my request • Grievance Monthly Reports, February through September 2011 • Q1 and Q2 Grievance Audits by the Chief Inspector's Office • Youth Grievances from March, June, August and September 2011 • Interviews with n=20 youth in the general population, conducted by the DOJ attorney in late October 2011

III.D.2 Grievances Explained to Youth. A clear explanation of the grievance process shall be provided to each youth upon admission to the facilities during orientation and to their parents or guardians, and the youth's understanding of the process shall be at least verbally verified.	
Compliance Rating	Non-Compliance
Self Assessment	The Grievance Officer held "Grievance Clinics" during the most recent Intersession. These clinics discussed the mechanics of the grievance process and what youth should expect. A learning activity asked youth to critique sample grievances as to whether 1) the issue was grieveable and 2) all necessary information had been included. Youth reported an improved understanding of the process after attending the clinics. Given that many of the youth involved have been released from the facility, the Clinics will be offered again in December 2011. The facility continues to audit a random 10% sample of admissions files every month to ensure compliance with policy and procedure. Each month, February through September 2011, 100% of the youth sampled received a complete orientation to the facility, which included information on how to access the grievance system.
Steps Taken to Assess Compliance	I did not need to conduct any additional inquiry to assess compliance. As noted in III.D.1, the orientation process has not yet been adapted to inform youth that they will be advised when grievances that are referred for investigation are concluded and whether the allegation was substantiated. Policy revisions are reportedly underway. The Monitor would like to review the revisions prior to the policy being finalized. When this process is explained to youth during Orientation, the facility will be in substantial compliance with this provision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Adapt the orientation process to explain how grievances alleging staff misconduct will be handled and that youth will be informed that the investigation is concluded and whether the allegation was substantiated.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.2, prepared at my request • Intake Audit Report, February through September, 2011

III.F.1 Structured Programming. The State shall provide adequate structured rehabilitative services, including an appropriate mix of physical, recreational or leisure activities during non-school hours and days. The State shall develop and implement structured programming from the end of the school day until youth go to bed, and on weekends. For youth housed in closed-cell environments, programming shall be designed to ensure that youth are not confined in locked cells except: a) from after programming to wake up; b) as necessary where youth pose an immediate risk of harm to self or others; c) following an adequate disciplinary hearing, pursuant to an appropriate disciplinary sanctions. The programming shall be designed to modify behaviors, provide rehabilitation to the types of youth committed at the facility, address general health and mental health needs, and be coordinated with the youth's individual behavioral and treatment plans. The State shall use teachers, school administrators, correctional officers, caseworkers, school counselors, cottage staff, and any other qualified assistance to develop and implement structured programming. The State shall provide youth with access to programming activities that are required for parole eligibility.	
Compliance Rating	Non-compliance
Self Assessment	*Structured Programming* The facility's Youth Activity Tracking System (YATS) is now operational and is used to track youth participation in the variety of programs available to them. These include recreation, religious programming, programs delivered by volunteers and those facilitated by direct care staff. Data from the YATS's first month of implementation (September 2011) were not particularly promising. A one-weekday snapshot showed that youth were involved in an average of only 1.2 hours of structured programming that day. A one-weekend-day snapshot showed that youth were involved in an average of only 1.5 hours of structured programming that day. Further investigation into these trends revealed problems with data collection (Unit Managers were not completing youth sign-in sheets, collecting them or delivering them for data entry). Two interventions were designed to target this problem: 1) using a student clerk to prepare attendance sheets for each day's activities and to ensure they are collected and submitted; and 2) requiring youth to sign the attendance sheets before the activity begins, rather than after. These measures should improve the quality of the data so that in subsequent months, the extent to which staff are actually providing access and delivering programs as required can be discerned. *SBBMS* With Scioto's conversion to a long-term program, staff are now required to deliver the fully-loaded SBBMS rather than the SBBMS-lite program that operated in the reception units. Since the long-term

	population arrived at Scioto, the Grievance Officer has received a significant number of informal complaints and formal grievances indicating that some staff have not properly implemented the fully-loaded SBBMS. Youth complained that staff did not provide access to earned incentives, reported that commissary orders were not delivered, and were confused about Phase Freeze. Staff errors may be training-related—approximately 65 direct care staff have not yet completed training on the fully-loaded SBBMS used in the long-term program. Facility administrators continue to oversee the program's implementation carefully, through the monthly meetings in which staff practices around the use of Character Coupons and other features of the system are tracked. The SBBMS has a solid program design; in the past, when properly implemented, the SBBMS was compelling to youth and contributed to the effective management of aggressive behavior.
Steps Taken to Assess Compliance	The YATS data reported in the State's self-assessment mirror the youth's comments about the programming available to them. Youth reported excessive idle time in the afternoons and particularly on the weekends. Many youth at Scioto have graduated from high school or have obtained their GED. These students complained that there were too few work assignments and post-secondary options available to them and that they spent the majority of the weekdays on the units with nothing to occupy their time. Education staff reported that the Career-Based Intervention program has identified approximately 60 jobs on campus, but has yet to be implemented. Once implemented, the State will need to devise additional self-assessment mechanisms to capture these data. Technical assistance toward this end is available upon request. At one time, the facility had achieved notable success in requiring direct care staff to provide structured programming during non-school hours, but it appears staff compliance with the unit schedules has waned. These programs served an essential role in reducing youth idle time, developing rapport between staff and youth, and building the skills necessary for effective youth rehabilitation. The lack of programming is caused by staff shortages of two types. The shortages of direct care staff noted in III.A.3, above, have caused multiple institution-wide lockdowns over the past several months. Not only do these shortages result in an increased reliance on isolation to ensure the safety of the youth, but they also deny these same youth access to the education, treatment and recreational programming to which they are legally entitled. In addition, 9 of the facility's 18 social worker positions are unfilled (7 are vacant, 2 are on FMLA) which compromises the ability to run CBT groups and other

	treatment programs. The language of this provision also addresses programming for youth in closed-cell environments to ensure they are not confined to their cells unnecessarily and that they have access to rehabilitative services that meet their needs. The facility now operates the PROGRESS unit, which is a closed-cell program. Concerns about the amount of time these youth spend in their rooms due to staff shortages and "Phase Freeze" were discussed in III.A.3, Seclusion. The PROGRESS unit is newly implemented and additional program planning is needed to address the following problems: • Orientation is relatively unstructured and often does not occur until several days after the youth has been assigned to the unit; • Treatment plans lack specific goals with discrete behavioral objectives and a specific timeline for movement to the next phase; • Treatment Teams do not appear to assess youth's progress toward these goals systematically nor facilitate youth movement to a less restrictive environment in a consistent manner; • Contact standards for individual sessions with social workers and mental health staff have not been clearly articulated; and • Performance measures to determine program effectiveness have not been established. Fully developing and implementing the PROGRESS program design is required to meet the requirements of this provision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Provide structured programming to general population youth during non-school hours and on weekends to minimize the amount of idle time. 2. Ensure all direct care staff are trained and properly implement the SBBMS. Continue to utilize the grievance system and monthly administrative meetings to identify emerging problems with the SBBMS. 3. Develop structured activities for youth who have graduated from high school or obtained their GED so that they are engaged in meaningful activities throughout the day. 4. Address direct care staff and social worker shortages to ensure that all youth have access to structured activities and rehabilitative programming throughout the day. 5. Fully develop the PROGRESS unit's program features (e.g., treatment plans, treatment teams, individual sessions, etc.) to ensure youth have maximal access to structured

	programming, given their legitimate safety concerns.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.1, prepared at my request • Interviews with n=20 general population youth conducted by the DOJ attorney in late October 2011; interviews with n=29 youth on PROGRESS units conducted by the Monitor and DOJ attorney in October 2011 • SOP 303.01.07 "PROGRESS Unit", draft dated 10/20/11 • Draft "PROGRESS Unit Handbook" and "Transition Unit Manual", received October 26, 2011 • "Unit PROGRESS and Transition Training," PowerPoint presentation slides, received October 26, 2011

III.F.2 Orientation. a) Admissions Intake and Orientation. The State shall develop and implement policies, procedures and practices to establish a consistent, orderly admissions intake system, conducive to gathering necessary information about youth, disseminating information to staff providing services and care for youth, and maintaining youth safety. The orientation shall also clearly set forth the rules youth must follow at the facility, explain how to access medical and mental health care and the grievance system, and provide other information pertinent to the youth's participation in facility programs. b) Notice to Youth of Facility Rules and Incentives/Consequences for Compliance. The State shall explain the structured programming to all youth during an orientation session that shall set forth the facility rules, the positive incentives for compliance and good behavior and the sanctions for rule violations. The State shall provide the facility rules in writing. c) Introductory Handbook, Orientation and Reporting Abuse. Each youth entering the facilities shall be given an orientation that shall include simple directions for reporting abuse and assuring youth of his/her right to be protected from retaliation for reporting allegations of abuse.	
Compliance Rating	Partial Compliance
Self Assessment	During the current monitoring period, the DYS changed from a centralized reception process at Scioto to a decentralized intake process at each facility. The intake process at Scioto is now only 4-days long. The facility continues to audit a random 10% sample of admissions files every month to ensure compliance with policy and procedure. Each month, February through September, 100% of the youth sampled received a complete orientation to the facility which included, among other things: • Youth Handbook • Orientation Video • Facility rules and consequences (IRAV) • Strength Based Behavior Management System (SBBMS) • Obtaining legal assistance • Accessing medical and mental health care • Sexual abuse and sexual assault information • Grievance system
Steps Taken to Assess Compliance	*Religious Accommodations* Given the audit results above, the Orientation program for youth in the general population at Scioto nearly meets the requirements of this provision. However, this provision also requires the State to provide youth with "information pertinent to the youth's participation in facility programs," which includes participation in religious programming. As discussed in DOJ's compliance letter issued

	at the end of the term for the original Stipulation, the facility's Youth Handbook still needs to be adapted to describe the youth's rights related to practicing their religion of choice, in particular, how they may seek accommodations for religious beliefs, practices or observance as described in SOP #507.02.06. A draft of the revised Handbook was reviewed while on site in October 2011 and suggestions for stating the youth's rights more clearly were offered at the time. Just prior to the final report being issued, the State reported that the Youth Handbook had been revised to include better information on the youth's right to practice their religion of choice. The Handbook now informs youth that they have a right to the resources to practice their religion of choice providing it does not interfered with the safety and security of the institution. The revised Handbook was put into use on January 12, 2012. Although this revision was not put into practice during the Monitoring period, as long as youth's religious beliefs are adequately accommodated, the State will remain in substantial compliance. Note that the State must seek alternative ways for the youth to practice his/her religion, even when a legitimate safety concerns exists. *PROGRESS Unit Orientation* While most of the youth at Scioto undergo an Orientation to the general Scioto population, youth can also be admitted directly to the PROGRESS Unit, and thus the Orientation for that program is relevant to this provision. Draft SOP 303.01.07 "Progress Unit" requires the Unit Manager to ensure that the PROGRESS Youth Handbook is available to all youth and that a staff member provides a thorough orientation to youth upon their admission to the Unit. Youth must sign the Handbook's signature page to acknowledge receipt of the information. The most recent version of the Handbook is dated January 10, 2012 and remains in draft form. It includes information on the Unit's rules and expectations; phases, treatment planning and treatment team meetings; programs (education, mental health, recreation, religion); telephone use, mail and visitation; grievance procedures; and access to legal services. The signature pages for the youth admitted to the Progress Unit were requested for review. A total of 51 youth were admitted between September 1, 2011 and January 7, 2010. Of these, no documentation was provided for 13 youth (25%). Among the remaining youth, nearly all received the Orientation between 1 and 4 months AFTER their admission to the Unit. A timely orientation to the unit is essential to ensure that youth are aware of the Unit's rules and the consequences for breaking them, understand how to progress to the transition phase and back to the general population, and how to access services

	while on the Unit. The lack of a timely, structured orientation to the Unit likely contributed to the frustration that many youth expressed about their placement and their lack of progress moving through the Unit's phases.
Recommendations	In order to achieve substantial compliance with this provision, the State must: 1. Finalize SOP 303.01.07 and the PROGRESS Unit Student Handbook. 2. Provide a comprehensive and timely Orientation to all youth admitted to the Progress Unit to ensure that youth understand the rules, expectations and how to access services.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.2, prepared at my request • Intake Audit Report, February through September, 2011 • Scioto Youth Handbook, dated January 10, 2012 • Draft SOP 303.01.07 "Progress Unit," dated October 20, 2010 • Draft PROGRESS Unit Youth Handbook, dated January 10, 2012 • Orientation records for youth admitted to the PROGRESS Unit between September 1, 2010 and January 7, 2012.

MENTAL HEALTH SERVICES

III.B. 1 Mental Health Screening. The State shall implement policies, procedures and practices to ensure that all youth admitted to the facilities are comprehensively screened for mental disorders, including substance abuse, depression, and serious mental illness, within twenty-four hours of admission. This screening shall be performed by qualified personnel, as part of the intake process, consistent with generally accepted professional standards of care.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the SJCF self-assessment, the facility continued to function as the intake facility for all youth admitted to ODYS. According to the self-assessment, "the recently developed policy and procedure 'Behavioral Health Assessment, Screening, Appraisal and Evaluation' has been implemented and quality assurance monitoring and clinical supervision is being documented in the format provided in policy." Per the documents reviewed, it was evident that there was a process in place to screen youth admitted to the facility for mental health and substance abuse disorders. Ten recent intake packets were reviewed; six of these youth were identified as needing mental health follow-up. In reviewing policy 404.01: "Behavioral Health Services," it stated "all youth committed to ODYS shall receive a Behavioral Health screening within one hour of admission into reception, in accordance with ODYS Policy 403.10…The screening shall identify risk/need areas and assist in the classification and future case planning processes, in accordance with ODYS Policy 404.01.01…" In reviewing the admission date and administration of the Reception Assessment Summary, which includes the initial mental health screening, nine of the ten youth appear to have been screened within 24 hours of arrival at the facility. With regard to the nursing intake screening/assessment, all youth records provided for review revealed that this assessment was performed on the date of admission. It was not possible to determine if this was performed within one hour of admission, as although the time the instrument was administered was documented on the form, data regarding the time the youth entered the facility was not included in the documentation. Most of the assessment packets provided included the ODYS Behavioral Health Appraisal. The timing of the administration of this

	tool varied from one day after admission to two weeks after admission. This tool provided a detailed exploration of symptoms that youth could be experiencing. It was reported during the previous monitoring tour that this document would provide information required for improved case conceptualization and diagnostic clarifications with recommendations for treatment. However, it was unclear at this time how this tool is utilized to formulate diagnoses and case conceptualizations. Again, the clinical summaries were minimal and did not identify specific diagnostic criteria. Additionally, the use of this document as a means to identifying recommendations appears basic. The identification of mental health symptoms and case conceptualizations are further discussed in provision 4 below.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Full implementation of policy and procedure "Behavioral Health Assessment, Screening, Appraisal and Evaluation." Given the change in facility mission, review and revise this policy as necessary. 2. Begin quality assurance monitoring or clinical supervision regarding the reception assessment summary documents. 3. Begin quality assurance monitoring to ensure that timelines required by policy and procedure are adhered to.
Sources of Information	• Review of provided documents • Staff interview

III.B.2 Immediate Referral. If the mental health screen identifies an issue that places the youth's safety at immediate risk, the youth shall be immediately referred to a qualified mental health professional for assessment, treatment and any other appropriate action, such as transfer to another, more appropriate setting. The State shall ensure that, absent extraordinary circumstances, qualified mental health professionals are available for consultation within 12 hours of such referrals.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self-assessment, several changes were implemented in order "to ensure that qualified staff are available for consultation within 24 hours of an emergent need." This included extended work hours for social work and psychology staff, placement of psychology offices on the living units, and installation of secure boxes on each unit. Per the self-assessment, mental health staff were scheduled to be at the facility until 8pm on weeknights and from 8am to 4:30pm on weekends. This was echoed by the review of staff schedules provided via the document request. The self-assessment admitted that historically, the documentation of response times to requests for services was not a priority. "In addition to the new formal process for requesting services represented by the secure boxes on units, we have begun to include not only the time of the visits in case notes, but also the time a verbal request was made." Please see the discussion documented regarding provision 9 below for further information regarding this topic. Given that facility administrative and behavioral health staff as well as DYS administrative staff verbalized the need to revise behavioral health policy and procedure, this process must be formalized in policy and procedure. Following the development and implementation of policy and procedure to guide this process, data regarding the time interval between identification of an issue that places the youth's safety at risk and when he or she is actually assessed by a mental health professional must be collated and reviewed via a quality assurance process. This provision includes a requirement for staff ability to access transfer of a youth to "another, more appropriate setting." During the last two monitoring tours, youth with exacerbated mental illness requiring intensive mental health treatment were discovered at SJCF. As discussed in provision 16 below, it was concerning that during

	both of these tours, facility mental health staff were unable to access more appropriate placements. During upcoming monitoring tours, this will be a focus of attention.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revise policy and procedure to address the newly instituted process regarding immediate referral to a qualified mental health professional. 2. Collect data regarding the time lapse between referral and actual evaluation or assessment for quality assurance monitoring. 3. Ensure that staff are aware of the process by which a youth may access other appropriate mental health services (e.g. a facility based mental health unit or an inpatient psychiatric facility). This may be accomplished via policy and procedure development, staff training, and staff supervision.
Sources of Information	• Review of provided documents • Observation • Staff interview

III.B.3 Identification of Previously Unidentified Youth. The facilities shall implement policies, procedures and practices consistent with generally accepted professional standards of care to identify and address potential manifestations of mental or behavioral disorder in youth who have not been previously identified as presenting mental health or behavioral needs requiring treatment.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self-assessment, "under our current mission, we are anticipating that this will be a more common occurrence." The self-assessment identified numerous steps that the facility had identified in order to ensure that youth with mental health disorders were identified. These included: "the new Behavioral Health Appraisal…includes an enhanced…MSE [mental status exam]…psychology staff meet on a weekly basis…standard component of…meetings a….discussion of 'red-flag' youth." Per the facility assessment and staff interviews, given the change in facility mission, with more male youth residing at the facility as their primary site, this was opined to become more of an issue. In the past, the facility housed greater numbers of female youth, the majority of who were added to the mental health caseload upon admission. Currently with an increased census of long term male youth, many of whom were not initially identified as requiring mental health services, this was likely to become a significant issue. Per the most recent monitoring tour, there were concerns that facility mental health staff were experiencing difficulty with recognizing and responding to signs and symptoms of serious mental illness. Deficiencies of this type were discussed in the previous monitoring report regarding Youth 060. Youth 060 was experiencing the signs and symptoms of a serious mental illness including but not limited to, experiencing auditory hallucinations, engaging in bizarre behavior, refusing to leave his cell, and refusing to engage in mental health treatment. While staff had identified him as mentally ill, they were having difficulty with the development of a treatment plan, and with making the determination regarding his appropriateness for placement at SJCF. Ultimately, following prompting from the monitor, this youth was transferred from SJCF into a treatment facility. A similar issue occurred during the most recent monitoring tour.

	Youth 040 was reportedly declining to engage in mental health treatment and programming. Upon the request of the monitor, this youth was interviewed by the facility psychiatrist and was noted to exhibit signs and symptoms of psychosis requiring his transfer to another facility so that he could receive mental health treatment. It was concerning that while behavioral health staff had questioned the existence of psychiatric illness; they had not taken steps to ensure that he received a further assessment or necessary treatment. Observation of and interaction with several of the male youth currently housed on the Progress Unit at SJCF raised concerns regarding their mental health needs. The need for comprehensive assessments of these youth is discussed in the ensuing provisions (see the discussion regarding provision 10 below). The goal of this provision was to ensure that youth who may not present with a history of mental illness and who are not identified at the time of initial assessment as being at risk for mental illness or behavioral challenges, are monitored over the course of their incarceration for exacerbations of symptoms and referred for mental health treatment. Administrative staff were aware of the need for ongoing and improved quality assurance to review documentation and the decision-making process regarding youth mental health needs. As discussed in provision 4 below, multiple assessment documents were being generated, however, there were no acceptable case formulations reviewed in the documents that tied all the information obtained together in a coherent package for the reader. This was an area that would be amenable to quality assurance, peer review process and clinical supervision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop quality assurance monitoring regarding re-evaluation of youth who experience an exacerbation of mental health symptoms or behavioral challenges. 2. Ensure the creation of a case conceptualization for each youth. 3. Ensure that direct care staff and behavioral health staff are trained to recognize and respond to signs and symptoms of serious mental illness.
Sources of Information	• Review of provided documents (e.g. Policy and Procedure, draft Policy and Procedure, youth records). • Staff interview

III.B.4 Mental Health Assessment. The State shall implement policies, procedures and practices to ensure that, as part of an overall assessment of the youth's health, risks, strengths and needs, youth who are identified in screening as having possible mental health needs receive timely, comprehensive and accurate assessments by qualified mental health professionals, consistent with generally accepted professional standards of care. Assessments shall be designed and implemented so as to identify youth with mental disorders in need of specific treatment and contribute to a full plan for managing the youth's risk. Assessments shall be updated as additional diagnostic and treatment information becomes available.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the previous monitoring report, policy and procedure entitled "Behavioral Health Assessment, Screening, Appraisal and Evaluation" was scheduled for full implementation 3.1.11. Per interviews with facility administrative and mental health staff as well as DYS administration, there were plans to review and revise current policy and procedure regarding behavioral health. This was necessary not only due to omissions in the previously authored documents, but due to the recent change in mission incurred at SJCF. Per the facility self assessment, "we have implemented all recommendations including…peer review (quarterly)…documentation of clinical supervision…the psychology department meets weekly for group discussion and supervision, and includes a round table discussion of 'red flag' youth, as well as seriously mentally ill youth in the facility." This self-assessment statement was referring to recommendations included in previous monitoring reports. The following information will note the status of the implementation of these recommendations per the monitor's review. Documentation regarding quarterly peer review provided as part of the document request revealed one peer review performed 3.14.11. It was apparent that the treatment provider under review provided copies of the case summary and treatment plan, then presented the information to a panel of peers who then completed rating forms and made commentary regarding the documentation and presentation. A review of the case summary and treatment plan regarding Youth 070 revealed that there was no case conceptualization documented. The document contained a review of the youth's history. There was little documentation regarding specific mental health symptoms that the youth was experiencing

	that qualified for diagnoses including: Major Depressive Disorder with possible Psychosis; Conduct Disorder; Posttraumatic Stress Disorder; Polysubstance Abuse; Rule Out Bipolar Disorder." The list of symptoms, characterized as current behaviors included: "periods of not eating; self isolates; bites wrist/left forearm when upset; gets himself restrained to relieve tension; and noted periods of manic like behavior-can see building up before acts out." This list of symptoms did not indicate that this youth met diagnostic criteria for any of the reported diagnoses. Additionally, following a review of this document, it was unclear what treatment modalities would be beneficial to address the youth's specific risk factors. A review of the integrated treatment plan provided in this case revealed no measurable goals or objectives other than a requirement that the youth attend trauma group twice weekly, and that the youth remain 100% compliant with prescribed medications. Other interventions were vague, for example, "begin to address underlying triggers driving current symptoms and behaviors... I will tell a staff member when I want to hit something." Given the positive results of the review and the positive commentary provided, it was apparent that members of the peer review committee did not appreciate the absence of the case conceptualization, which would have been necessary for the development of the treatment plan. Additionally, the lack of measurable goals and objectives along with targeted quantified interventions in the treatment plan was also an issue. A necessary part of any mental health assessment is the case conceptualization or diagnostic formulation. This information is intended to review specific symptoms experienced by the youth in order to justify a specific diagnosis. In addition, the diagnostic formulation or case conceptualization must integrate relevant factors impacting a youth's development/behavior/mental status, including biological, psychological, social, and cultural perspectives that can be utilized by the clinician to identify specific risk factors or targets for ongoing behavioral and mental health therapies. From this information, an individualized and integrated treatment plan could be derived. A review of ten assessment packets provided as part of the document request revealed that a variety of tools were utilized in the assessment process. These included: Reception Assessment Summary, ODYS Behavioral Health Appraisal, Juvenile Automated Substance Abuse Evaluation and Staffing Form, Nursing Intake Screening/Assessment, MAYSI-2, Reception Risk Assessment

	Interview, and PREA Flier. As stated above there was a lack of utilization of these tools in the development of comprehensive case conceptualizations. It was reported during the monitoring tour that staff have begun to develop case conceptualizations. Provided as part of the document request were ten case conceptualization examples, which served to further demonstrate the need to evaluate and train staff on case conceptualizations. For example: Youth 090 was admitted 8.26.11 and his case conceptualization was completed 9.7.11. There were no diagnostic criteria or clear symptom picture documented. His diagnoses at the time of the report were: History of Bipolar Disorder, history of ADHD, history of Learning Disorder. Youth 210 had been at the facility since at least October 2010 (an exact date was unclear from the assessment) and the case conceptualization was completed on the psychological services summary form on 7.5.11. The writer expanded on this youth's history and summary of services, as well as explaining testing results. However, the diagnostic picture was unclear, despite a long incarceration. Diagnoses at the time of the report were: Mood Disorder, NOS; Schizoaffective Disorder; R/O Bipolar Disorder; Conduct Disorder; and Polysubstance Abuse, by history. Per a review of the 10 reception/assessment summaries provided per the document request, six youth were identified at intake as requiring mental health follow-up. Four of these were diagnosed with Mood Disorder, NOS. The fifth was diagnosed with Depressive Disorder, NOS. The sixth youth reported auditory and visual hallucinations and was also placed on the mental health caseload; however, no mental health diagnosis was given during the intake process. Three of the youth were also diagnosed a disorder in the spectrum of attention deficit hyperactivity disorder. In no case were diagnostic criteria expounded upon, making it difficult to ascertain the reason behind the clinical impressions. It is necessary to identify the specific symptoms a youth identifies, in addition to utilizing collateral information from parents or guardians and treatment providers, in order to develop a comprehensive mental health assessment. As indicated in the previous monitoring report, despite the generation of multiple assessment forms, there was no document to tie all the

	information obtained together in a coherent package for the reader, treatment team, or future treatment provider inclusive of a diagnostic formulation or case conceptualization. This is an area that would be amenable to quality assurance, peer review process and clinical supervision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue and expand quality assurance measures including a peer review process and clinical supervision to ensure the development of a case conceptualization that ties together information gleaned in the assessment process. In order for quality assurance to be meaningful, a subset of case records must be reviewed, one case review does not suffice as quality assurance. 2. Consider individual clinical supervision regarding the assessment process and development of the case formulation. 3. Ensure that behavioral health staff are aware of the necessary components of a quality case formulation. 4. Review and revise policy and procedure to reflect the requirements of this provision and the new facility mission.
Sources of Information	• Review of policy and procedure • Review of youth records • Review of other provided documents • Staff interview

III.B.5 Adequate Mental Health Care and Treatment. The State shall implement policies, procedures and practices to ensure that adequate mental health and substance abuse care and treatment services (including timely emergency services), and adequate rehabilitative services are provided to youth in the facilities by qualified mental health professionals consistent with generally accepted professional standards of care.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self-assessment, the Freedom New Phoenix Cognitive Behavioral Health Program (NFP) was implemented on all units. This program was reportedly a component of the "Ohio Model…a comprehensive program that includes evidence-based concepts of cognitive-behavioral therapy (CBT), motivational enhancement (MET), motivational interviewing (MI), and social learning." Per the facility self-assessment, NFP was implemented "after training all staff including Youth Specialists on how to conduct the Managing Anger and Violence groups. Social Workers were trained on Core A which is the Social Worker component and Social Workers and Psychology staff were trained on the overlay components of the program." Following the training, the self-assessment described coaching by administrative staff as well as the formation of a Cognitive Behavior Therapy Oversight Committee (CBTOC). The reported purpose of coaching was to assist staff with "understanding the curriculum, how to run groups, how to complete documentation, etc." Following the change of mission and focus of the SJCF, personnel changes necessitated by the "pick-a-post" resulted in staff unfamiliar with the CBT processes in place at SJCF. "Pick-a-post" allows direct care staff to choose, according to seniority, where they will work. With this process in place, staff who have not been properly trained in a specific modality (e.g., CBT), can request work on a particular unit in the absence of training. Per the self- assessment, "we then began a QA/QI process to implement a new coaching project for each of the teams so that we could provide technical support and assistance to the teams as they began their new missions. This process is in the beginning stage." In reviewing the Freedom New Phoenix Cognitive Behavioral Health program curriculum, the inclusion of direct care staff is vital to the success of the program. Per the documents provided and the self-assessment, it was reported that youth specialists are being

	integrated into treatment team meetings to further involve them in group process and gather information regarding their observations of youth. Youth specialists facilitate CBT groups on the units. It appeared from the two youth specialist run groups observed during the monitoring tour that additional training, coaching, modeling was required. Basic tenets of effective group facilitation were not utilized, these included environment, review of group rules, direction of group topic, and engagement of the youth. In one group observed, youth were spread about a large room, seated in groups at tables. Youth were not engaged in the group process, rather talking amongst themselves or playing cards. The facilitator did not attempt to engage the youth, but continued to read directly from a prepared document regarding the scheduled group topic for that day. When youth continued to avoid engagement in the group process, another youth specialist, not the group facilitator, began to shout at the youth, threatening, "if you aren't going to participate, you can go to your rooms." As the group progressed, the youth facilitator became understandably frustrated. It was noted by the monitor that the facilitator was attempting to lead the group, but was ill equipped for the task. This was an untenable situation for both the youth specialist and the youth participants. It was pertinent to note that concurrently, mental health staff assigned to this unit was conducting a group. There were two youth in the mental health group and approximately twenty youth in the group facilitated by the youth specialist. This was another factor contributing to the youth specialist's inability to engage the youth. Effective groups should have no more than eight to ten youth participants. A second group facilitated by a youth specialist was observed. This group was comprised of seven female youth. These youth were initially engaged in the group process. There were periods of good interaction between the youth and the facilitator, however, the topics discussed ran the gamut, and the monitor was unclear with regard to the CBT topic being addressed. Maintaining order was a challenge, as in middle of group, three youth stood and walked away from the discussion, while another began to talk loudly with no redirection from the group facilitator. Again, it was opined that the youth specialist was attempting to lead the group, but was ill

	equipped for the task. Both of these examples indicate that additional modeling and coaching are necessary. Also, administration needs to review group structure in order to ensure that appropriate numbers of youth are assigned to a specific group interaction. With regard to treatment provided by mental health staff, two group interactions were observed. One of these groups held on the girls mental health unit was well run. The group leader engaged the six youth participants. Appropriate topics were introduced and supported with toys and other visual aides to ensure that youth "got the message." This was a trauma -focused group, and toward the end, one youth became visibly distressed. The mental health staff appropriately addressed this youth's issues, but other youth became distressed as a result. The unit social worker, unit manger and youth specialists did a good job of ensuring the safety of all youth participating in group and of addressing the distress of all youth participants. A second trauma focused mental health facilitated group was observed on Cedar unit. This group was attended by six youth. Unlike the group observed with the female youth where the unit social worker was in attendance, this group had no other mental health staff in attendance. The mental health facilitator had prepared documents for the youth to read and review. The facilitator attempted to engage the youth; however, these attempts became futile following her disclosure of confidential information that three separate youth had disclosed to her during individual sessions (e.g., statements from the mental health professional such as "you know about that [insert youth name]…you told me about that in therapy.") Following this, youth became frustrated and the facilitator lost credibility. Youth were noted to mumble under their breath, looking at peers across the room, stating audibly, "I didn't say that …she don't know what she is saying." Concerns regarding this inappropriate disclosure of confidential information were discussed with administrative mental health staff during the monitoring tour. Subsequent documentation received from the facility indicated that it was being addressed via supervision. Per the requested documents, sign-in sheets for groups completed during the 90 days prior to the monitoring visit were provided. According to these sign-in sheets, attendance and participation in each group varied. Documentation indicated anywhere from one to

	18 youth in attendance at group sessions. As stated above, the facility must address the issue of too many youth assigned to one group therapy interaction. Additionally, one youth in attendance does not qualify as a group therapeutic interaction. Additionally, per the documentation provided, there were groups cancelled due to mental health staff being unavailable. This issue was further discussed with regard to staffing patterns in the discussion of provision 11. When fully staffed, there must be provisions to provide services in the absence of primary staff. Review of progress notes regarding individual therapy sessions revealed marked variability in the quality of the documentation, the duration of the therapeutic interactions and the frequency of the therapeutic interactions. Some mental health providers were noted to meet frequently with youth for brief periods of time (15 minutes to 30 minutes), where others met less frequently for longer periods (45 minutes). A review of treatment planning documents did not reveal documentation regarding the level of care or frequency of interaction prescribed for each individual youth. Therefore, it was not possible to determine if the frequency noted via record review was appropriate for a particular youth. On a positive note, documentation and observed interaction between occupational therapy staff and youth was superior. Given the above, it was apparent that while some treatment was occurring, improvements to the overall treatment program and documentation of treatment planned and provided will be necessary for the facility to meet the requirements of this provision. In the upcoming monitoring tour, additional information regarding the facilities mental health treatment program will be requested and reviewed. Specific concerns were noted regarding the treatment program for youth housed in the Progress unit. It was concerning that this particular unit relied on room confinement with a paucity of mental health treatment for youth, some whom, were identified as having serious mental health issues. As discussed with the facility administration, facility mental health staff and DYS administration, the programming on this unit must be a priority and will be the focus of future monitoring visits. In the meantime, it is strongly recommended and discussed via this monitoring report that the facility begin to reevaluate all the youth housed in this program with respect to their mental health and intellectual functioning in order to

	determine if they are appropriate for this type of setting.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue the implementation of mental health programming. 2. Ensure that all staff (i.e., direct care staff) have received appropriate training to participate in the required mental health and rehabilitative programming activities on each unit. 3. Improve documentation of group therapeutic interaction. 4. Improve documentation of individual therapeutic interaction. 5. Ensure the provision of evidence based group therapeutic interactions. 6. Increase modeling and coaching for youth specialists responsible for group therapeutic interactions. 7. Determine and ensure that appropriate numbers of youth are assigned to specific group therapy sessions. 8. Continue the integration of treatment provider disciplines in order to achieve an interdisciplinary model. 9. Continue to engage and encourage direct care staff to participate in group modalities and in the overall treatment program for the youth. 10. Ensure available mental health staff to provide scheduled treatment. If a particular mental health staff is unavailable (e.g. on vacation, ill), ensure clinical coverage such that the youth's treatment program is not impeded. 11. Begin quality assurance monitoring regarding the mental health treatment program that addresses both adherence to the required procedural elements but also measures youth outcomes related to the treatment modality (e.g. reduction in SHU referrals, reduction in facility violence). 12. Review the Progress program, and ensure that youth are receiving appropriate mental health treatment via this program. 13. Utilize clinical supervision to address confidentially and other pertinent topics with mental health staff. This supervision must be documented. 14. Reevaluate all youth housed in the Progress unit to determine if they are appropriate for this type of placement given potential mental health disorders or intellectual/developmental disabilities.
Sources of Information	• Review of provided documents (e.g. group schedule, youth records, policy and procedure, description of treatment modalities) • Observation of three group interactions • Youth interview

	• Staff interview

III.B.6 Treatment Planning. The State shall develop and implement policies, procedures and practices so hat treatment service determinations, including ongoing treatment and discharge planning, are consistently made by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated treatment plan.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self assessment, "with the identification that Integrated Treatment Plans needed improved [sic], the Psychology Supervisor and Social Worker Supervisors…had planned to provide case note documentation, as well as Integrated Treatment Planning Training for all of the Behavioral Health Services staff…a meeting to review and critique a sample of ITP's written by SJCF Behavioral Health Staff was held on 9.22.11…training for all Behavioral Health Services staff on ITP development will be scheduled immediately upon implementation of the ITP policy which is expected by the end of 2011." For additional discussion regarding Treatment Planning and IDT meetings, please see the discussion regarding the provisions below (7 and 8).
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review, revise, and implement policy and procedure regarding treatment planning and the IDT process. 2. Address recommendations provided regarding provisions 7 and 8 below.
Sources of Information	• Staff interview • Review of provided documents (e.g. Policy and Procedure, Integrated Treatment Plans)

III.B.7 Treatment Teams. At a minimum, the interdisciplinary treatment team for each youth in need of mental/behavioral health and/or substance abuse treatment should: a) be guided by a trained treatment professional who shall provide clinical oversight and ensure the proper functioning of treatment team meetings; b) consist of a stable core of members, including at least the youth, the social worker, a JCO, one of the youth's teachers, the Unit Manager, and as warranted by the needs of the youth, the treating psychiatrist, the treating psychologist, registered nurse, and, as appropriate, other staff; c) ensure that needed psychiatric evaluations are conducted on a youth before administering psychotropic medications to the youth; d) monitor as appropriate but at least monthly, the efficacy and the side effects of psychotropic medications, including consultation with family medical, counseling and other staff who are familiar with the youth; e) for youth under a psychiatrist's care: ensure the provision of individual counseling and psychotherapy when needed, in coordination with facility psychologists; ensure that all youth referred as possibly in need of psychiatric services are evaluated and treated in a timely manner; and provide adequate documentation of treatment in the facility medical records; f) include to the fullest extent practicable, proactive efforts to obtain the participation of parents or guardians, unless their participation would be inappropriate for some reason (e.g., the child has been removed from the parent's custody), in order to obtain relevant information, understand family goals and concerns, and foster ongoing engagement; g) meet to assess the treatment plan's efficacy at least every 30 days and more often as necessary; and h) document treatment team meetings and planning in the youth's mental health records.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per policy and procedure entitled "Behavioral Health Services", Interdisciplinary Team Meetings are "a structured meeting of the IDT for youth and staff to discuss, at least monthly, progress related to ITP. This meeting can also address problem solving, implementing and evaluating operational functions within each unit of the facility." It was evident via both a review of documents provided and observations conducted during the monitoring visit that IDT meetings were a combination of staff meeting and youth treatment team. Similar announcements were documented in team minutes across units, demonstrating continuity in the delivery of information from the facility administration. Generally, IDT minutes reflected significant time spent in the discussion of "housekeeping" issues such as the unit schedule and youth rules. With the exception of the girls mental health unit (where documentation of IDT addressed youth mental health issues) documented discussions, particularly regarding mental health treatment issues appeared to be minimal. One of the recommendations from the March 2011 report was to

	integrate youth specialists into weekly IDT meetings. The self-assessment reported "a QI process was implemented regarding the integration of direct care staff…there has been an increase in Youth Specialist presence and involvement in all Interdisciplinary Teams." During the observed IDT meeting, two officers were present, indicating an effort to include all disciplines in review and planning of youth treatment. Reportedly due to a paucity of psychiatric resources, the psychiatrist was not a consistent participant in IDT meetings other than the girls mental health unit. This was not acceptable as there were mentally ill youth housed on units other than Davey who required the presence of their treating psychiatrist at their IDT meeting. The monitor noted the focus on security rather than treatment issues during the IDT meeting observed in the Progress Unit (Cedar) as part of the monitoring visit. At this meeting, announcements were made and phases were reviewed. There was no discussion regarding the youth or their specific phases, nor was there discussion regarding what each youth needed to accomplish in order to progress to the next phase of the program. Both youth and staff were unclear regarding movement between specific phases, the ability to freeze phases, and the ability for youth to transition out of the Progress unit (due to concerns regarding space on the identified transition unit). These concerns were addressed with facility and statewide administration. Per the monitor, the facility administration and staff must focus on the Progress unit in order to ensure that not only are appropriate youth assigned to this program, but that the program is implemented correctly. Additional issues identified during this IDT observation were the lack of focus and decision-making regarding mental health issues. Staff spent approximately one hour discussing unit issues, then reviewed each youth briefly prior to the youth entering the IDT. In general, youth were presented in IDT for less than ten minutes. There was one exception, Youth 444. Reportedly, this youth was experiencing difficulties with respect to "self secluding" in his cell, refusing to interact with staff, and refusing treatment with psychotropic medication. Staff met with him for approximately 20 minutes until the unit psychologist signaled to discontinue the conversation with him. During the youth's interaction with the team and following his departure, no clear mental health interventions or goals were identified or planned. This lack of decision-making and formal planning with respect to IDT team meetings was consistent with observations made during the

	previous monitoring period. Per the facility self-assessment, "coaches have been assigned to every IDT…a kick off meeting is scheduled for 11/15/11 to clarify the role of each coach…[to] increase participation in the meeting from all members; work with the team in developing and monitoring measurable goals and objectives related for each youth; conduct on the spot feedback to allow for a more improved process and clarification of goals for each youth; [and] coaches are to attend all meetings whenever possible." Full implementation of the coaching plan may improve communication and treatment planning within the IDT. Unfortunately, the facility had not begun the QA process for IDT meetings. A review of two quality assurance reports dated 9.13.11 (covering months January, February, and March 2011) and 9.14.11(covering months April, May, and June 2011) revealed no QA data for IDT meetings. Per the documentation 9.13.11, "Supervisor attended treatment team on the boys mental health unit, but did not document the reviews for 1st quarter…Supervisor needs to be given more time to conduct IDT reviews and to make sure that he documents the ones that he is able to review…Psychology supervisor does not have time to attend IDT meetings due to his host of other duties." Per the documentation 9.14.11, "Supervisor did not conduct IDT reviews this quarter. The Supervisor should be given time to sit in on these meetings once per month. Current workload does not permit this…Supervisors time is so consumed that he does not have the opportunity to sit in on the IDT meetings."
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure psychiatric resources are available to allow participation in Interdisciplinary Treatment Team meetings. 2. Ensure that direct care staff are included in and valued members of the IDT. 3. Begin Quality Assurance monitoring of treatment planning efforts and IDT meetings. 4. Increase staff training/education regarding the timely formulation of a treatment plan and interventions developed as a result of, among other things, the discussion in IDT. These plans must then be implemented, first via training direct care staff. 5. Review the psychology supervisor duties and schedule to determine the need for additional resources such that this

	staff member can complete the current assigned tasks.
Sources of Information	• Staff Interview • Observation of Interdisciplinary Treatment Team meeting • Review of provided documents • Youth interview

III.B.8 Integrated Treatment Plans. The State shall ensure that each youth in need of mental/behavioral health and/or substance abuse treatment shall have an appropriate, integrated treatment plan, including an appropriate behavior management plan that addresses such needs. The integrated treatment plan shall be driven by individualized risks and needs, be strengths-based (i.e., builds on an individual's current strengths), account for the youth's motivation for engaging in activities contributing to his/her wellness, and be reasonably calculated to lead to improvement in the individual's mental/behavioral health and well being, consistent with generally accepted professional standards of care.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self-assessment, Integrated Treatment Planning (ITP) remains an area in need of improvement. Per the self-assessment, "training for all Behavioral Health Service staff will be scheduled immediately upon implementation of the ITP policy which is expected by the end of 2011." This statement was somewhat confusing, as it was previously understood by the monitor that policy and procedure entitled "Behavioral Health Integrated Treatment Plan" was approved and implemented as of 1.1.11. Discussions with facility and DYS staff during the monitoring tour revealed plans to review and revise multiple policy and procedure documents governing Behavioral Health Services at DYS facilities. As such, given the lack of policy and procedure, the lack of training regarding integrated treatment plans, and document review that revealed no change in the quality of documentation in the intervening period since the prior monitoring tour, the issues outlined in the previous monitoring report remain. For example, most treatment plans were not individualized, did not include measurable goals, and did not give examples of appropriate/desired behaviors or skills the youth should focus on developing. As indicated elsewhere in this monitoring report, this facility was in a state of chaos as a result of massive institutional changes (change of mission, change of facility population, change of programming) and was in dire need of an organized planned approach to Behavioral Health program development and implementation. Training needs aside, this facility required stability with regard to the system and program, a full complement of staff, and a cogent action plan for the future Given the lack of progress with regard to this provision indicated via

	the facility self-assessment and review of the provided documents, information included in the previous monitoring report will be italicized below for review: *"Per the recently implemented policy entitled "Behavioral Health Services" the Integrated Treatment Plan is "a formal strategy developed to address the habilitation, education, rehabilitation, social, mental health and psychiatric needs of a specific youth. The plan is developed by an assigned Clinician or Provider in collaboration with the youth and the Interdisciplinary Team (IDT), and is implemented by both the youth and all Behavioral Health Services staff who work with the youth...Acceptable Integrated Treatment Plans must include measurable goals and objectives, with available targeted interventions to address each goal. Progress notes authored regarding the youth's treatment should refer to the youth's treatment goals and document the response (or lack thereof) to the prescribed interventions…Integrated Treatment Plans should be reviewed at each Interdisciplinary Treatment Team meeting scheduled for the youth, and must be authored and reviewed with the participation of the youth and their parent or guardian (if appropriate)."*
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Finalize and implement policy and procedure regarding Integrated Treatment Plans. 2. Train Behavioral Health Staff regarding development of Integrated Treatment Plans. 3. Ensure that Integrated Treatment Teams utilize the Integrated Treatment Plans as a road map for youth treatment and progress, and that the Integrated Treatment Plans are updated regularly as per policy and procedure pending implementation. 4. Develop quality assurance monitoring tools that are both process (e.g. were the targeted interventions appropriate for a particular youth; were measurable goals and objectives identified; per a review of the youth's progress notes, did treatment provided to the youth follow the outline of the Integrated Treatment Plan) and outcome oriented (e.g. did the youth improve over the course of treatment per the Integrated Treatment Plan).
Sources of Information	• Staff interview • Review of provided documents (e.g. draft policy and procedure) • Review of youth records

III.B.9 Access to a QMHP. The State shall develop and implement policies, procedures and practices to ensure that youth who seek access to a qualified mental health professional are provided appropriate access in a timely manner.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the review of policy and procedure entitled "Mental Health Referral, Evaluation and Disposition," and the associated policy entitled "Referrals to Mental Health Services" performed for the previous monitoring report, these documents outline the process for any facility staff to refer a youth for an assessment to determine the need for mental health services. There are designated time limits for response to requests. Psychology must respond within five working days, psychiatry within ten working days and if the request is for additional evaluation, there is a fourteen working day response window. Per the documents provided and observations made during the most recent monitoring visit, psychology staff offices were located on the housing units, providing access to mental health professionals. Per the documents received regarding this provision, it was noted, "…youth typically ask to be seen directly and face to face, and when their psychology staff is not available, they typically wait until he or she is available." It was further noted that "when a youth…needs to see psychology staff urgently, unit staff will call…all urgent requests are seen within 24 hours…notification of these needs typically is done by phone without the intermediate step of form completion…completion of forms…would be more likely to slow down the process of accessing psychology services." A review of sample documentation regarding psychology response time to urgent mental health requests revealed six examples. Of these, two youth were seen immediately following their request, one was seen 1.5 hours following their request, and one was seen ten minutes following their request. Request times were not documented on the other two examples provided. Per the self-assessment, secure mailboxes have been provided on the units for youth to request services without reliance upon direct care staff to communicate their request. Psychology or social work staff check these boxes daily. Youth interviewed during this monitoring tour were able to show the monitor the box within which to place their requests for services on their individual units. It is imperative that youth are able to independently access mentalhealth

	care; as unfortunately, there may be situations where direct care staff could unintentionally or purposefully impede the youth's access to necessary mental health treatment with resultant negative outcomes. One concern noted and communicated during the monitoring tour was access to mental health services for youth housed on the Progress unit. These youth were assigned to single cells where they remained the majority of the day. Youth on phase one of the program are in ambulatory restraints ("gators") when they are outside of their cells. Youth and psychology staff interviewed revealed that these youth were not assessed by mental health staff on a daily basis, they were reportedly being checked three times weekly. These youth are at high risk for self-injury and for the exacerbation of mental health symptoms. As such, they must be assessed on a daily basis by mental health staff. Following recommendations made by the monitor during the monitoring tour the facility self-assessment revealed that now "Behavioral Health staff assigned to Progress programs will make rounds daily as a check in with all youth. They are required to speak with all youth and follow up where needed." Per a review of mental health staff schedules provided, mental health staff scheduling included both evening (until 8:00 p.m.) and weekend hours, allowing for better daily coverage of youth mental health needs. However, of the mental health staff, only the psychology supervisor was on-call 24 hours per day.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revise policy and procedure to reflect requirements for daily mental health assessments for those youth housed on the Progress unit. 2. Develop quality assurance monitoring to audit requests for mental health services inclusive of staff response time as well as timelines for completion of other mental health services as outlined by facility policy and procedure. 3. Ensure the youth's open access to mental health services
Sources of Information	• Facility self-assessment • Review of provided documents • Youth interviews • Staff interviews

III.B.10 Mental Health Involvement in Housing and Placement Decisions. The State shall develop and implement a system for ensuring that significantly mentally ill youth who do not have the adaptive functioning to manage the activities of daily living within the general population are provided appropriate housing and supports to assist them in managing within the institutional setting.	
Compliance Rating	Non compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the policy and procedure entitled "Mental Health Referral, Evaluation, and Disposition" reviewed for the prior monitoring report, this policy "identifies the process for consideration and referral for mental health treatment, including placement on a mental health unit when determined to be necessary. Youth demonstrating serious mental health issues and/or who are determined to be unable to adequately manage the demands of living in the general population are referred for placement on an alternative living unit." Policy and procedure implemented January 1, 2011 entitled "Behavioral Health-Special Services Living Units" included "guidelines for the referral of youth identified through clinical assessment as needing specialized housing and programming for the stabilization of the symptoms of an identified mental illness and program modifications due to cognitive and/or developmental limitations." This policy guided the creation of the "Behavioral Health Review Panel" whose responsibility it was to "review information obtained in the reception process and determine the best options for each youth in regard to housing, programming…" In the intervening period since the last monitoring visit, the facility has undergone a change in mission. Per a memorandum dated 8.4.11 authored by legal counsel from DYS, "SJCF will serve all security classifications as a permanent facility for both male and female youth. It will include initial intake for youth from all 88 counties with referral and transfer to other sites within 4 days. SJCF will continue to have Central Medical Facility and will now house behaviorally challenged boys on a specialized unit named PROGRESS (Programming for Real Opportunity through Growth, Respect, Education, Safety, and Success) that will include a transition program. The male mental health unit has been transferred to Indian River Juvenile Correctional Facility (IRJCF)…Reception is Condensed to a Four Day Process at SJCF and Continues at the Youth's Parent Facility…Day Twenty-five: Behavioral Health Review Panel meets, Reception Assessment Summary completed…" Per interviews with facility and statewide

	mental health administration, policy and procedure revisions required by the aforementioned change in mission remained pending at the time of the most recent monitoring visit. This is concerning as there has been a significant lapse in time between the change in mission and adjustment of facility policy and procedure to govern processes. Per a review of provided documents, the behavioral review panel at SJCF had met on a weekly basis. The review of the panel's meeting agenda and recommendations was limited by the documents provided. Minutes of the meeting consisted of a listing of youth reviewed that day. Additional documentation was not provided for review. A review of other provided documentation revealed concerns with the outcome of the intake assessment and housing unit assignments. For example, there were six female youth identified per the document request who were initially approved for placement in the general population. These youth, however, ultimately required enhanced services and required referral to the mental health unit. It should be noted that all six of these youth were appropriately assigned to the mental health caseload upon admission. It may be useful to complete retrospective record reviews for these youth to determine if there were any patterns or warning signs that may aid in formulating recommendations for youth in the future. Additional concerns regarding this particular provision include youth identified as appropriate for assignment to the Progress Unit. A review of the youth reviewed by the Behavioral Health Review Panel did not reveal reviews of these youth for appropriateness of placement. During the monitor's most recent monitoring tour, there were concerns brought to the attention of both facility and statewide mental health staff regarding the appropriateness of youth currently assigned to the Progress unit. One youth was determined to be experiencing psychotic symptoms (e.g., mumbling, unable to engage in conversation, staring without blinking for periods as long as 90 seconds, appearing to respond to internal stimuli) requiring treatment in another more appropriate setting. Other youth were identified as having mental health disorders. Given the restrictive nature of this unit and the unique behavioral and mental health challenges of youth assigned to this unit, a thorough evaluation of each youth currently residing on this unit and of youth proposed for placement on this unit must be performed. This process must be completed for all youth considered for

	placement on the Progress unit. For those youth who are deemed appropriate for participation in the Progress unit program, but are not successfully navigating the program, a review of their individualized treatment plan must ensue in order to determine alternative interventions they may require in order for them to succeed.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review and revise policy and procedure to reflect the change in facility mission. 2. Improve documentation promulgated by the Behavioral Review Panel to include rationale for specific placement recommendations. 3. For those youth who require enhanced treatment following the initial placement determination, consider performing retrospective record review (e.g. QA) in order to improve the function of the panel. 4. Perform a thorough evaluation of all youth currently housed or proposed for placement in the Progress unit to determine the appropriateness of their participation in this type of restrictive program. This evaluation must include specific recommendations for other more appropriate settings per the youth's individual needs. 5. For youth housed on the Progress unit who are not progressing through the program, a review of their current status and treatment plan must ensue in order to determine specific individualized treatment or interventions that may assist them with their progress.
Sources of Information	• Staff interview • Review of provided documents • Review of youth records • Youth interview and observation

III.B.11 Staffing. The State shall staff, by contract or otherwise, the facilities with adequate numbers of psychiatrists, psychologists, social workers, and other mental health professionals qualified through training and practical experience to meet the mental health needs of youth residents, as determined by the acuity of those needs. Mental health care shall be integrated with other medical and mental health services and shall comport with generally accepted practices. The State shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to allow youth reasonable access to structured programming.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per staff interviews, the facility self-assessment, and a review of provided documents, it was clear that there continued to be staff shortages at the Scioto facility. Currently, the psychiatrist contract is for 20 hours per week. Please see the discussion in provision 13 for further information regarding psychiatric staffing issues. The self-assessment reported that all psychology positions were filled. Based on the spreadsheet of mental health positions provided, psychology staff was comprised of six psychology assistants, three psychologists, one psychiatric nurse, and one psychology supervisor. Both staff interviews and the self-report indicated that the workload for psychology staff had increased due to vacancies in social work staff positions. Once social work positions are filled, it will be necessary to examine the current psychology staffing pattern to determine the need for additional staff. In order to accomplish this, the facility administration and mental health leadership should consider the development of workload indicators to objectively determine the need for additional staff. These indicators must be based on the mental health treatment program planned for this facility. Unfortunately, to assess this at the present time would be a wasted effort, as this facility was in a state of flux, with little direction or course with regard to the mental health programming. The only exception to this criticism was programming currently provided on the female mental health unit. As stated above, deficiencies in social work staffing continued in the intervening period since the last monitoring report. In fact, the self-assessment and spreadsheet of mental health positions reported seven current vacancies. These positions have been vacant since: 5.9.10, 9.25.10, 10.25.10, 4.15.11, 7.30.11, and 7.31.11 (two). Three positions have been vacant for over a year. It was reported that more recently, six licensed social workers have been hired; however,

	they had not begun work at the facility at the time of this monitoring tour, as all were required to attend pre-service training. Per staff interviews and documentation provided regarding support staff for psychiatry, the psychiatric nurse was carrying a large workload. According to the documents reviewed, the nurse provided the following support services to psychiatry: scheduling new and follow-up appointments; preparing medical records for review; providing dictated reports for review; updating the mental health database; attending team meetings and providing updates to the psychiatrist when he was unavailable to attend; responding to staff concerns and preparing assessment information for psychiatry; assisting with the notification of parents/guardians of any changes in the youth's mental health status or treatment; providing updates, changes, and concerns regarding youth to psychiatry; assisting in education of youth regarding mental health issues; monitoring, counseling, and reporting regarding medication compliance; and communicating day to day issues regarding psychiatric care to the health services administrator. This list of tasks was daunting, and physically impossible for one individual to complete, although the individual currently in this position was doing her best to manage the workload and did not complain. During the previous monitoring tour, there were two mental health nurse positions at the facility. It was explained to the monitor that due to budgetary issues, and the transition of the male mental health unit to another DYS facility, that this position was eliminated. It was evident, however, that the nursing duties had not only expanded, but the number of youth requiring mental health treatment and treated with psychotropic medication at the facility had doubled in the intervening period since the last monitoring tour. As such, the need for additional staff coverage in this area was obvious. There were several examples in the provided documentation of the compromise of clinical services as a result of inadequate mental health staff. There were multiple documents indicating that CBT group was cancelled when the social worker responsible was on leave or otherwise detained. Additionally, in the quality assurance documents provided, other staffing deficiencies were identified. A staff member was placed on a performance improvement plan due to failure to document individual counseling sessions. Per the quality assurance chart review, "the clinician explained to the supervisor that she was spending too much time out of the facility doing CBT

	training/coaching at other sites. The clinician was pulled out of the CBT training/coaching so that she could provide services to the youth on her caseload." It is necessary to have sufficient coverage in order for staff to complete training and continue to provide adequate services. This topic was reviewed in detail in the discussion regarding provisions 14 and 15 below.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Recruit and fill current vacancies 2. Determine the need for additional staff via workload indicators 3. Improve coordination between staff disciplines. 4. Ensure coverage for staff during required trainings and other absences. 5. Review the mental health nurse position and consider additional staff. 6. Per the discussion included in provision 13 below, address the need for additional psychiatric clinical resources at the facility.
Sources of Information	• Staff interview • Review of provided documents

III.B.12 Medication Notice. Before renewing a psychoactive medication prescription from a community provider or commencing the administration of a psychoactive medication to a youth, the State shall ensure that the youth and to the fullest extent practicable and appropriate, his or her parent or caregiver, are provided with information regarding the goals, risks, benefits and the potential side effects of the medication and given an explanation of the potential consequences of not treating with the medication, and that the youth has an opportunity to consent to such medication. A) Involuntary administration of psychotropic medications to juveniles shall comply with applicable federal and state laws and regulations. The DYS clinical director, in consultation with the DYS medical director, shall review and request with DYS Legal Services prior to the approval for involuntary administration.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the draft policy and procedure reviewed for this monitoring report entitled "Psychotropic Medication, Use and Management" education including "addressing the goals, risks, benefits, and potential side effects associated with any given medication is given to each youth and his or her parent or guardian… the prescribing physician provides an explanation of the potential consequences of not taking the medication and explains that the youth has an opportunity a consent or withhold consent to be treated…provides guidelines within which medical professionals may petition the court to authorize involuntary administration of psychotropic medication." During the previous monitoring visit, it was identified that the psychiatric practitioner was not performing appropriate informed consent. In reviewing the 15 medical charts provided as part of the documentation request, it was noted that informed consent documentation was not included. As stated in provision 13 below, it was considered that perhaps documentation did exist, however, it was not included in the part of the medical record copied for off site review. Ten examples of informed consent documentation were provided via the document request. These examples included a form entitled "Information about and consent for medications for youth with mental health diagnoses." These forms, competed by the youth, outlined what information the youth retained following their discussion with the psychiatrist regarding the prescribed medication. The form also allows for documentation by the psychiatrist of attempts to or successful contact with the youth's parent or guardian in order to review potential psychotropic medications and obtain parental consent. Additional information (i.e. medication

	information sheets) should be provided to the youth and their parents for their review such that full disclosure of potential medication side effects is provided. Interviews with youth at the facility revealed that in general, youth were able to name their prescribed medication. Youth also had some knowledge regarding the potential side effects associated with their prescribed medication. This indicated that informed consent practices were occurring with respect to treatment with psychotropic medications. Per the document request, there were no court petitions for involuntary administration of psychotropic medications in the 90 days prior to this monitoring visit.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue documentation regarding informed consent that is consistent with generally accepted practices and facility policy and procedure. 2. Finalize policy and procedure regarding informed consent. 3. Consider a peer review or quality assurance process for informed consent and other psychiatric documentation. 4. Consider the development of or use of commercially available information regarding side effects of psychotropic medication that is written such that an individual unfamiliar with medical jargon would understand the information. This information should be provided to the youth and sent via mail to their parent or guardian.
Sources of Information	• Youth record review • Review of provided documents • Youth interview • Staff interview

III.B.13 Mental Health Medications. The State shall develop and implement policies, procedures and practices to ensure that psychoactive medications are prescribed, distributed and monitored properly and safely, and consistent with generally accepted practices. The State shall provide regular training to all health and mental health staff on current issues in psychopharmacological treatment, including information necessary to monitor for side effects and efficacy. The State shall issue and implement policies and procedures for the administration of appropriate tests (including, for example, blood tests, EKGs, and Abnormal Involuntary Movement Scale tests) to monitor the efficacy and any side effects of psychoactive medications in accordance with generally accepted professional standards. The State shall also: a) share medication compliance data with the psychiatrist and document the sharing of this information; b) not withhold the provision of psychostimulants to youth when such treatment is clinically warranted.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Currently, Policy 403.18.03, entitled "Psychotropic Medication, Use and Management Of," dated as being in effect 7/1/02; remains in the pending policy/draft section. Per staff interviews performed during the most recent monitoring tour, there were plans to review and revise the facility behavioral health policies. This should include a review and finalization of the policy and procedure regarding psychiatric treatment. From the records provided, it was determined via a review of the "Youth on MH Caseload with Recent Meds and Chronic Conditions" that 74 youth were prescribed medication by the psychiatrist. This was an increase over the previous monitoring period where 33 youth were prescribed psychotropic medication. As such, despite greater than 100% increase in the number of youth requiring psychiatric services at the facility, there has, of yet, been no increase in psychiatric clinical resources. It was recognized, however, that there might be inaccuracies in the "Youth on the MH Caseload with Recent Meds and Chronic Conditions" provided via the document request. This made it difficult to ascertain the exact make up of the psychiatric caseload at this time. For example, 63 youth entries included in this document had no information of why they were included. The pages below their names were essentially blank forms. Additionally, there were multiple youth included in that list who were discharged (these youth were not included in the calculations above). Medication orders do not appear to be updated consistently in the system tracking, as many prescriptions appeared outdated. The written

	report of medication adjustments did not consistently match the medication log. This was an area in need of improvement. Maintenance of a regularly updated listing of all youth assigned to the mental health caseload along with their most recent evaluation dates and prescribed psychotropic medication would be useful to all treatment providers. Per staff interview and document review, there had recently been difficulties with regard to psychiatric availability. Due to circumstances beyond his control, the current psychiatrist required time away from the facility and a temporary reduction in his clinical availability. Given current contracts and the paucity of available psychiatric treatment providers, there was no clinician available to cover for him in his absence. While per interview and review of the self-assessment it was stated that a psychiatrist from another DYS facility was available to cover psychiatric clinic, there was no documentation that another psychiatrist ever performed clinical consultation at Scioto. As a result of this, psychiatric treatment of some youth was delayed. According to the documentation reviewed via the "Youth on MH Caseload with Recent Meds and Chronic Conditions," there were six youth referred for initial psychiatric evaluations who were not evaluated for over three weeks after referral for an initial evaluation. Four out of these six youth were referred in the month of September 2011. Per review of the draft policy and procedure noted above, youth referred for psychiatric evaluation that entered the facility with prescribed medication must be evaluated within two weeks of referral. There was no timeline indicated in policy and procedure within which the psychiatrist must complete a routine evaluation. There were 33 youth treated with psychotropic medications that were not assessed by the psychiatrist during the month of September 2011. Generally accepted practices and draft facility policy and procedure require that youth treated with psychotropic medications are assessed by the psychiatrist a minimum of monthly. This was an untenable situation for the current treating psychiatrist, as he has no reliable back up coverage should he require time away from the facility. Per staff interview, DYS has recently recruited and hired an administrative psychiatrist who will be addressing clinical coverage requirements. Once coverage needs are addressed, the facility will still require additional clinical resources, as the current contract for 20 hours of

	psychiatric time per week was inadequate to provide clinical services, participate in treatment team meetings, for response to crisis situations, for provision of on-call/after hours consultations; and for the psychiatrist to function as an integral member of the treatment team. As such, the facility must investigate other avenues in order to address the paucity of psychiatric clinical services. These could include telemedicine; developing an association with a residency training program where residents or fellows (with appropriate clinical supervision) could provide services; or if they remain unable to recruit a child and adolescent psychiatrist, contracting with an adult psychiatrist to provide services. In the latter case, the adult psychiatrist could appropriately evaluate and treat youth aged sixteen years and older. For younger youth, clinical supervision for a treating adult psychiatrist with a child and adolescent psychiatrist could be considered. Per the document request, 15 youth medical charts were provided for review. Of these, 13 youth were prescribed psychotropic medication. Review of the records did not reveal appropriate laboratory examinations for treatment with specific medications. For example: Youth 020 was prescribed psychotropic medication including the antipsychotic medication Geodon and the mood stabilizing medication Depakote. A review of this youth's medical record revealed no mention of assessment for abnormal involuntary movements. Additionally, while a Depakote level was obtained, other ancillary laboratory examinations (e.g. complete blood count and liver functions) were not ordered or discussed in the progress notes. Youth 010 was prescribed psychotropic medication including the antipsychotic medication Abilify, the mood stabilizing medication Depakote and the anticholinergic medication Cogentin. A review of this youth's medical record did not reveal requests for laboratory examinations, nor did it reveal abnormal involuntary movement monitoring. Youth 050 was prescribed psychotropic medication including the antipsychotic medication Abilify, the mood stabilizing medication Depakote, the stimulant medication Concerta, and the antihypertensive medication Tenex. A review of this youth's medical record did not reveal laboratory examinations, abnormal involuntary movement monitoring, or vital sign monitoring.

	It should be noted that the above medical record reviews were performed off site, with documentation provided by the facility. It was recognized that the required laboratory or monitoring items may be in the youth's total medical record, however, they were not provided for off site review. This is important to note, as there were examples of medical records that did evidence appropriate laboratory monitoring (four out of 13 records reviewed). Observations of the facility psychiatrist with youth in clinic revealed that he was knowledgeable, caring, and invested in the mental health treatment of the youth. Documentation regarding the youth's history of mental health issues, diagnoses, and psychiatric treatment plans varied with regard to detail. It was apparent that there were not enough clinical resources allocated for the physician to perform his duties adequately.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Update policy and procedure regarding behavioral health to include timelines for psychiatric services. 2. Investigate other avenues to increase psychiatry clinical resources at the facility (e.g. telemedicine, association with academic institutions, use of residents or fellows with appropriate supervision). 3. In order to determine the appropriate number of full time equivalent psychiatric clinicians required by the facility, consider workload indicators inclusive of all clinical responsibilities required of the physician (e.g. clinic, documentation, treatment team meetings, crisis response). 4. Ensure clinical coverage for the current psychiatric treatment provider. 5. Update and maintain the document regarding the current mental health caseload. 6. Ensure that youth are receiving proper laboratory examinations and side effect monitoring commensurate with the psychotropic medication they are prescribed.
Sources of Information	• Staff interview • Clinic observation • Treatment Team observation • Youth record review

	• Review of provided documents • Youth interview

III.B.14 Mental Health and Developmental Disability Training for Direct Care Staff. The State shall develop and implement strategies for providing direct care and other appropriate staff with training on mental health and developmental disabilities sufficient for staff to understand the behaviors and needs of youth residents in order to supervise them appropriately.	
Compliance Rating	Non compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the facility self-assessment, staff interviews performed during the most recent monitoring tour, and the review of provided documents (outlined in the discussion regarding provision 15 below), specific training regarding mental health and developmental disabilities as required by this provision has not begun. Facility staff reported, "we have not done this yet…we have had so many other trainings…do a lot of training." Per the facility self-assessment, "due to the many training demands over the past six months, additional mental health training have not been developed or offered to direct care staff." As stated in the previous report, the goal of this provision paragraph is to provide training to facility staff such that they have a working knowledge of the youth's challenges (both from a mental health and developmental perspective) and to provide them with strategies to assist in their daily supervisory tasks with the youth. Training for direct care staff is important as in the correctional setting; they function as the de facto parents of the youth in their care. As direct care staff are an integral part of the youth's treatment team, they should be aware that due to specific mental health diagnoses, youth may have special needs (i.e. a youth diagnosed with ADHD may not respond to you the first or even second time that you call his name because he is distracted by extraneous stimuli). They should also be aware of which youth are being treated with psychotropic medication and have a basic knowledge of the potential side effects of the medication so that they can monitor the youth in their care. As discussed in detail in provision 15 below, there is a need for an organized response to facility training needs.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop an organized training schedule and training curriculum for facility staff that addresses the requirements of this provision and addresses the facility mental health programming initiatives.

	2. This training must be based on facility policy and procedure that given the facility mission change must be revised. 3. Continue to track staff compliance with training requirements.
Sources of Information	• Review of provided documents • Staff interview

III.B.15 Staff Mental Health Training. The facilities shall train: a) all staff who directly interact with youth (e.g., JCOs , social workers, teachers, etc.) on: (i) basic mental health information (e.g., diagnosis, specific problematic behaviors, psychiatric medication, additional areas of concern) and recognition of signs and symptoms evidencing a response to trauma; and (ii) teenage development, strength-based treatment strategies, suicide, and for staff who work with female youth, female development; b) clinical staff on the prevalence, signs and symptoms of Post Traumatic Stress Disorder and other disorders associated with trauma.	
Compliance Rating	Non compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	Per the SJCF Self-Assessment dated 11/7/11, there are further steps that need to be taken to ensure appropriate training is being provided to all staff providing direct care. The self-assessment indicated, "due to the many training demands over the past six months additional mental health trainings have not been developed." It also reported a plan for the Central Office of Behavioral Health to develop an "organized, mandatory training schedule." The development of an organized, mandatory training schedule was a recommendation from the previous monitoring visit. Given the issues noted during this monitoring tour, it is absolutely necessary to develop and implement a training schedule for all staff providing care for youth with regard to mental health issues. This training must also address staff recognition of and response to the signs and symptoms of a serious mental illness in evolution. Staff challenges with this particular task were noted in both the most recent and prior monitoring visit. The training schedule must be reasonable and address specific topics to ensure that staff are able to implement the facility mental health program. It was concerning that in the intervening period since the last monitoring visit, while multiple training sessions were conducted, staff were reportedly required to attend so many trainings that they were unable to perform their basic job duties. While training is important, the facility must be able to maintain sufficient staff onsite to ensure that treatment and security services are available. Another recommendation from the previous monitoring visit was to create a spreadsheet that delineates staff attendance and completion of required training modules. This spreadsheet was

	submitted with the documents requested. There were 297 staff identified from various disciplines. The trainings identified for 2011 were: 1. Meal Refusal Policy (1 hour); 2. MYR 1st Quarter (4 hours); 3. PSB Review (1 hour); 4. MIS Test Out (.5 hour); 5. Safety and Security Policy Test Out (.5 hour); 6. MYR 2nd Quarter (4 hours); 7. Child Abuse and Neglect (.5 hour); 8. Youth Grievance (.5 hour); 9. Emergency Response (1 hour); 10. Blood Borne Pathogens (.5 hour); 11. Ethics (.5 hour); 12. PREA (.5 hour); 13. General Work Rules (.5 hour); 14. Equal Employment Opportunity (.5 hour). It was unclear which, if any, of these trainings were considered to be mental health related, as curriculum for the individual training programs was not included in the documents received, however, per the facesheet attached to this document request, these were "mandated trainings" for active staff. Per the provided spreadsheet, attendance at the required trainings varied from 88.77% to 89.98% of required attendees. This demonstrates that further work needs to be done in order to ensure all staff are being trained appropriately, while ensuring available staff for job duties as noted above. Additionally, the 2010 training spreadsheet was provided in the document review. The trainings for 2010 were: 1. Medical Risks with Restraint Use (1 hour); 2. Strengths Based Behavior Management System (2 or 24 hours); 3. Emergency Response Training (2.5 hours); 4. Verbal Strategies (2 hours); 5. Mental Health Training (2 hours); and 6. Behavioral Health Policies (2 or 8 hours). For 5 of the 6 trainings, the completion rate was between 89.51% and 97.9%. However, Behavioral Health Policies had a 63.64% completion rate. This may explain some of the facility challenges with respect to implementation of behavioral health interventions. As there was no curriculum provided, it was not possible to explore the appropriateness of these trainings based on their content. Additionally, it was unclear whether these trainings were completed one time or whether these were annual trainings focused on the review and improvement of skills related to behavioral health interventions. Per the documents provided, "since February 2011 SJCF Staff have participated in three (3) different trainings, preparing them to implement and oversee the New Freedom Phoenix Program." It was reported during the monitoring visit and in the documentation provided for review that 174 staff members attended a three-day training that included an overview of the New Freedom Phoenix Program. One of the stated goals of this training, "to provide Youth Specialists and Social Workers with facilitation skill training." However, the groups observed during the monitoring visit indicated

	that further training and supervision was needed. According to the self-assessment, additional mental health training was provided including: CBT training; sex offender training; Gang curriculum, training the trainer; SBBMS training, IDT training; Progress/transition training; site specific training regarding youth transferred into the facility from ORV and Circleville; Behavior Management training for Progress and Transition teams; and Behavioral Analysis training. Information regarding training attendance or curriculum for these trainings was not included in the documents available for review. As can be seen from the information documented above, multiple trainings regarding a myriad of topics have been offered to facility staff in the intervening period since the previous monitoring report. Unfortunately, given the multiple trainings and the shift in facility focus and mission over the six months prior to this monitoring tour, it appeared that trainings and program initiatives were occurring haphazardly, with little organization or planning. The review of trainings was very confusing for the monitor, so the monitor can only imagine how difficult this must be for staff attempting to provide behavioral health services or security services at the facility.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop an organized training schedule and training curriculum for facility staff that addresses the requirements of this provision and addresses the facility mental health programming initiatives. 2. Over time, the facility may identify the need for enhanced training on a particular topic (i.e., more time devoted to a particular topic) or additional specialty topics via quality assurance or staff recommendation that may be useful (e.g., abuse reporting). 3. Consider offering multiple trainings for each topic so that staff can schedule trainings while ensuring that their regular job duties are addressed. 4. Continue to track staff attendance and compliance with training requirements.
Sources of Information	• Review of provided documents. • Staff interviews.

III.B.16 Suicide Prevention. The State shall review and, as appropriate, revise current suicide prevention practices to ensure that suicide preventions and interventions are implemented consistently and appropriately, consistent with generally accepted professional standards of care.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating.
Steps Taken to Assess Compliance	According to the facility self-assessment, "the revised Suicide Prevention and Response policy became effective 11/1/2011." This policy was not included in the provided documents, where policy and procedure (both currently implemented and draft documents) were requested. The self-assessment further stated that quality assurance for suicide precautions "is an ongoing process by way of direct supervision and discussion of all recommendations for precautionary status made by unlicensed psychology staff, daily updating of a shared Precautionary Status table that documents each incident of placement on or change in Precautionary Status, and continual review of incidents and patterns of behavior during the group and individual supervision meetings." Per the document request, a written description of the process by which psychiatry is informed of youth's placement on suicide watch was provided. This document indicated "psychology staff will send an email to [psychiatrist] when they place a youth on suicide watch or when they learn a youth has been placed on watch when psychology staff are not available on campus." Staff were required to copy this email to the psychology supervisor, health services administrator and mental health nurse. Several emails were provided as evidence of this process. Per the email documentation, a review of the listing of youth requiring precautionary status over the previous three months, and a review of available youth medical and mental health records, youth 444 was placed on precautionary status on 9.8.11. A review of this youth's medical record revealed that the youth was not evaluated by psychiatry in a timely manner following placement on watch status. This youth was ultimately evaluated by psychiatry one month later on 10.7.11. A review of the mental health record revealed that this youth was seen by psychology staff 8.23.11, approximately two weeks prior to placement on precautionary status. Following placement on precautionary status, he was seen by psychology staff 9.9.11, 9.12.11, 9.13.11, and 9.17.11. It should be noted that this youth resides on the Progress Unit, where he spends a great deal of time in his cell. The absence of documented daily mental health

	contacts for this youth, or any youth in similar circumstances was unacceptable. Youth 777 required suicide precautions 8.19.11. The psychiatrist ultimately saw this youth over two months later on 10.25.11. A review of this youth's psychology file revealed no documents other than those generated at intake. There was no documentation of mental health contact visits included. Youth 888 required suicide precautions 9.11.11. Per a review of this youth's medical record, there were no psychiatric clinical encounters as of the date of the monitoring tour 10.24.11. A review of this youth's psychology file revealed no documents other than those generated at intake. There was no documentation of mental health contact visits included. On a positive note, Youth 555 was admitted to the facility on precautionary status. This youth had reportedly attempted suicide prior to admission, and was therefore placed on precautionary status immediately. This youth was admitted 9.14.11 and was evaluated by the psychiatrist 9.15.11. A review of this youth's psychology file revealed consistent contact with a mental health treatment provider. The above review was performed regarding youth who reportedly required precautionary status during their stay at SJCF. It is recognized that although additional documentation may exist, this documentation was not provided for review off site. Per the document request submitted for this monitoring tour, a copy of any reviews or quality assurance data regarding suicide precautions was requested. Per the document request response, the "Suicide Precaution Performance Indicators are audited during the annual Ohio Standards audit. The audit for Scioto…is scheduled for later this year; therefore, we do not have any new audit data since February 2011." It is generally accepted that youth in seclusion are at higher risk of self-injury and suicide. In reviewing the Seclusion Tracking data provided as part of the quality assurance materials, there were noted concerns. Specifically, when youth were in seclusion, documentation available for off site review revealed that mental health staff did not assess some for over 24 hours. For example during the week of 6.30.2011-7.6.2011:

- Youth 999 was assessed at 9:55am and then was not reassessed until 4pm the following day.
- Youth 010 had an undocumented time for one assessment. Therefore, it was impossible to determine if the assessment was performed within an appropriate margin of time.
- Youth 020 was assessed at 11:45am and not until 9:30pm the following day. This is over 33 hours without review of mental health staff.

During the week of 9.1.11-9.7.11:

- Youth 030 was on seclusion status from 9.4.11-9.7.11; however, there were no documented visits on 9.5.11 or 9.6.11.

The above are selected examples, further review of the data revealed multiple similar situations. When youth are placed in seclusion, they must be seen a minimum of every twenty-four hours. Similar deficiencies were observed in the Progress Unit, where youth were decompensated with regard to their mental health status, however, as they were not evaluated daily, their condition could go unchecked for a period of time, leading to further decompensation. During this monitoring tour, mental health staff indicated that they were assessing youth on the Progress Unit approximately three times per week. Per discussions with mental health staff, some youth had extended periods where they did not engage with a mental health treatment provider because they were "asleep" or refused to talk to the provider. One such youth, Youth 040, was described by the mental health staff as "always asleep…he doesn't want to talk." The psychiatrist evaluated Youth 040 during the monitoring tour at the monitor's insistence. This youth was observed by the monitor to be psychotic. Given the youth's presentation, the facility psychiatrist arranged for transfer to a mental health unit at another DYS facility.

This event raised multiple concerns, including but not limited to the appropriateness of all youth currently housed on the Progress Unit, the need for daily mental health contact with youth housed on the Progress Unit, mental health staff's ability to recognize and respond to signs and symptoms of serious mental illness, and the facilities ability to advocate for and transfer those youth with serious mental illness to a more appropriate setting.

Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review and revise policy and procedure to reflect time limits for psychiatric evaluation following a youth's placement on suicide precautions. 2. Review and revise policy and procedure to reflect the minimum frequency of clinical contact with mental health treatment providers following a youth's placement on suicide precautions. 3. Review and revise policy and procedure to reflect the frequency of clinical contact with youth on the Progress Unit. Youth must be evaluated on a daily basis. 4. Review and revise if necessary policy and procedure to reflect the frequency of clinical contact with youth in seclusion. Youth must be evaluated on a daily basis. 5. Define the requirements for and documentation necessary for youth assessed while in seclusion or housed in the Progress Unit. 6. Ensure that all mental health staff are appropriately trained to recognize and respond to signs and symptoms of serious mental illness. 7. Consider a mental health re-evaluation of all youth currently housed on the Progress Unit in an effort to determine the appropriateness of their placement in this program.
Sources of Information	• Review of provided documents. • Staff interview. • Youth interview.

III.B.17 Transition Planning. The State shall ensure that staff create transition plans for youth leaving the facilities, consistent with generally accepted professional standards of care.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	In response to a document request for transition plans for the last ten youth prescribed psychotropic medication discharged from the facility, the monitor was provided with medical release summary documents for the youth, as well as the psychological services summary form. Of these ten youth, nine were prescribed psychotropic medication at the time of release. Also examined were the facility self-assessment and policies related to transition planning. Per the facility self-report, transition planning continues to be an area of development. Per the facility self-assessment, while there are treatment teams that have the experience to develop comprehensive transition plans, this strength is not consistent throughout the facility. "As young, inexperienced teams, transition planning is and has been minimal, with great reliance on the social work staff being able to make a connection with regional staff and parole…experienced treatment teams…routinely engage in detailed…transition planning that frequently includes day trips to counties for interviews and planning meetings…parents…court appearances to advocate…for a particular placement recommendation." In reviewing both the self-assessment and policies related to transition planning, there was ambiguity regarding who the responsible party is for creating and implementing transition plans prior to release, particularly with regard to mental health follow-up. It will be necessary to determine what tasks need to be completed as part of transition planning and who the responsible party will be in order to ensure youth leave the facility with appropriate scheduled follow-up services. For example, in the policy entitled "Transition Planning for Age 21 Youth," the policy clearly states that the juvenile parole officer "shall provide each youth with a comprehensive list of community based resources specific to the youth's needs." This is to include "treatment links/mental health services." With regard to youth under age 21, there was no specific policy included in the documents for review regarding transition planning; rather this is incorporated into the policy entitled, "Behavioral Health Services." Per this policy,

	"youth in need of continued mental health services shall receive, as part of their re-entry plans, referrals for continued treatment. Efforts shall be made to connect the youth and family directly with the community provider." The policy does not denote which staff are responsible for this task. Of the transition documents regarding ten youth provided through the document request, nine of the psychology summaries were completed between one day and two weeks of release from the facility. As discussed in the previous report, transition planning should be examined from intake throughout a youth's incarceration. There was little documentation that the recommendations made for needed services were completed by mental health staff. One youth was being transitioned to adult custody, but of the remaining nine, only three had follow-up appointments scheduled upon release. These appointments were scheduled by the mental health nurse. It was unclear whether the referrals coincide with the recommendations made by psychology staff based on youth needs. Due to the state of outpatient mental health services, appointments may take more than 30 days advanced notice to schedule. As youth are released with 30 days of medications, it is vital that they have appointments scheduled in advance to ensure continuity of care. One positive example was Youth 111, who was scheduled for an outpatient mental health appointment the same day of his release. However, youth with intensive mental health follow-up needs were not all linked to services or scheduled appointments prior to release. Other challenges at the time of transition included incomplete or unjustified diagnoses. For example, Youth 222 had a psychological services summary completed the day before his release with recommendations for follow-up services. This youth had diagnoses of Schizophrenia; Conduct Disorder; Sexual Abuse of a Child (Perpetrator); and Borderline Intellectual Functioning, by history. His intellectual functioning was apparently not determined through testing during his five-year incarceration, as per the Psychological Services Summary Form completed the day prior to his transition, "no intellectual testing is on record. He has a history of borderline intellectual functioning. It was also indicated that he may have 'MR functioning.'" This youth's intellectual functioning would impact his treatment needs post-discharge. At the time of his release, Youth 222 was prescribed the

	antipsychotic medication, Haldol D, via a monthly injection. The psychological summary of services form noted "at this time, youth's symptoms appear to have stabilized but he will continue to require a high level of wrap around services in the community." The medication management and consistency that an intramuscular medication provides would assist in stabilization. However, this youth's history indicates a need for continuity of care in order to avoid a relapse of symptoms once released. This youth has a documented history of psychosis including command auditory hallucinations that tell him to kill himself. He has a documented history of suicidal ideation, gestures, and attempts. Although a community treatment provider was identified, no follow-up appointment was scheduled. As he was prescribed an intramuscular medication, he will need services based on the last date his injection was given. As noted in the medical release summary, he was released 1/11/11 with his next injection due 2/9/11. A contact name and telephone number was provided via the medical release summary; however, an appointment was not scheduled. Any delay in services and medication administration may lead to decompensation of his mental status. Further, it is unclear whether the identified treatment provider matches the level of care this youth will need upon release. It is necessary to identify the services youth are being referred to and make a determination as to whether these are the appropriate services. Youth 333 had diagnoses including Pervasive Development Disorder, NOS; Conduct Disorder; Bipolar I Disorder, most recent episode depressed; Alcohol Abuse; and Cannabis Abuse. This youth's psychological services summary was completed 2.7.11 and she was not released until 9.6.11. The recommendations include "With PDD and [youth's] other mental health symptoms in mind it is very important for [youth] to maintain on going mental health treatment…" The writer of the psychological services summary form identified that this youth would likely need respite services and/or residential treatment in the future. In providing appropriate transition planning and continuity of care, it was necessary for this youth's treatment provider discuss future treatment needs and assist the family in understanding how to link with services that may be needed in the future. Despite the advanced recommendations in the psychological services summary, there was not a follow-up mental health appointment scheduled for this youth at the time of her release. In reviewing transition documents, it was clear that this youth would need intensive mental health and rehabilitation services, family counseling, substance abuse treatment, and further evaluation. However, none of these services were arranged prior to

	her release from ODYS custody. Also reviewed were ten examples of mental health case formulations, which were provided through two different psychological services summary forms, one a progress form and one a summary form. On the progress forms (five of which were provided), there was space to discuss discharge needs including continuity of care, referral information, and aftercare options. In three of these care formulations; discharge issues were not addressed in detail. In two, it was stated that youth "recently transferred to SJCF and is new to this institution and the treatment team." Two of these summaries indicated plans for discharge had been discussed with youth's PO and were in the planning stages. It is important that discussions surrounding discharge needs and appropriate community services consistently begin at the time of intake to the facility. Other summaries were provided on a similar but different psychological services summary form. This form also has space for recommendations/plans. In these sections, vague recommendations regarding level of care needed in the community were provided. These above examples are similar to those documented in the previous monitoring report, where recommendations were made, and the need for community linkages and appointments was clear, but there were no resources documented. Given the facility staff's self-assessment documented above, it was apparent that they were aware of the need to develop transition planning services at the facility to include linkage with community resources. Transition planning for all youth should include referral to appropriate community resources. For mentally ill youth this is especially important, and must include linkages to community mental health clinics and a scheduled appointment such that youth can access follow up care without an interruption in medication treatment.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revise Behavioral Health Policy and Procedure to reflect the requirements of this provision. This should include delineating the responsible party for transition planning to include mental health aftercare appointments. 2. Begin transition planning at the time of admission to ensure that youth receive appropriate services at the time of discharge. This must include involvement of the youth's parent or guardian.

	3. Provide clinical supervision to treatment teams inexperienced in transition planning.
Sources of Information	• Review of provided documents. • Staff interview

III.B.18 Oversight of Mental Health Services. The facilities shall ensure that youth receive the care they need by developing and implementing an adequate mental health Quality Assurance/Improvement Program; annually assessing the overall efficacy of the staffing, treatments and interventions used at the facilities; and as appropriate revising such staffing, treatments and interventions.	
Compliance Rating	Non Compliance
Self Assessment	N/A, the facility did not assign a compliance rating
Steps Taken to Assess Compliance	The facility has developed policy and procedure regarding Quality Assurance/Improvement. This policy, with an effective date of January 1, 2011 entitled "Behavioral Health Quality Assurance/Quality Improvement." This policy outlines the process for clinical supervision and audit of clinical documentation. Completed quality assurance audits dated 9/13/11 and 9/14/11 were provided for review. These audits included: Clinical Supervision Document Review, IDT Document Review, Group/Activity Document Review, Behavioral Health Service Meeting, and Follow-up. Eight clinicians were reviewed on the quality assurance audit dated 9/14, five out of eight had three months of supervision documented in their supervision file. Of these clinicians, three had clinical licensure documents updated. A review of clinical supervision documentation required by the facility policy and procedure revealed marked differences in the documentation between disciplines. While there was room for improvement in social services supervision documentation, there was a paucity of documentation regarding psychology supervision. It was apparent that the supervisee was responsible for completing the psychology supervision form, which was then signed by the psychology supervisor. Additionally, QA documents reviewed indicated that IDT Documentation Review and Group/Activity Documentation Review were not completed because "psychology supervisor does not have time to attend IDT meetings due to his host of other duties." An undated document entitled "2nd Quarter SJCF QA Documentation Review," was a review of two youth health records for the months of April, May, and June 2011. While the effort with regard to the review was laudable, the use of only two records rendered results of limited utility. For QA of this sort to be meaningful, a percentage of youth records would need to

	be reviewed (i.e. a 10% sample). Additionally, both youth records utilized in the above sample were female youth and as such, not a diverse sample, which further inhibited the utility of the resultant information. Review of available documentation regarding quality assurance revealed a disjointed process that did not lend itself to a cogent review of the system or services provided. During the most recent monitoring tour, the monitor was informed that the facility had identified individuals who would be responsible for the development of a system of quality assurance and quality improvement. Additionally, at the time of this monitoring tour, there was no formal quality assurance monitoring occurring with respect to the psychiatric physician. Per interviews conducted during the tour, DYS had recently identified and hired an administrative psychiatrist, who reportedly would be responsible for implementing audits in this area. While these were important steps, as stated previously in this monitoring report, the facility has been in a state of flux for the previous six months. There was little cohesive mental health programming or treatment occurring. In order for QA to be meaningful and effective, there must be a functioning program for review. Per information obtained via the monitoring tour, there were plans to revise the facility behavioral health policies. Therefore, at this time, the implementation of QA other than direct clinical supervision, observation of group therapeutic interactions, and document review was premature. As stated in the facility self-assessment, the facility staff were aware of the immediate tasks that must be accomplished and they must focus on these in order to ensure the health and safety of the youth and staff. Once mental health programming is fully implemented, the facility should consider the development or review of youth outcomes to determine the efficacy of the treatment program.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revise behavioral health policy and procedure. 2. Develop quality assurance monitoring based on policy and procedure. 3. Improve documentation of clinical supervision.

Sources of Information	• Staff Interview. • Review of the provided documents.

G.1 Progress Notes. The Facilities shall promulgate and implement a policy requiring that all health professionals be required to create and use progress notes to document, on a regular basis, interactions and each assessment of youth with mental/behavioral health or substance abuse needs. In particular, progress notes shall: a.) In the assessment, address the efficacy of interventions, currently presenting problems, and the available options to address those problems; and b.) Provide thorough documentation of all crisis interventions or, if not thoroughly documented in the progress notes, provide a reference to alert staff to another document in the youth's file containing the details of the crisis intervention.	
Compliance Rating	Non-Compliance
Self Assessment	The facility self-assessment did not include information regarding this provision.
Steps Taken to Assess Compliance	Per interviews with mental health staff from both the facility and DYS administration, a review and revision of mental health policy and procedure is pending. Mental health documentation reviewed for the preparation of this monitoring report revealed deficiencies in clinical documentation. Specifically, mental health assessments did not include case conceptualization information required to develop a treatment plan. Treatment plans did not include measurable goals and objectives. As such, the documentation included in the individual youth progress notes did not reflect interventions aimed at addressing specific treatment goals. There was wide variability in the quality of progress notes documenting treatment. As discussed during the monitoring tour, this was an area that may be amenable to quality assurance monitoring. Crisis intervention documentation was improved over the previous monitoring tours. What was missing was routinely documented follow-up with the youth's assigned clinician at the subsequent clinical encounter with regard to the mental health crisis situation.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that progress notes reflect interventions aimed at addressing specific treatment goals. 2. Ensure that, in their follow-up care, clinicians reference youth's previous crises in the progress notes. 3. Complete the planned review and revision of policy and procedure.
Sources of Information	• Mental health records • Interviews with DYS and facility mental health staff

G.2 Accessibility of Relevant Information. The Facilities shall ensure that youth records are organized in a manner providing treatment teams prompt access to relevant, complete, and accurate documentation regarding the youth's status.	
Compliance Rating	Non-Compliance
Self Assessment	The facility self-assessment did not include information regarding this provision.
Steps Taken to Assess Compliance	Currently, the record-keeping program at the facility is cumbersome. There are multiple databases where information is stored, making access to information challenging. Per interviews with DYS administration, there are plans to implement the OYAS system at the facility, which will reportedly allow for staff to access information from one database allowing for electronic access to mental health information. Pending this improvement, mental health staff (including psychiatry staff) are hampered by the current documentation system. A review of the records provided for off site review did not include the documentation of social workers. The provided documents were limited to psychology-derived documentation. As such, a review of the completeness and accuracy of the documentation was limited. Regardless, as stated in G1 above, per the review of youth records and mental health documentation available for off site review, there was considerable variability in the quality of documentation regarding mental health treatment. This is an area that would be amenable to quality assurance (with associated corrective action) and peer review.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that all mental health staff, including psychiatrists, have access to relevant, complete and accurate documentation regarding the youth's mental health status and treatment. 2. Continue and expand quality assurance monitoring of mental health documentation. This would include a review of a percentage of mental health records along with corrective action plans as needed.
Sources of Information	• Mental health records • Interviews with DYS and facility mental health staff

MEDICAL SERVICES

III.C.1 General Medical Care. The facilities shall ensure that the individuals they serve receive routine, preventive, and emergency medical and dental care consistent with current, generally accepted professional standards. The facilities shall ensure that individuals with health problems are identified, assessed, diagnosed, and treated consistent with current, generally accepted professional standards of care.	
Compliance Rating	Substantial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) self assessment rated the level of medical and dental care at SJCF at or above the level that was observed for the Third Compliance Report, wherein SJCF received a rating of substantial compliance.
Steps Taken to Assess Compliance	Off site review of ten youth health records housed at the Scioto Facility. Review of Youth Injury and Assessment Forms of eleven youth exposed to OC spray, three of which were at Scioto. Health records of three female youth at Scioto in response to a complaint made to the Monitor on the October 2011 site visit. A review was also made of internal quality assurance monitoring documents for 2011. In general, according to the documents provided to me by ODYS, the medical and dental care continues to be consistent with the third compliance report. The health record review included assessing completeness of the Problem List, the presence and timeliness of the Nursing Intake Screening, Mental Health Screening, Physical Exam, Dental Exam, Oral Hygiene Instruction and Growth Chart. Admission labs were checked for completion and results within 20 days. STD screening for Gonorrhea and Chlamydia was completed on all youth except one. It was commendable that ODYS was screening for HIV and Hepatitis C on all admissions. All youth received tuberculosis screening with documented results. One youth was enrolled in chronic care clinic as a result of a positive PPD skin test for tuberculosis exposure. Dental treatment was provided as a result of the dental examination or as in one case, from a Health Request. All youth allergies were noted in their health record. There were only two youth with chronic medical conditions provided in the ten health records provided. Both received appropriate assessments, treatment plans, and specialty consultations. Seven of the ten youth records reviewed had some indication of a mental health diagnosis, either through the mental health screening, transfer notes or psychiatric evaluations in the health record. Most of these diagnoses were not on the youth's problem list nor contained much detail in the psychiatry tab of the health record. There was documentation of special diets,

	optometry consults and eyeglasses provided. One youth even received a second pair after losing the first. Health Requests were reviewed and in each case traced back to a corresponding progress note to determine if the complaint had been addressed. In all cases, the requests had been adequately assessed and treated by registered nursing staff and in some cases by the physician. Progress notes also included assessments that did not have a corresponding Health Request slip in the health record. When nurses made isolation checks, they were documented in the progress notes. I cannot determine if all youth housed in segregation/isolation were assessed daily by the nursing staff based on the information provided to me for review. One youth in particular had several seclusion checks documented while there were others that did not have any. Daily checks of youth in seclusion/segregation by medical staff are a requirement of the National Commission on Correctional Health Care Standards for Juvenile Detention and Confinement Facilities. Documentation on the Youth injury and Assessment Reports for youth sprayed with OC did not always include vital signs, flushing of all exposed areas with water, showering or documentation of clothing decontamination. Medication administration records and physician orders were also reviewed for accuracy and medication compliance. Immunization records were reviewed for completeness. With the exception of Hepatitis A and HPV, youth immunizations were current. Internal Quality Assurance documents were reviewed that were provided by ODYS. The overwhelming majority of the items monitored were found to be in 100% compliance. Three female youth health records were reviewed as a result of allegations of unresponsive health requests. One female complained of a “bump” in the genital area. Two health requests were in her health record. She was seen by the nurse for both requests. She was referred to the physician and the bump was examined by the MD and diagnosed as a carbuncle. The other two females complained of menstrual irregularities, but both were on DepoProvera injections for birth control, which is a common side effect of this medication. Both female’s health requests were addressed appropriately in the health record. One female with abdominal pain complaints received a CT scan and pelvic ultrasound, with negative results. Youth with complaints of menstrual cramps were prescribed anti-inflammatory medications for pain as needed. One female expressed concern over having a male gynecologist to examine her. Chaperones of the same sex as the patient are always required whenever a medical

	professional examines the female patient's breasts or genitalia.
Recommendations	The State is in substantial compliance with this provision. In the spirit of continually improving services, the following are recommended: 1. Expand the immunization program to Include Hepatitis A and HPV vaccinations of youth. 2. Develop protocols for decontamination and medical assessment of youth after exposure to OC spray. Documentation on the Youth injury and Assessment Reports for youth sprayed with OC did not always include vital signs, flushing of all exposed areas with water, showering or documentation of clothing decontamination. 3. Provide AEDs (Automated External Defibrillators) on site, train staff in its use and include them in the Emergency Medical Response and Services Policy. 4. Improve completeness of youth Problem List in health record to include all chronic diagnoses, including mental health, substance abuse and acute diagnoses such as headache, shoulder pain, etc. 5. Improve Quality Assurance (QA) activities by considering a review at least annually by a source external to ODYS Health Services. ODYS should also consider expansion of the QA process to include some additional quality indicators.
Sources of Information	• Review of ten youth health records: ID # 216224, 215725, 211428, 215728, 214897, 217657, 217487, 215980, 217724, and 216734. Youth Injury and Assessment Forms: 5505111337, 2105111709, 2105111710, 5505111288, 2105111712, 2105111716, 2105111715, and 2105111711. Health records of three female youth at Scioto: ID#217709, 217497, and 217002

III.C.2 Health Records. The State shall develop and implement policies, procedures and practices to ensure that, consistent with State and federal law, at a minimum, the juvenile courts in the State, all juvenile detention facilities and all placement settings from which youth are committed shall timely forward to Scioto, or to the facility of placement (if the records arrive after the youth has been placed), all pertinent youth records regarding medical and mental health care. The facilities shall develop and implement policies, procedures and practices to ensure that health care staff, including mental health care staff, have access to documents that are relevant to the care and treatment of the youth.	
Compliance Rating	Substantial Compliance
Self Assessment	The relevant policies, procedures, and practices are at or above the level that was observed for the Third Compliance Report, wherein it was observed that the State "demonstrate[s] a commitment to continuity of care for Scioto's youth." [*See* Doc. 79-1, at 56]. SJCF is no longer a reception facility. Therefore, the provision about forwarding to the facility of placement is moot. In the Third Compliance Report, the Department of Justice (DOJ) stated that substantial compliance with this provision would be achieved by "combin[ing] medical and psychology records." *See id.* Due to the physical layout of SJCF, combining medical and psychology records into one record would prove extremely difficult, if not impossible. There is a great distance between the Clinic and the nine housing units. Removal of a medical record from the clinic could lead to the lack of access to critical medical information in an emergency situation. SJCF has a Mental Health Database that psychologists may access. Although not all inclusive, this database includes diagnosis, medication information and medication compliance. Psychology staff directly involved with the care and treatment of the Youth at SJCF have access to the psychiatry notes via the Mental Health Nurse. And treatment teams are verbally informed of medication compliance by the psychology staff when necessary and relevant on a weekly basis to allow any issues to be addressed. Because all relevant staff have access to the relevant health records (and because the policies, procedures, and practices continue to be in place as stated above), SJCF is in substantial compliance with this provision.
Steps Taken to Assess Compliance	Review of ten youth health records. Review of Policies and Procedures and Standard Operating Procedures (SOP) effective 7/1/11 provided by ODYS. A few health records contained some transfer health information from the county probation offices or other facilities. Since Scioto is no longer a reception center, transfer information is no longer required. As stated in the first section, there was little mental health information housed within the health record of youth in the majority of cases. Since this assessment was completed based on the information submitted, I cannot determine

	how successful the process for sharing health information occurs between medical and mental health. A better determination would be made based on a facility site visit.
Recommendations	The State is in substantial compliance with this provision. In the spirit of continually improving services, the following are recommended: 1. Continue to improve process for sharing of health information between medical and mental health to include psychologists, possibly through the use of a summary sheets provided to medical for inclusion in the health record and pertinent medical information provided for the mental health record. 2. Consider implementation of electronic health record or if not possible now, allow medical staff to access to the Mental Health database. 3. Continue to review and update policies and procedures annually. There was a five and a half year period lapsed between the current ODYS Policies and Procedures implemented 7/2011 and the previous set of ODYS Policies and Procedures implemented 1/2006. 4. Reduce length of policies and procedures and attempt to consolidate some. Try to eliminate references back to other policy numbers within the text. Some policies and Standard Operating Procedures (SOP) should be shortened and some details removed and placed into protocols (for example, the details of the World Health Organization's Pandemic Phases included in the 18-page Pandemic Response Plan for Medical and Mental Health Services SOP). When policies become too lengthy and cumbersome, it is more difficult for staff to understand them and maintain compliance.
Sources of Information	• Review of ten youth health records: ID # 216224, 215725, 211428, 215728, 214897, 217657, 217487, 215980, 217724, and 216734. • Review of Policies and Procedures supplied to me by ODYS effective July 1, 2011 to include: Pharmaceutical Management; Health Education and Prevention; Emergency Medical Response and Services; Communicable Disease Management; Health Services Internal Review, Quality Assurance Monitoring and Reporting. Review of Standard Operating Procedures (SOP) effective July 1, 2011: Pharmaceutical Prescribing, Procurement and Documentation Procedures; Pharmaceutical Receipt, Storage, Inventory, and Disposal Management; Medication Administration and Documentation; Pharmaceutical Transfer within the Department; Aftercare Pharmaceuticals; First Aid and Emergency Care; HIV Screening, Testing and Management;

	Hepatitis Screening, Testing and Management; Tuberculosis Testing and Management; Chicken Pox Management; Ectoparasite Management; Immunization Program; Exposure Control and Standard Precautions; Pandemic Response Plan for Medical and Mental Health Services; Methicillin-Resistant Staphylococcus Aureus (MRSA); Supervisor and Peer review-Health Services Administrators; Peer Review- Physicians and Dental Personnel; Peer Review- Nursing; and Peer review-Psychology.

III.C.5 Access to Health Services. The facilities shall ensure that youth can request to be seen by medical staff confidentially and independent from JCOs and custodial staff.	
Compliance Rating	Substantial Compliance
Self Assessment	All youth assessments are completed by Registered Nurses. The Ohio Department of Youth Services has abolished the LPN positions. Every youth at SJCF has direct access to medical care whether emergent or non-emergent. Upon admission to SJCF, all youth are educated on the process to access healthcare. Youth have the ability to confidentially request an assessment by the medical staff by placing a written request in one of the locked Healthcall boxes on campus. More urgent matters require the youth to have the unit staff notify the clinic.
Steps Taken to Assess Compliance	Progress Notes and Nurse Health Requests were reviewed in all 10 health records selected and provided by Ohio DYS for youth at the Scioto Facility. No Nurse Health Request Forms were present in 3 of 7 records. Two of these 3 health records contained progress notes that indicated medical care was provided by nursing staff without a health request. Health requests included in these 7 health records were responded to adequately and documented by medical staff 100% of the time. A few examples of Nurse Health Request responses included, a youth that complained of feeling like he was "breathing through a straw" that received a complete assessment including peak flow and O2 saturation evaluation; youth complaining of shoulder pain from an old injury received an orthopedic consult, MRI and anti-inflammatory medications creating a common abdominal pain side effect that was appropriately treated; youth with a complaint of a "bump" received an incision and drainage for treatment. All records included documentation that the youth had received information on how to access health services at the facility. During the site visit in October 2011, Dr. Dedel directly observed the nurse health request boxes on the Sycamore/Cedar Units as accessible to youth. None of the youth on those two units expressed any complaints about access to medical treatment.
Recommendations	The State is in substantial compliance with this provision. In the spirit of continually improving services, the following are recommended: 1. Encourage youth to complete Health Call forms in non-emergency situations in order to fully document medical responses to youth requests. Again, in many instances nurses provided services to youth documented in progress notes without the presence of a Health Request form. This becomes important when you review medical response times to youth requests, as well as to determine if youth are going through JCO and custodial staff in order to be seen by medical.

	Without a health request form completed by the youth with the date, there is no way to know if the nursing assessment completed and documented in the progress notes was the result of a medical complaint today or a week ago. Also, I cannot tell if the youth had to request to be seen by medical through a JCO without a health request form completed. The location of the health call boxes in common areas and designated pick up times by medical staff should be included in a Standard Operating Procedure.
Sources of Information	• Review of ten youth health records: ID # 216224, 215725, 211428, 215728, 214897, 217657, 217487, 215980, 217724, and 216734; email correspondence from Dr. Dedel.

SPECIAL EDUCATION

III.E.1 Provision of Special Education. The State shall, at all times, provide all youth confined at the facilities with adequate special education in compliance with the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400-1482, and regulations promulgated thereunder, and this Stipulation.	
Compliance Rating	Non-Compliance
Self Assessment	Prior to the Monitor's visit, the State was asked to produce data and explanations for a limited range of issues related to the three education-related provisions that are included in the Amended Stipulation. The first provision pertains to the provision of special education services in general. In the past, the key compliance issues were related to providing education services to youth who were removed from school during the day or who were held on the unit for disciplinary reasons. In the past, youth who exhibited non-compliant behavior in the classroom could be suspended from school and returned to their living units where they did not receive education services of any kind. The State ceased suspending students in June 2011, relying more heavily on its in-school suspension room (the ABC room) and a newly developed procedure for Unit Instruction. The ABC room allows youth an opportunity to regain control of their behavior and to be returned to the classroom setting without going back to their living units. Between February and mid-September 2011, 262 students were referred to the ABC room (approximately 33 per month) for rule violations pertaining to offensive or threatening conduct or being outside an authorized area. Of these, approximately 95% satisfactorily completed the requirements of the ABC room and were returned to their classrooms. Beginning mid-September, a Youth Specialist was permanently assigned to the ABC room, which should strengthen the already effective program model. Over the past six months, the State negotiated an agreement with the Parties to the *S.H.* lawsuit regarding the delivery of education services to youth who are confined to the living units for disciplinary reasons. Beginning in July 2011, students in seclusion must now receive instruction from a certified teacher four times per day, for at least 30 minutes per visit (i.e., Unit Instruction). While the facility asserted that students received the services as required, problems with the data tracking system for these services prevented their producing data to verify this assertion.

Steps Taken to Assess Compliance	When interviewed, youth reported short stays in the ABC room and the opportunity to talk through their issues with staff. Many of those who had spent time in disciplinary seclusion reported that they did not receive instruction from teachers or work packets during the time in their room. An attempt was made to verify these claims using the Unit Instruction binder maintained by the school, but as reported by the Assistant Principal, many of the records were missing or incomplete. Although these data are therefore not sufficient to demonstrate compliance with this provision, the Unit Instruction paperwork and process appear to be sufficient to the task once fully implemented (i.e., data is captured for all youth in seclusion, every school day). Since my last visit, the facility began to operate a maximum-security segregation unit, the PROGRESS Unit. This unit consists of two 18-bed housing units. Students on the PROGRESS unit attend school separately from the general population, in two mobile units specifically dedicated for this purpose. The classrooms are well appointed and sufficiently spacious to serve students from both units. To assess the extent to which youth on the PROGRESS units have access to the education program, attendance records for the two weeks following the October Intersession were reviewed. These records revealed very sporadic attendance. On both units, school was held on the unit for 3 of the 10 days. It is unknown whether youth received services in their rooms, or whether instruction complied with the Unit Instruction format recently developed with the *S.H.* monitors. Attendance for the remaining 7 days was coded using the following schema: a youth was considered to have been “present” for the day if he attended at least 3 of the 4 academic classes. A youth was considered to have been “excused” for the day if he was excused from 2 or more academic periods. A youth was considered to be “unexcused” for the day if he refused or was removed from 2 or more academic periods. Of the 12 youth on the Sycamore unit, only one youth was considered “present” for all 7 days. Another youth was present for 4 of the 7 days. The remaining 10 youth (83% of Sycamore youth) were present on 2 or fewer days. Equal proportions had “excused” and “unexcused” absences. Of the 11 youth on the Cedar unit, four youth were considered “present” for 6 or 7 of the days. The remaining 7 youth (64% of Cedar

	youth) were present on 2 or fewer days, with 2 of those never attending school at all. Equal proportions had "excused" and "unexcused" absences. Clearly, additional work is needed to increase the level of attendance at school among PROGRESS youth. First, the reasons underlying the high rates of excused absences should be reviewed to determine if these activities could be scheduled in a way that does not conflict with the school day. Second, the incentives for school attendance and the consequences for refusing should be reviewed to determine how to make school attendance more compelling to youth on the PROGRESS units.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Document the provision of Unit Instruction to all youth held in disciplinary isolation. This instruction should include four daily visits of at least 30 minutes each by certified teachers. Audit these data on a monthly basis to ensure sustained compliance with the requirements of this provision and the *S.H.* Agreement. 2. Increase the level of attendance at school among youth on the PROGRESS units. 3. Reach substantial compliance with the other two education-related provisions in the Amended Stipulation.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.1, prepared at my request • Interviews with n=20 general population youth conducted by the DOJ attorney in late October 2011, along with interviews with n=29 youth on the PROGRESS units conducted by the Monitor and DOJ attorney in October 2011 • Unit Instruction binder maintained by Scioto school administrators • Attendance records for Cedar and Sycamore units, October 18 through 31, 2011

III.E.7 Individual Education Plans. (a) The State shall develop an IEP as defined in 34 C.F.R. §300.320 for each youth who qualifies for an IEP. Following development of the IEP, the State shall implement the IEP as soon as possible. As part of satisfying this requirement, the State shall conduct required annual reviews of IEPs, adequately document the provision of special education services, and comply with requirements regarding participation by the professional staff, parents and student in the IEP process. The State shall, if necessary, develop, review or revise IEPs for qualified special education students; (b) In developing or modifying the IEP, the State shall ensure that: the IEP reflects the individualized educational needs of the youth and that services are provided accordingly; each IEP includes documentation of the team's consideration of the youth's need for related services and transition planning, and identifies the party responsible for providing such transition services; the student's educational progress in monitored; teachers are trained on how to monitor progress toward IEP goals and objectives; and teachers understand and use functional behavioral assessment and behavior intervention programs in IEP planning and implementation.	
Compliance Rating	Non-Compliance
Self Assessment	The State provided data on youth recently admitted to the facility in July, August and September 2011. A total of 17 special education students were admitted, 9 of whom entered the facility with an expired IEP. These student's IEPs were updated in a timely manner (or scheduled to be updated, for those admitted in September). The other students' IEPs were either adopted or an IEP meeting was schedule to correct deficiencies on the incoming documents. According to the facility's self-assessment, a total of 22 students' IEPs were updated in the previous 90 days. All of the meetings included the required participants; 82% of the IEPs adequately described the students' present levels of performance; approximately 70% included measurable goals that were clearly articulated; and all of the IEPs described the transition resources to be mobilized on behalf of students (although about 30% needed to identify the staff persons responsible for assisting the students). My last report expressed concerns about teachers' failing to monitor student progress and prepare IEP progress reports at the conclusion of each grading period. Facilitating students' progress through the curriculum is the entire point of special education, and without assessing progress, the program cannot identify whether it is meeting students' special education needs. The State reported that progress reports were drafted for each of the 64 students who were at Scioto at the end of a grading period in July-September 2011. This is a significant improvement from the rates observed in the previous report. However, the facility's audit of the content of these reports

	indicated that 63% lacked specific data related to the goals listed on the IEP. Non-specific indicators of student progress (e.g., "Completes work" "Adequate progress") offer little to the assessment of whether the student is acquiring the skills needed to progress through the curriculum.
Steps Taken to Assess Compliance	A random sample of four IEPs (18% of the 22 IEPs revised in the previous 90 days) was reviewed to verify the findings of the self-assessment. In all cases, portions of the IEPs were extremely well written. The description of the student's present levels of performance was connected to goals in each area and led to a clear roadmap for supporting students in the regular or special education classrooms. A set of progress reports from the most recent grading period (ending September 2011) was reviewed for four special education students. Their quality was inconsistent—some student's progress reports were well-written and featured specific data to describe the youth's progress, but others were not updated or were vague and lacked specific indicators of progress that reflected each goal. These findings mirror those of the State's self-assessment. So, while the teachers have shown great improvement in complying with progress reporting requirements, the content of those progress reports needs to be grounded in data that are responsive to the way in which the goals were articulated. If the incoming IEP did not articulate measurable goals, the IEP must be revised upon admission. Particularly now that youth are committed to Scioto are likely to spend significant periods of time there, the facility must improve its practices around measuring student progress in order to maximize the ability of the special education program to meet students' needs.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that the content of IEP progress reports is grounded in data that are responsive to a set of realistic, measurable IEP goals. If needed, update incoming IEPs to ensure that students' goals are properly articulated.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.7, prepared at my request • Review of n=4 IEPs of current Scioto students' IEPs and progress reports from the most recent grading period

III.E.8 Vocational Education. The State shall provide appropriate vocational services that are required transition services for disabled youth under the IDEA.	
Compliance Rating	Non-Compliance
Self Assessment	The State submitted data on student enrollment in the three currently available vocational classes. Of the 168 youth at Scioto: • 22 students (18 boys, 4 girls; 13% of the population) are enrolled in Administrative Office Technology; • 10 students (5 boys, 5 girls; 6% of the population) are enrolled in Career-Based Intervention (a work program that includes Math and English courses); and • 23 students (18 boys, 5 girls; 13% of the population) are enrolled in Transition Skills. The State also provided information on a recently established community partnership. This partnership will allow both students and graduates to obtain industry-standard certificates in restaurant hospitality, customer service, and OSHA regulations. Other courses may be added depending on student needs and interests.
Steps Taken to Assess Compliance	Opportunities for students to develop job skills are very limited, with less than half of Scioto students participating in any meaningful vocational coursework or employment experience. The community partnership is very promising and, if implemented as designed, should provide sufficient program slots to meet demand and should offer valuable job skill development and work experience. Once this program is implemented, the State will need to develop additional self-assessment measures to capture the relevant data. Technical assistance toward this end is available upon request.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Develop sufficient vocational opportunities to engage all students in meaningful job skill development and/or work experience.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.8, prepared at my request