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

Civil Action No: 2:08-cv-475

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

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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 Reed 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 second report on the State's progress toward the reforms required by the Amended Stipulation. The monitoring period is October 1, 2011 through March 31, 2012. 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 Monitor's first report used only two compliance levels: substantial compliance and non-compliance. This report uses a three-tiered system (substantial compliance, partial compliance and non-compliance), defined as follows:

- ***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.

- ***Partial Compliance*** means that the facility has drafted policies and procedures, has trained staff responsible for implementation, and has sufficient staff to implement the required reform. While progress has been made toward implementing the procedures described by policy, performance has been inconsistent throughout the monitoring period and additional modifications are needed to ensure that procedures are sufficiently comprehensive to translate policy into practice.

- ***Non-Compliance*** means that the facility has made only very preliminary efforts to implement the required reform, but significant work remains. Policy may need to be overhauled, the majority of staff may need to be trained, procedures may not have been developed, and no one has begun to ascertain whether the procedures accomplish the outcome envisioned by the provision.

The Monitor does not intend to change the meaning, spirit or requirements of the Stipulation in any way. Rather, the rating scheme was expanded in an effort to better recognize the State's progress (which is essential for staff morale during long-term reform efforts), to provide an easy mechanism for determining which provisions will require the greatest amount of time and effort to reach substantial compliance, and to promote greater compatibility with the *S.H. v. Reed, et al.* Monitor's report on Scioto, which also uses a three-tiered system. In order to highlight the areas in which progress has been made or slippage has been noted, the Monitor and subject matter experts revised the compliance levels from the first report, using the new three-tiered system. Both ratings are presented in the chart below. Ratings that were upgraded since the previous Monitor's Report are presented in green; ratings that were downgraded are presented in red.

The DOJ disagrees with this change, particularly the revisions to the compliance levels for the Monitor's First Report (used as the basis for comparison to the current compliance ratings in the table below). While the Monitor recognizes that the Parties did not have an opportunity to comment on the revised compliance

levels, the Monitor believes that using a revised rating provides a more accurate sense of whether the State has made progress since the prior reporting period. Otherwise, many provisions would show a Non-Compliance rating for the first monitoring period (although the provision would have been rated in Partial Compliance had the three-tiered system been in use), and then would appear to have been promoted to Partial Compliance when, in reality, the level of compliance remains the same. The Monitor apologizes for the disruption caused by this mid-course correction, but truly believes it is the best course of action to support the State's progress in complying with the Stipulation.

Table 1. Compliance Ratings for Each Provision			
No.	Provision	1st Report (revised)	2nd Report
Protection From Harm			
III.A. 1	General Protection From Harm	NC	PC
III.A.3	Seclusion	NC	PC
III.A.5	Investigation of Serious Incidents	SC	PC
III.D.1	Grievances	PC	PC
III.D.2	Grievances Explained to Youth	PC	SC
III.F.1	Structured Programming	NC	NC
III.F.2	Orientation	PC	PC
Mental Health Services			
III.B.1	Mental Health Screening	PC	PC
III.B.2	Immediate Referral to QMHP	PC	PC
III.B.3	Identification of Previously Unidentified Youth	NC	PC
III.B.4	Mental Health Assessment	NC	PC
III.B.5	Adequate Care and Treatment	NC	PC
III.B.6	Treatment Planning	NC	PC
III.B.7	Treatment Teams	PC	PC
III.B.8	Integrated Treatment Plans	NC	PC
III.B.9	Access to QMHP	NC	PC
III.B.10	Mental Health Involvement in Housing and Plcmt	NC	PC
III.B.11	Staffing	NC	PC
III.B.12	Medication Notice	PC	PC
III.B.13	Mental Health Medications	PC	PC
III.B.14	MH/DD Training for Direct Care Staff	NC	NC
III.B.15	Staff Mental Health Training	PC	PC
III.B.16	Suicide Prevention	PC	PC
III.B.17	Transition Planning	PC	PC
III.B.18	Oversight of Mental Health	NC	NC
III.G.1	Progress Notes	PC	PC
III.G.2	Accessibility of Information	NC	NC

Medical Services			
III.C.1	General Medical Care	SC	PC
III.C.2	Health Records	SC	PC
III.C.5	Access to Health Services	SC	SC
Special Education Services			
III.E.1	Provision of Special Education	PC	PC
III.E.7	Individual Education Plans	PC	PC
III.E.8	Vocational Education	NC	NC

Overall, the State is in substantial compliance with 2 of the 33 provisions (6%), in partial compliance with 26 provisions (79%) and in non-compliance with 5 provisions (15%). As noted earlier, the Monitor and subject matter experts revised the ratings from the previous monitoring period using the three-tiered system, so that comparisons could be made. Across the 33 provisions, the compliance rating was upgraded for 11 provisions (33%) and downgraded for 3 provisions (9%). 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. It is in non-compliance with the provision related to Structured Programming. The following actions should be prioritized:

- Continue to utilize aggregate data on youth violence to identify trends that threaten youth and staff safety. Identify the underlying causes of youth violence and develop targeted violence prevention strategies to address the factors that contribute to assaultive behavior among youth.
- Ensure that adequate numbers of well-trained staff are present on each unit so that youth do not endure unnecessary seclusion and have access to the full range of academic, rehabilitative and other structured programming.
- Launch the planned initiative to expand the conversation surrounding the allegations by some of the female residents that a few 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.
- Revisit the duration of pre-hearing seclusion prescribed by the IRAV to ensure that youth remain in pre-hearing seclusion no longer than necessary to de-escalate their behavior and ensure they do not pose a threat to the safety of other youth or staff.
- Limit the use of disciplinary seclusion, relying instead on sanctions that provide an opportunity for skill-development and treatment in order to create behavior change.
- Operate the PROGRESS Unit as it was designed, adhering to the prescribed limits on a youth's time in cell (i.e., address staff shortages, design a strategy to address the interference of Phase 1 youth movement on Phase 2 youth's time out of cell; facilitate youth's advancement through the phases and to the Transition Unit with quality treatment plans and progress reporting). Ensure

that PROGRESS youth have access to intensive programming and support that addresses their violent behavior. Finalize the PROGRESS Unit's policy and Youth Handbook.

- Address the serious deficits in the quality of investigations that are conducted by facility staff.
- Ensure grievances are resolved in a timely manner and are supported by appropriate documentation, attached to the grievance.
- Fully implement the process for notifying youth of the outcome of any investigation referred by the grievance process.
- Develop an appropriately focused rehabilitative program for youth who have graduated from High School or obtained their GED. Include both post-secondary educational opportunities and job skills and vocational training.

Mental Health Services

The facility is not in substantial compliance with any (0%) of the 20 provisions related to mental health services and documentation. It is in partial compliance with 17 (85%) of the provisions and in non-compliance with 3 of the provisions (15%). The following actions are required:

- ODYS has recently completed a collaborative policy and procedure review and revision process. These policies are currently in the process of review by the Monitors in both this case and S.H. v. Reed. The policies must be completed and implemented.
- The facility must be staffed with sufficient psychiatric (both psychiatric physicians and psychiatric nurses) resources to provide psychiatric evaluation, medication monitoring, and treatment team interaction.
- 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. This should include treatment integrity checks (e.g. observation of group interaction with subsequent education and training as necessary).
- 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 proposed for placement in the future.
- Continue the current practice of assigning all youth housed in the Progress Units to the mental health caseload.
- Ensure youth receive proper laboratory examinations and side-effect monitoring commensurate with the psychotropic medications prescribed and reflecting generally accepted practices.
- Develop a coherent, coordinated quality assurance process that provides a cogent review of social work, psychological and psychiatric services at the facility. This should include peer review. It should also include both process and outcome measures.
- Address limitations to treatment resulting from the fragmented recordkeeping process via the creation of a unified record.

Medical Services

The facility is in substantial compliance with one of the provisions (33%) related to medical services and in partial compliance with the other 2 provisions (66%). The provisions related to General Medical Care and Health Records were downgraded to partial compliance.

During this assessment period, the Scioto facility for the most part ensured that youth received routine, preventive, medical and care consistent with current, generally accepted professional standards. Concerns identified during this period were a result of being on site at the facility as opposed to only an off-site medical record review and the charts reviewed on this audit. The Subject Matter Expert's concern is whether youth were being adequately assessed while in seclusion for very long periods of time and after fight-related injuries occurred. Many times youth are refusing to be seen by the nurse after a fight or use of restraints or the nurse completes an assessment with the youth still inside the cell. Youth assessments should be done at a time that youth is cooperative enough to conduct an adequate face-to-face examination including vital signs. It is unacceptable to conduct clinical assessments on youth while they are still inside their cell. Policy time frames may need to be adjusted to allow a later assessment in these cases. This is also why the Subject Matter Expert recommended the addition of a satellite clinic and medication room for the Buckeye units. It is often difficult to get these youth down to the main medical clinic for an adequate medical evaluation.

The Subject Matter Expert had no concerns about individuals with health problems being identified at intake, assessed, diagnosed, and treated consistent with current, generally accepted professional standards of care. There were no concerns regarding dental care. With the exception of one unit that failed to have the health request slips out next to the drop box, the facility was ensuring that youth could request to be seen by medical staff confidentially and independent from JCOs and custodial staff. The health call slips are kept in a separate binder rather than the medical record. A self-assessment is needed to be sure all health requests from the slips are addressed within each youth's medical record progress notes.

The health record is still fragmented due to the psychological and counseling notes being housed separately on the housing units. However, after the site visit and observation of the facility layout, it would

be impractical to have a combined physical health record. It is imperative that an electronic health record is established for the sharing of the mental health and medical information by expansion of the existing mental health database to include pertinent health data, and if not, purchase of a new electronic medical record computer program.

Policies, procedures and forms reviewed for the March 2012 effective date were very good. There were cases were the effective date had not been revised to show as current. All policies should be reviewed on an annual basis. All Quality Assurance activities are not fully operational as outlined in the National Commission on Correctional Health Care Juvenile Health Standards. Based on those QA audit tools provided for review, there were the same compliance issues identified as found by the Subject Matter Expert, such as not charting vital signs for all assessments and failure to adequately complete the Problem List.

Resolution of these identified issues will allow the facility to obtain substantial compliance in all areas.

Special Education

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

- Ensure that sufficient direct care staff and education staff are available to provide students with dependable access to education services.
- Address students' chronic absenteeism with individualized plans to improve attendance and by delivering services to youth in alternative settings as needed.
- Provide dependable staffing and space to ensure that the ABC room is available to teachers and students each school day.
- Improve the consistency with which Unit Instruction data are recorded and entered so that compliance with this policy can be demonstrated. Toward this end, cross-referencing with the list of youth on Disciplinary Seclusion will be necessary to demonstrate that all eligible youth receive services.
- Improve the specificity of 1) Student Profiles and 2) Present Levels of Academic and Functional Performance sections of IEP documents to ensure that the skills students need to acquire in order to progress through the curriculum are clearly articulated in IEP goals. Develop objectives that address these skill deficits.
- Ensure that IEP Progress Reports are skill-specific and provide a clear description of what the student has mastered and what still needs to be addressed in order for the student to meet the goal.
- Develop sufficient vocational opportunities to engage all students in meaningful job skill development and/or work experience. The choice among the vocational options should be tailored to the risks and needs of youth at Scioto.

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. This change in mission required staff to adjust to a new type of youth (generally higher-risk) and to new responsibilities for their long-term care and treatment. In addition, the facility

received an entirely new Administrative Team in February 2012. This new team has an impressive array of skills, experience and enthusiasm and the Monitor is encouraged by their approach to the facility's reform.

One of the common themes affecting compliance in nearly all areas of the Stipulation is staffing. Ensuring that a facility is adequately staffed to implement the reform consistently is a complicated endeavor. First, the facility must have an adequate number of *funded positions* to ensure that youth are supervised at the proper ratios. Facilities must also ensure that the number of *vacancies* is not excessive and must address any systemic barriers to filling open positions. In addition, facilities must ensure that staff who are filling the positions actually *report to work*. Once these conditions are met, the facility must address the usual and customary staff resignations efficiently to ensure that security is maintained and youth's access to programming is not disrupted.

At various points throughout this report, the Monitor comments on the impact of staffing on the State's ability to comply with the Stipulation. In the area of Protection From Harm, the facility appears to have an adequate number of funded positions. While there are several vacant direct care staff positions, the main barrier to adequate staffing is the number of staff who are currently filling a position but who do not report to work. Remedies, currently underway, are discussed in III.A.1, below. In Education, the facility appears to have an adequate number of funded teachers' positions but struggled to fill key vacancies throughout the past two grading periods. At the time this report was drafted, these vacancies had reportedly been filled for the upcoming grading period. The Monitor has endeavored to explain the nuances of the staffing issues in each area and to identify the systemic barriers to the facility's having a sufficient number of trained staff actually reporting to work so that youth and staff safety and programming are not compromised.

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	Partial 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 any changes. While the interpretation of these data leads to significant concern for the safety of youth and staff at Scioto (particularly the rate of youth-on-staff assault, the facility's response to allegations of misconduct and inappropriate treatment by staff, and the overreliance on seclusion as a response to non-compliant behavior of all types, discussed throughout this report), the fact that the facility continues to collect and analyze these 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 contributed to youth violence. The facility's new Administrative Team has brought an increased focus on the use of data to manage the facility. Weekly team meetings discuss data related to youth safety and delve into the underlying causes of notable trends. Since the previous monitoring period, the State has also produced lower rates of youth violence, restraints and seclusion, which are the key outcome indicators associated with this provision. While additional reductions are needed in specific areas (discussed below and throughout this report), the progress in this area is recognized by upgrading the compliance rating to Partial Compliance. 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* As noted in the Introduction, at the end of the previous monitoring period, 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 compared to historical trends. The rate of youth-on-youth violence in September 2011 was .54. As shown in the table below, the rates of youth-on-youth violence have decreased significantly throughout the monitoring period, from a high of .22/.23 in the beginning of the

monitoring period, to .07/.06 at its end.

Youth Violence, October 2011 through March 2011		
Month	# Youth-Youth Rate	# Youth-Staff Rate
Oct 2011	36 .22	31 .19
Nov 2011	38 .23	36 .22
Dec 2011	21 .13	12 .08
Jan 2012	23 .14	33 .21
Feb 2012	10 .07	24 .18
Mar 2012	8 .06	20 .16

However, the rate of youth-on-staff violence has been more resistant to change. Discussions with facility administrators revealed that many of these assaults do not involve youth striking a staff person per se, but rather throwing a bodily fluid on the staff person. In March 2012, the facility adopted "container-less meals" as a sanction for this behavior. These meals meet the all of the State's nutritional requirements but vary in the way the food is packaged, and are perceived by the youth to be less desirable. For the first offense, youth are provided container-less meals for a one-week period. The second offense is sanctioned with two weeks of these meals, etc. Anecdotal reports suggest this environmental strategy (i.e., a response that does not attempt to impact the offender, but rather the environment which provides the tools used for the offense) is producing the intended effects. Data for the next monitoring period will provide more objective evidence.

The facility identified factors believed to contribute to youth-on-youth violence and implemented the following strategies:

- Assigning an Operations Manager to the school, where many of the assaults were occurring.
- Separating close custody youth from medium custody youth during the school day to limit opportunities for gang recruitment and intimidation.
- Ensuring that all units have a Unit Manager (two units did not have a UM during the beginning of the monitoring period).
- Expanding the weekly Administrative Team meeting to include a broader range of staff and to review data on youth violence collectively and to discuss targeted intervention strategies.

	Restraints Decreases in the rates of restraint are proportionate to the decreases in acts of violence, discussed above. During the beginning of the monitoring period, the number of restraints was very high (average 240 per month for the first three months), but decreased significantly during the last half of the monitoring period (average 128 per month). Based on the Monitor's experience in other facilities throughout the United States, even with this decrease, the number of restraints at Scioto is excessive. [*Caveat*: the mental health population at Scioto makes it unique compared to other similarly sized facilities, and this population generates a significant proportion of the restraints.] Overall, significant work remains to reduce the number of restraints. This is not to say that staff should not restrain youth who pose a legitimate threat to the safety of other youth, staff or themselves, but rather that the facility as a whole needs to better address the underlying causes of the misconduct and distress that leads to the restraint. Over the past six months, Scioto investigated 18 allegations of excessive or inappropriate uses of force. Two of these (11%) were substantiated for improper technique. The facility's well-developed use of force review by the Operations Administrator and Deputy for Direct Services and its vigilance surrounding adherence to policy and procedure contributes to the number of referrals, but also to greater protection from harm by staff. These 18 allegations flowed from nearly 1,100 restraints during this time period (rate of allegations is 2%; rate of substantiated allegation is less than 1%). However, although the rate of allegations is relatively low, the poor quality of the investigations completed by facility-based staff creates concern about the extent to which staff who use force improperly can be accurately identified via the investigation process. These concerns are discussed in detail in III.A.5, below, but are relevant to this provision insofar as a poor constructed investigation does not adequately protect youth from harm at the hands of staff, as required by this provision.
Steps Taken to Assess Compliance	Overall, the major indices of youth violence suggest that safety issues at the facility stabilized toward the end of the monitoring period. The new Administrative Team's use of data to identify hot spots for violence and other contributing factors appears to have properly targeted the underlying causes, has led to creative interventions, and has begun to produce the desired effects. *Staffing* One of the major contributors to the facility's difficulty in reaching substantial compliance with the Stipulation (e.g., programming, seclusion in the operation of the PROGRESS Unit) is direct care staffing. When insufficient numbers of staff are present, youth are denied access to programming and the safety of both youth and staff is compromised by inadequate supervision. The facility appears to have an adequate number of funded direct care positions, however, many of the individuals filling those positions do not regularly report to work. A significant

number of staff are off work on Occupational Injury Leave (OIL) or FMLA. Historically, little effort was made to bring these staff back to work, even when they had exhausted their benefits. In January 2012, the facility began to hold Involuntary Disability Separation (IDS) hearings. If the staff has exhausted his/her benefits and cannot return to work, he/she is terminated and the position becomes vacant—which means the agency is able to recruit and fill the position with someone who is able to report to work. Since the IDS hearings began, the number of vacant positions that can now be filled has doubled (e.g., in December 2011, there were 8 vacant positions; 21 in January, 18 in February and 17 in March 2012). Conversely, the number of staff who were not reporting to work has decreased from approximately 40 at the beginning of the monitoring period to approximately 20 at the end of the monitoring period. In other words, these dormant positions have been transformed into positions that can now be filled by an able-bodied individual who can report to work as expected. The Central Office gave approval for a special pre-service training class so that recruits could come on the job more quickly. This is an extremely positive development, and signs of relief were clearly visible toward the end of March 2012.

The facility has also used data on staff turnover to develop strategies to increase retention. In 2011, the turnover rate was 64%. Further, 47% of those who went through pre-service training were not at DYS one year later. Initiatives to improve coaching for new staff, increases in staff safety, and efforts to provide a more welcoming community for new staff are underway. New procedures to bring services (e.g., laundry, meals) to the unit, rather than staff having to go fetch them, will further support Youth Specialists in their youth supervision roles.

These initiatives are absolutely essential to the State's ability to comply with the Stipulation. Without sufficient numbers of well-trained staff, the facility will be unable to reduce violence, limit the use of seclusion, and provide adequate programming, as required.

Allegations of Sexually Inappropriate Comments or Relationships

The previous Monitor's report discussed the historical frequency with which Scioto youth have alleged to the DOJ attorneys and the Monitor that staff make sexually inappropriate comments, touch youth inappropriately, or engage in inappropriate relationships with youth. DYS had not received the same volume of allegations through its grievance process or other avenues for youth to report mistreatment, and thus the DOJ and the Monitor encouraged the State to develop additional avenues for reporting mistreatment and for increasing the integrity of the response to these claims. In order to ensure that DYS is providing adequate opportunities for girls to voice this type of concern and to reinforce the prohibition on these types of behaviors among staff, the new Administrative Team has planned the following initiatives, to be implemented in April 2012:

- The topics of inappropriate conduct by staff, boundary issues, etc. will be added to the girls' Trauma Group curriculum and youth will be given the opportunity to discuss any problems they experience with the

	psychologist who facilitates the groups. Even though the Trauma Group's dialog had not yet begun, several of the girls the Monitor interviewed commented that the issue of inappropriate staff behavior, and how to report it had been a topic of discussion during community meetings on the unit. • The topic of over-familiarization and boundary issues between staff and youth will become a standing topic on the agenda of the girls' units weekly Interdisciplinary Team meetings (IDTs). The Unit Managers will initiate discussions about girls who may have sexualized behavior and will provide staff with guidance about how to respond in these difficult situations. Staff will also be taught how to recognize and respond to indicators of over-familiarization if they occur on the unit. The prohibition on sexualized language, inappropriate touching and personal relationships will also be reinforced. Three cases involving sexually inappropriate relationships are pending with the CIO. The nature of the allegations include a) staff having inappropriate contact with a youth following release from the facility; b) two staff having a sexual relationship with a youth; and c) staff making sexually inappropriate comments to and having inappropriate physical contact with a youth. The youth's parent reported one allegation to a facility social worker and the youth's mental health clinician reported the other allegation. The source of the third referral was not clear in the documents received by the Monitor. Each of the allegations was entered into AMS on the day they were received (which triggers the CIO response) and were also reported to Child Protective Services as required by law. The Chief Inspector also submitted a list of investigations into sexually inappropriate conduct completed by the State since 2007 (n=42). Investigations from 2010 and 2011 were reviewed (n=13; the 3 investigations opened in 2012 were still pending). Across the 13 completed investigations: • 8 were unsubstantiated or unfounded (62%); • 5 were substantiated (38%). Many of these did not substantiate the original allegation, but substantiated a less serious form of misconduct: o Staff had contact with a paroled and discharged youth via Facebook. o Staff lingered in front of a youth's door for an extended period of time during her shift. o Staff placed her hand on a youth's leg and hugged him. o Staff engaged in inappropriate conversations with youth regarding each person's personal life and dating history. o Staff told a youth she loved her and hugged her. As noted in the discussion for provision III.A.5, below, investigations conducted by the CIO are high-quality and exhibit sound interviewing techniques with a broad range of witnesses, clear efforts to use other sources of evidence (e.g., videotapes) to corroborate or refute the allegation, and result in findings that

	have a sound basis in the available evidence. The 13 sexual abuse related investigations were all completed by the CIO and were of equally high quality. The Monitor and the DOJ attorney both interviewed a sample of girls while on site. Across these 17 interviews, we heard of only one situation in which staff was alleged to have engaged in sexually inappropriate behavior. Those who mentioned the incident indicated they had spoken with an investigator about the issue. Further, the accused staff had been placed on administrative leave. In summary, evidence suggests that the facility is handling matters regarding reported allegations of sexually inappropriate contact appropriately. In addition, the forthcoming initiative to broaden the dialog with both youth and staff about this issue will afford even greater protection to youth.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Reach substantial compliance with provisions related to seclusion and investigations of abuse and neglect. 2. Continue to utilize aggregate data on youth violence to identify trends that threaten youth and staff safety. Identify the underlying causes youth violence and develop targeted violence prevention strategies to address the factors that contribute to assaultive behavior among youth. 3. Ensure that adequate numbers of well-trained staff are present on each unit so that youth do not endure unnecessary seclusion and have access to the full range of academic, rehabilitative and other structured programming required by the Stipulation. 4. Launch the planned 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, respond to, and report such behavior.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.1, prepared at my request • Interviews with n=6 girls currently housed at Scioto; consultation with DOJ attorney who interviewed an additional n=11 girls • Review of CIO log of investigations into sexually inappropriate conduct since 2007 • Review of 13 investigations of sexual abuse allegations completed by the CIO in 2010 and 2011

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>Compliance Rating</td><td>Partial Compliance</td></tr>
<tr><td>Self Assessment</td><td>The State presented data on the use of seclusion across the previous six months.

Regular Seclusion
Regular seclusion is a time-out, or short period of isolation imposed by direct care staff in response to mid-level, non-violent misconduct such as throwing things, property damage, storming around the unit, etc. As discussed in the previous Monitor's report, the facility witnessed a huge spike in the use of regular seclusion just after the facility converted to a long-term facility. Historically, the facility averaged about 70 regular seclusions per month. In August and September 2011, the number skyrocketed to approximately 400 and well over 50% of the seclusions lasted longer than 4 hours. [Note: staff must obtain approval from a supervisor before placing a youth in regular seclusion and at the one-hour mark. If the youth remains in seclusion at the three-hour mark, the supervisor must document in writing the reason that seclusion remains necessary.]

The current monitoring period witnessed the use of regular seclusion returning to historical levels. In October 2011, the most disruptive youth were placed in the PROGRESS Unit (PU), which explains the rather immediate, large decrease in the use of regular seclusion. With the facility's new Administrative Team's emphasis on CBT groups and the SBBMS along with recent stability in Unit Manager and social worker staffing, the use of regular seclusion decreased even more. The rate of regular seclusion in February/March 2012 was down about 25% from the previous 4 months. Further, the vast majority of regular seclusions last 4 hours or less. [Note: Four hours is an arbitrary cut point. Most of the regular seclusion documentation reviewed indicated that youth spent an hour or less in regular seclusion.]

<table>
<tr><td colspan="4">Regular Seclusion, September 2011 through March 23, 2012</td></tr>
<tr><td>Month</td><td>#</td><td>Rate (#/ADP)</td><td>% 4hrs or less</td></tr>
<tr><td>Sept 2011</td><td>430</td><td>?</td><td>~50%</td></tr>
<tr><td>Oct 2011</td><td>68</td><td>.42</td><td>93%</td></tr>
<tr><td>Nov 2011</td><td>77</td><td>.48</td><td>81%</td></tr>
<tr><td>Dec 2011</td><td>73</td><td>.46</td><td>88%</td></tr>
<tr><td>Jan 2012</td><td>71</td><td>.45</td><td>96%</td></tr>
<tr><td>Feb 2012</td><td>54</td><td>.39</td><td>73%</td></tr>
<tr><td>March 2012</td><td>47</td><td>.38</td><td>94%</td></tr>
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Pre-Hearing Seclusion

Pre-Hearing Seclusion (PHS) is a period of isolation imposed following an act of violence, pending a disciplinary hearing. Youth on PHS remain in their rooms except for showers, rec and Unit Instruction (i.e., education)). The length of time a youth remains on PHS is determined by his or her IRAV score, which is based primarily on the severity of the current rule violation, but also attends to the youth's history of non-compliant behavior. Subject-matter experts on the *S.H.* case are currently working with the State to pilot test revisions to the IRAV policy that will permit reductions in the length of stay in PHS based on the youth's current behavior.

Data on PHS showed significant decreases throughout the monitoring period. In October and November 2011, the number of PHS was still elevated due to the increase in AOV that occurred when the facility changed to a long-term, close custody population. Beginning in December 2011, the rate of PHS began to decrease, impacted most significantly by reductions in the number and seriousness of AOV, discussed in III.A.1, above.

Pre-Hearing Seclusion, October 2011 through March 23, 2012			
Month	#	Rate (#/ADP)	% 24+ hours
Oct 2011	99	.61	67%
Nov 2011	110	.68	65%
Dec 2011	53	.33	58%
Jan 2012	75	.47	69%
Feb 2012	47	.30	74%
March 2012	31	..25	68%

While this is a promising trend, PHS continues to be the major contributor to the total number of seclusion hours experienced by Scioto youth. The facility has made important strides in developing alternatives to Intervention Seclusion (discussed in the next section), but it must examine its use of PHS to determine whether the lengths of stay generated by IRAV are excessive. IRAV is a structured decision-making tool designed to classify youth according to their risk of harm to other youth and staff. Depending on the risk category IRAV prescribes the length of stay in PHS. Self-assessment data revealed that youth who scored in the A-range on the IRAV (high risk) spent an average of 56 hours in PHS during the current monitoring period [typically, about ½ of youth in PHS score as A-level on the IRAV]. Data-driven, thoughtful modifications to the IRAV could produce significant reductions in the length of PHS, without jeopardizing facility safety.

Intervention Seclusion

Intervention hearings are held to determine whether youth are culpable for serious misconduct and whether additional time in seclusion is warranted. While on Intervention Seclusion, youth remain in their rooms except for showers, recreation and Unit Instruction (i.e., education). The rate of Intervention Seclusion has decreased significantly (by about 60%) since the beginning of the monitoring period, due in part to an overall reduction in AOVs and also to the new Administrative Team's commitment to use alternatives sanctions more frequently.

Intervention Seclusion, October 2011 through March 23, 2012			
Month	# Seclusion	ADP	Rate
Oct 2011	80	163	.49
Nov 2011	64	161	.40
Dec 2011	73	159	.45
Jan 2012	40	158	.25
Feb 2012	21	137	.15
March 2012	22	125	.18

Although the number of youth who serve seclusion as a disciplinary sanction has decreased significantly, no major changes were noted in the duration of Intervention Seclusion. Throughout the monitoring period, roughly 25% of seclusions were for less than 24 hours, between 60 and 75% were for 24 to 72 hours, and the remaining 10 to 20% were for more than 72 hours. Of additional concern is the accumulation of time spent behind a locked door if youth do not receive credit for time served on PHS. Anecdotally, the new Scioto administration appears to award credit for time served on PHS often, but the Monitor did not collect aggregate data.

Overall, the total number of hours of seclusion utilized in the day-to-day operation of the facility has decreased significantly from the high rates witnessed surrounding the facility's conversion to a long-term, close custody population. In February and March 2012, the total number of seclusion hours hit all-time low levels. However, these data should be interpreted with caution—while the use of seclusion has decreased, it remains the primary vehicle for sanctioning misconduct. As discussed in previous reports, 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. Efforts to reduce the duration of PHS and to reduce the reliance on seclusion as a sanction must continue.

Steps Taken to Assess Compliance	The facility's self-assessment accurately depicted trends in the use of the various types of seclusion. While significant work remains to comply with the various requirements of this provision, progress toward the key outcomes associated with

	this provision (i.e., seclusion is used less often and for shorter periods of time) was sufficient to justify an upgrade to Partial Compliance. A few issues deserved additional attention. First, with regard to *Pre-Hearing Seclusion*, significant changes to policy and practice appear to be forthcoming. Guided by the *S.H.* monitoring team, the State has begun to recalibrate IRAV in order to reduce the length of time youth spend in PHS. The initial impact of these changes began to emerge in March 2012, where the average length of A-level youth decreased to 39 hours. This is a promising trend and the facility should continue to push forward to examine how the IRAV can be adapted to reduce the amount of time youth spend in PHS, without jeopardizing the safety of other youth and staff. Second, with regard to the use of *Intervention Seclusion* as a response to serious misconduct, the new Administrative Team is clearly committed to develop appropriate alternative sanctions. A sample of IH documents from March 2012 was reviewed to examine the types of alternative sanctions currently in use. Of the 16 IH packets reviewed, no seclusion was ordered for 6 youth (38%), despite their having committed relatively serious AOVs. Instead, these youth received some combination of privilege suspension, Intervention Time (time added to their sentence), treatment work, apology letters or essays on a topic related to their misconduct. This trend is very encouraging and should be maximized. Third, 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 over one year, the facility has conducted random reviews of videotaped footage to ensure that staff were conducting safety and welfare checks at the required intervals. These checks continue to reveal that staff properly and consistently implement these procedures. A review of 5 sets of Intervention Monitoring logs completed in March 2012 revealed that staff make entries throughout the period of confinement. While most of the checks are properly documented, staff should be reminded not to make entries at exact 15-minute intervals (not only is this contrary to the requirement for random checks, but this level of punctuality is nearly impossible to accomplish; staff should use the actual clock time when documenting their checks). Also, in the event that the youth has covered his window with something, the staff must still verify and record the youth's activity while in the room (i.e., "window covered" is not an acceptable entry). While the facility should still make spot checks to ensure monitoring procedures are properly implemented, this component of seclusion practices appears to operate according to policy. Finally, the proper method for categorizing and recording the time that PROGRESS Unit (PU) youth spend in their rooms has been discussed since the previous monitoring period, when the PU was first opened. For the sake of clarity,

	the term *Programmatic Seclusion* is used when referring to time that youth spend in their room by virtue of being a Phase 1 or Phase 2 youth on the PU. Phase 1 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 2, youth may also spend their leisure time out-of-cell. Several problems have plagued the implementation of the PU which have resulted in youth spending a great deal of time in their rooms when, according to the program design, they should be out on the dayroom, in school, or in group treatment. The first problem is direct care staffing. The unit log on the Cedar side of the PU was reviewed in depth to ascertain the impact of short staffing on the implementation of the program. In March 2012, youth were locked down for at least part of the day because of staff shortages on 42% of the days (13 of 31 days). Comments throughout the logbook note that school, recreation, and group sessions could not be held because of insufficient staffing. As a result, PU youth spent all of this time in programmatic seclusion. Compounding this problem are shortages in the education staff, which caused school to be cancelled on 4 of 21 school days (18%). Instead of spending the 5-hour school day in a classroom, youth were confined in their rooms. In addition to this perfect storm of staffing shortages, the program is further impacted by the complexity of housing youth who must be restrained anytime they are out of their room (Phase 1 youth) on the same living unit as youth who are not restrained, but cannot be in the vicinity of youth who are in restraints (Phase 2 youth). Even though Phase 2 youth are supposed to be out of their rooms during leisure time, the need to transport Phase 1 youth to different locations on the unit means that Phase 2 youth are constantly returned to their rooms during the transports. This occurs frequently throughout the Phase 2 leisure time. The State bears the burden of demonstrating that youth are in their rooms only as much as the original program design permitted. The PU logbooks have a form for recording the location of each youth, each hour of the day. If completed properly, the facility would have a record of precisely how much time each PU 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. The previous Monitor's report discussed the various problems with the PU's documentation, but improvements have yet to be made. One way to limit the amount of time youth spend in their cells is to expedite their movement through the PU and onto the Transition Unit as quickly as possible. In order to do so, treatment plans must set up realistic, measurable behavioral goals and objectives that are regularly assessed to determine whether a youth is adequately prepared to advance to a less restrictive phase. The Monitor reviewed approximately 10 treatment plans for PU youth. Goal development is, and needs to be, a major source of emphasis among mental health staff. Goals were often

	overly vague, not measurable, or not appropriately focused on the behavior change that needs to occur in order for a youth to move to the Transition unit. Further, when youth are spending so much time in their cells, they have little opportunity to learn, practice and display the skills and behaviors that are prerequisites for phase advancement. As a result, youth stagnate in the PU and continue to suffer long periods of programmatic seclusion, both warranted (when they are Phase 1) and unwarranted (due to staff shortages and youth movement complexities). While solutions to all of these problems are reportedly underway (e.g., direct care staff positions are being freed up, as discussed in III.A.1; education staff has reportedly been hired for the upcoming grading period as discussed in III.E.1; and the facility intends to separate Phase 1 and 2 youth on opposite sides of the PU), throughout the current monitoring period, youth housed on the PU experienced far more programmatic seclusion than ever envisioned by the original program design. Unless this program begins to operate as a true segregation unit (where youth are segregated from the general population but NOT secluded), the facility will not be able to reach substantial compliance with this provision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Revisit the duration of pre-hearing seclusion prescribed by the IRAV to ensure that youth remain in pre-hearing seclusion no longer than necessary to de-escalate their behavior and ensure they do not pose a threat to the safety of other youth or staff. 2. Limit the use of disciplinary seclusion, relying instead on sanctions that provide an opportunity for skill development and treatment in order to create behavior change. 3. Operate the PROGRESS Unit as it was designed, adhering to the prescribed limits on youth's time in cell (i.e., a) address staff shortages; b) design a strategy to address the interference of Phase 1 youth movement on Phase 2 youth's time out cell; c) facilitate youth's advancement through the phases and to the Transition Unit with quality treatment plans and progress reporting). 4. Improve the quality of record keeping on the PROGRESS Unit so that the precise number of hours youth spend locked inside their rooms can be ascertained.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.A.3, prepared at my request • Youth Intervention Monitoring Logs for n=5 youth in seclusion in March 2012 • Intervention Hearing packets for n=16 youth with hearings in March 2012 • Interviews with n=6 female youth currently housed at Scioto

	• Observation of IDT meeting on Cedar Unit on April 5, 2012 • Treatment plans and IDT minutes for n=10 youth from the Cedar and Sycamore units • Unit logbooks for Cedar unit, March 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	Partial 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 completed during the current monitoring period. The Chief Inspector's Office (CIO) investigated the more serious allegations, while facility-based investigators addressed the less serious allegations. Between October 2011 and February 2012, the facility completed 32 investigations related to the topics covered by this provision. Four additional investigations were pending at the time of this report. In contrast to the previous reporting period where 39% of investigations were substantiated, only 3 of the 32 investigations (10%) resulted in a substantiated finding (2 for improper use of force, one for an inappropriate relationship with youth). The reasons for this sharp decrease are uncertain—the decrease may signify stronger adherence to policy and procedure among staff or, more likely, may be the result of inadequacies in the investigatory process (discussed below) that prevented staff misconduct from being accurately identified. The CIO conducts audits of the facility's investigations every quarter. These audits generally occur 2-3 months after the close of the quarter (Q3 2011 was conducted in November 2011; Q4 2011 was conducted in March 2012; Q1 2012 had not been conducted at the time of the site visit). As a result, no new information was available from the CIO's audits.
Steps Taken to Assess Compliance	*Investigations Conducted by the Chief Inspectors Office (CIO)* Given the high quality of the investigations conducted by the CIO in the past, a 50% sample (7 of 13 investigations) was selected for in-depth review. As in the past, the investigations were well done. They featured comprehensive interviews with all key witnesses, utilized videotaped footage effectively, 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 conclusions was clearly identified among the evidence. In terms of timeliness, only one of the 13 reports (8%) conducted by the CIO was completed within the timeline required by policy (i.e., 14 business days for use of force investigations; 30 calendar days for all others). Nine of the CIO use of force investigations were granted an extension (with the average time to complete 39 days). Throughout the CIO investigative reports, frequent references to staff call-outs and staff shortages when trying to conduct interviews with staff witnesses

	suggest that the facility's staffing problems create a systemic barrier to the timely completion of the investigations. *Investigations Conducted by Scioto Staff* The previous Monitor's report noted the poor quality of a segment of the internal investigations and cautioned the State that the quality of the internal investigations needed to improve in order to maintain the substantial compliance rating. A review of all 19 internal investigations completed during the current monitoring period revealed that the quality-related issues have become even more pervasive, and thus the compliance rating has been downgraded to Partial Compliance. Further, most of the internal investigations were not completed within the timelines required by policy. Of the 19 investigations reviewed, 7 were completed on time (37%) and 4 were granted an extension (21%; reasons not provided). A significant proportion (42%) was late without explanation. Timely investigations are essential for a robust process to address allegations of employee misconduct. Should the allegation be substantiated, staff training or discipline needs to occur as soon as possible so the individual can either return to duty, be retrained, or be terminated, as appropriate. If the allegation is not substantiated, the employee needs to be cleared so that he or she may return to full duty and be relieved of the stress and stigma of being "under investigation." Detailed feedback on each case was provided to the State to develop consensus around the essential elements of a quality investigation. To summarize: • Allegation statements need to be specific (who is alleged to have done what to whom, and when?) in order to set the context for the subsequent information. Too often, key facts were missing and it was not until several pages into the investigation that the nature of the allegation could be understood. • Any delays in assigning or initiating the investigation need to be explained. Long delays in initiating investigations were noted, and were unexplained. In part, the situation could be clarified if the investigator explained how and when the facility became aware of the allegation (which would account for those situations when the youth did not report the concern immediately after it happened). • Everyone who can contribute to the understanding of what occurred should be interviewed. In several cases, the investigator identified a very limited set of witnesses (e.g., the accused staff, the victim and possibly one other witness) even though other people were in the vicinity when the incident allegedly occurred. • Witnesses should be asked to describe what happened in their own words, and the investigator should seek clarification or additional detail through appropriate follow-up questions. Many times, it appeared that

	the witness was simply asked to respond to a set of yes/no questions. • The sequence of the interviews is important. The alleged victim should be interviewed first in order to obtain a complete accounting of the youth's concerns and to obtain details that can be used to construct questions with the witnesses and the accused staff. The accused staff should be interviewed last, so that he or she can be asked to respond to the specific allegations discovered during the previous interviews. In several cases, the accused staff was interviewed first, and thus the interview did not reflect the variety of issues raised in subsequent interviews. • The basis for the conclusions must be clearly articulated and must rest upon facts that were gathered during the investigation. Many of the investigators do not write coherent narratives and do not summarize the facts that supported the conclusion, and did not explain why they discounted facts that didn't fit. The underlying causes of this problem with the internal investigations are complex. The investigations are distributed across a large number of staff—in fact, 19 different people completed the 19 investigations reviewed. Dispersing the responsibility this broadly will inevitably lead to inconsistency, and because each staff person may only do one or two investigations per year, their opportunities to develop the appropriate skill set are very limited. Reducing the number of people who are authorized to conduct an internal investigation is strongly recommended, as is providing specific, intensive training to develop appropriate investigatory skills among those so authorized. Once properly trained, accountability measures should be enacted to address poor performance by staff tasked with the responsibility to investigate these issues. The poor quality of these investigations is of great concern. Although the allegations investigated at the facility-level are generally less serious in nature, the nature of the complaints is at the heart of the culture that the new Administrative Team hopes to change.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Produce high-quality investigations of all allegations of inappropriate conduct by staff. Whether completed by the CIO or by a facility-based investigator, the investigations must reflect timely, comprehensive interviews with all key witnesses and must arrive at reasonable conclusions based on the facts in evidence. Enact accountability measures to address poor performance by staff tasked with the responsibility to investigated allegations of all types. 2. Address direct care staff shortages that have historically made witnesses unavailable for interview by CIO and facility-based investigators, leading to the inability to complete investigations within the timelines required by policy.
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, October 2011 through March 2012" • Review of 7 CIO investigations completed since October 2011 (53% of total) • Review of 19 internal investigations completed since October 2011(100% of total)

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	Partial Compliance
Self Assessment	Since the previous Monitor's report, the Grievance Coordinator retired and an individual holding another facility position was transferred to the Grievance Coordinator position. Shortly before this report was issued, the position became vacant. The CIO conducts quarterly audits of the grievance process at Scioto. The 2011 Q4 audit was published in January 2012. As noted in the previous Monitor's report, when the facility changed its mission, Scioto youth began to submit more grievances. The number of grievances submitted in each of the 4 quarters of 2011 was 110, 94, 149 and 181, respectively. Historically, the rate of grievances (number of grievances divided by the average daily population for the month) was 0.8; in the latter part of 2011, the rate increased 50% to approximately 1.2. This increase has been attributed to both youth and staff's efforts to become adjusted to Scioto as a long-term placement, rather than a reception center. In Q1 2012, the number of grievances filed decreased about 34% to 119 (rate .85), which approximates the volume of grievances prior to the shift in the facility's mission. Across the 181 grievances from Q4 2011, complaints about the decisions by staff remained the largest category (14%), followed by living conditions (13%), concerns about personal possessions (11%) and program concerns (9%). In contrast to previous quarters, complaints about medical services were no longer in the top 4 grievance categories. The monthly grievance reports highlighted hot-button issues in the population. In October 2011, many youth were concerned that their personal possessions (mail and photographs) had not transferred with them when they moved to Scioto. From December 2011 through February 2012, grievances focused primarily on program disruptions caused by short staffing (e.g., no movement off unit; lockdown in cells; education delivered on unit or in room). Youth on the PROGRESS Units (PU) vocalized concerns about phase demotions and the "container-less meals" delivered to youth as a sanction for using food containers to assault staff with bodily fluids. The CIO reviews each grievance to ensure an adequate resolution that complies with policy and procedure. Of the 176 grievances reviewed for Q4 2011, 18% required clarification or supporting documentation. The proportion requiring this type of follow-up has increased significantly with the change in personnel. In Q1 2012, 38% required follow-up action. Most often, the action required was to attach supporting documentation, but in a small number of cases, facility policy had been misinterpreted (e.g., the SBBMS photo incentive) or needed to be discussed with the Administration (e.g., a number of the grievances complained

	about the lack of access to outdoor recreation). Data on the timeliness of grievances reveals that slippage has also occurred over the past few months. The Q4 2011 CIO report showed that of the 181 grievances, 16% were not resolved within the 14 days permitted by policy. (Historically, the facility has had very few, if any, overdue grievances). In Q1 2012, of the 119 grievances filed, 56% were not resolved timely. The Q4 2011 CIO report included a youth survey. This survey revealed that 87% of the youth at Scioto reported they knew how to use the grievance process, and that the grievance coordinator met with them face-to-face to discuss their concerns. However, the survey also identified a number of shortcomings to the grievance process. First, youth reported that a significant proportion of their grievances were resolved late. In response, the CIO changed the policy, which now requires CIO approval on all extensions. Further, significant numbers of youth reported that staff told them that they could not use the grievance process to report staff misconduct (17%), that staff treated them badly after filing a grievance (20%), or that staff told them nothing would happen if they filed a grievance (53%). In response, the grievance training module for staff has been adapted to address these concerns and to discuss more generally the ways in which staff may unintentionally impede or diminish the effectiveness of the grievance process. Although these findings are troubling, it is also clear that the State has a well-developed internal ability to identify and address its problems related to grievances. Hopefully, the actions taken in response to the youth survey will lead to improvements in the various performance measures required by this provision.
Steps Taken to Assess Compliance	The CIO's data included in the self-assessment revealed two key issues: • Lack of clarity in the resolution or a need to provide supporting documentation (38%; in Q1 2012, 45 of 119 grievances required additional information) • Timeliness (56%; in Q1 2012, 67 of 119 grievances were not resolved in 14 days, as required by policy) A sample of approximately 200 grievances submitted between October 2011 and March 2012 were reviewed, along with the follow-up action required by the CIO for 45 of them. In general, supporting documentation was needed to verify the Grievance Coordinator's statement that another staff member had handled the youth's concern or that the youth had received the service requested. Again, the quality of internal review of individual grievances is excellent; however, the grievance process must meet the outcomes envisioned by this provision (e.g., timeliness, appropriate corrective action or resolution) in order to be rated in substantial compliance. The previous Monitor's report required the State to develop a feedback

	mechanism to inform youth about the outcome of investigations that were initiated by their grievances. For several years, the policy has required youth to be informed that their grievance was forwarded for investigation and to be given the investigation number and the Scioto grievance coordinator complied with this policy. In March 2012, the procedure was expanded to include written notification to the youth of the outcome of that investigation. A letter to the youth from the facility's Labor Relations Officer (LRO) refers to the investigation number and indicates whether the allegation was substantiated or unsubstantiated. The Investigation Policy (#101.15) and the Youth Handbook have been updated to reflect this change in procedure. Historically, approximately 10 grievances are forwarded for investigation each quarter (Q4 2011 had 12; Q1 2012 had 7). Because the new policy was implemented in early March 2012, not enough time has passed to assess the implementation of the new procedure. Two letters have been issued to date; both included all of the required information, and one of the letters was mailed to a youth who had been released to the community. Anecdotes from the Chief Inspector and LRO suggest that the youth have been satisfied with this information and have not pressed for additional details that would violate personnel privacy regulations.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that grievances are resolved in a timely manner and that all resolutions are supported by appropriate documentation, attached to the grievance. 2. Throughout the upcoming monitoring period, fully implement the new procedure for notifying youth of the outcome of any investigation referred via the grievance process.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.1, prepared at my request • Q4 2011 Grievance Audit by the Chief Inspector's Office • Q1 2012 Grievance data, prepared at the request of the Monitor • Grievance Monthly Reports, October 2011 through March 2012 • AMS Grievance Summary and handwritten Youth Grievances from October 2011 through February 2012

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	Substantial Compliance
Self Assessment	The Orientation process includes two videos—one is a general Orientation video covering several topics including Youth Rights and the purpose of the grievance system. A second video focuses on the grievance process and includes information about what to do if the youth has a problem with living conditions, medical care, staff treatment, education services, etc. The video describes the differing roles of the Grievance Coordinator, the Chief Inspector's Office, and the Legal Assistance Program attorneys. Finally, youth are provided step-by-step instructions for navigating the grievance system. The information in the video is reinforced by a written Youth Grievance Handbook, which an intake staff member discusses with the youth. Youth are also provided in-depth information about sexual abuse and sexual assault in the correctional setting, and how to handle situations in which they may feel threatened or that the staff is being inappropriate. All youth are required to sign several forms indicating that they received and understand information about the grievance process. The facility audits a random sample of admissions files every month to ensure compliance with policy and procedure. Each month, October 2011 through February 2012, 100% of the youth sampled (21 total youth; 10% of all admissions) received a complete orientation to the facility, which included information on how to access the grievance system. The Grievance Officer also held "Grievance Clinics" with all youth in December 2011 and January 2012. The clinics included instructions on how to use the grievance process, how to address non-grievable issues (e.g., Intervention Hearing appeals; Release Authority decisions), and information on other, more informal processes designed to meet the youth's needs (e.g., clothing requests; mediation with staff; etc.). Each of the 6 youth interviewed by the Monitor understood the grievance process and how to use it. As discussed above, the Grievance policy was revised in early March 2012 to include procedures for informing youth about the outcome investigations that were initiated by their grievances. The new policy was introduced to current residents during February and March 2012 and the Youth Handbook and other Orientation materials were adapted to provide this information to new residents upon admission.
Steps Taken to Assess Compliance	I did not need to conduct any additional inquiry to assess compliance.
Recommendations	The State is in substantial compliance with this provision.

Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.D.2, prepared at my request • Intake Audit Report, October 2011 through February 2012

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 new Administrative Team has decided not to use the Youth Activity Tracking System, citing pervasive problems with implementation and unreliable data. They are seeking ways to track the involvement of youth in structured programming so that they can demonstrate compliance with this provision. Until then, the Monitor must rely on anecdotes and more indirect sources of information to determine the level of programming activity. While staff reports and unit schedules suggest that a variety of programming activities are scheduled (e.g., recreation, religious programming, programs delivered by mental health staff, social workers, volunteers and direct care staff), youth reports and other documentation suggest that staffing shortages at the facility often interfere with the actual delivery of these programs. While the facility provided detailed information about the staffing situation (see Provision III.A.1), it did not attempt to quantify the resulting program reductions, saying only that staffing problems have negatively impacted the ability to deliver the full range of programs on the unit schedules. *SBBMS* With the appointment of a new Unit Manager Administrator, the implementation of the behavior management system has been strengthened. Weekly meetings with the Unit Managers provide a forum to discuss implementation problems. Over the past couple months, Unit Managers are asked to address grievances submitted by youth on their units. In so doing, they have begun to ensure that youth receive their daily incentives, do not have access to privileges they have not earned, and that youth complete the assignments and sanctions as required before their privileges are re-instated. When the facility first changed over from a reception center to a long-term facility, youth frequently submitted grievances about the staff's implementation of the SBBMS. The volume of complaints about the SBBMS has decreased noticeably, particularly with the Operations Deputy's focus on this issue.

Steps Taken to Assess Compliance	The staffing issues discussed during the facility's self-assessment suggest that structured programming was frequently disrupted during the current monitoring period. Youth interviews and facility observations confirmed that direct care staffing is a major impediment to the delivery of rehabilitative programming required by this provision. A simple tracking system should be developed quickly so that a baseline for program delivery can be established and so that expanded access to programming can be tracked as the staffing issues are resolved. *Programming for Graduates* As discussed in the previous Monitor's report, graduates continue to voice complaints that they have nothing to do during the day. Indeed, information submitted by the State demonstrates the paucity of options for these youth. Across the facility, 22 students have graduated or obtained their GED. Of these, only 2 have permanent jobs (9%) and 4 have jobs on an "as needed" basis (18%). While short-term pilot programs serving a small number of students have come and gone over the years, on-going post-secondary education options (e.g., college courses, vocational training) are not available to graduate youth at Scioto. While the Administrative Team has created a few job opportunities, these involve too few youth, too sporadically to have an impact on the experience of the average graduate at Scioto. Historically, no one has "owned" this issue and the State is encouraged to invest both time and energy to develop a comprehensive, sustainable program for graduates. *PROGRESS Unit (PU)* 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 operates the PROGRESS unit (PU), which is a closed-cell program. Concerns about the amount of time these youth spend in their rooms due to staff shortages were discussed in III.A.3, Seclusion. Not only do the staff shortages cause youth to spend excessive amounts of time in their rooms, they also interfere with the delivery of the programming opportunities (e.g., recreation, education, group counseling, individual counseling) that are supposed to address the youth's behavior concerns and prepare them to reintegrate into the general population. The unit log on the Cedar side of the PU was reviewed in depth. In March 2012, youth were locked down for at least part of the day because of staff shortages on 42% of the days (13 of 31 days). In addition, there were at lease 4 days where school was not held due to both Youth Specialist and education staff shortages (4 of 22 days; 18%). Comments throughout the log note that groups were not held, recreation was not held or shortened, and youth could not be transported for medical or dental appointments because of short staffing.

	These shortages mean that the original design of the PU has not and cannot be implemented. By design, the programming on the PU was supposed to be intensive. Whether because the concept was not fully developed (as discussed in the previous Monitor's report) or because staffing has interfered with its operation, the PU has not been properly implemented and thus is not currently capable of creating the kind of behavior change needed for the youth housed there to be integrated into the general population. The sad irony is that these youth are the most in need of services, but seem to be receiving the least amount of service of any youth at Scioto. Youth progress through the Phases on the PU is an essential performance measure to ensure they have increasing access to programming that is more broadly available in the general population. Data on the movement of youth through the Phases should be maintained to identify systemic barriers (in contrast to those related to the youth's behavior). For example, in order for a youth to be promoted to Phase 2, he must first have the opportunity to demonstrate the skills required by his treatment plan. However, if he is rarely let out of his room because of staffing shortages, he will have very limited opportunities to do so. On a positive note, the PU interdisciplinary teams (IDT) have invested a great deal of time and energy in crafting Treatment Plans and holding weekly meetings to facilitate youth's progress through the behavior management system (i.e. Phases). Additional skill building is still needed, particularly on the Sycamore unit where the staff have more recent tenure, but progress on the Cedar unit is notable from the previous monitoring period. However, unless PU youth can be assured of dependable, consistent access to the full range of programming opportunities, the Treatment Teams and IDT meetings will have no hope of facilitating the type of behavior change that is so sorely needed by the PU youth.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Provide sufficient staffing in both the general population units and Progress Unit (PU) to ensure that youth have consistent, dependable access to all scheduled programming, including education, recreation, treatment groups, religious services and volunteer programming. 2. Develop an appropriately focused, rehabilitative program for youth who have graduated from High School or obtained their GED. The program should include both post-secondary educational opportunities and job skill and vocational training. 3. Fully develop the PROGRESS unit's program features (e.g., treatment plans, treatment teams, individual sessions, etc.) to ensure youth progress through the Phases and 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	The facility continues to audit a random 10% sample of admissions files every month to ensure compliance with policy and procedure. Between October 2011 and February 2012, 210 youth were admitted to the facility; 10%, or 21 youth, were included in the audit. Each month, 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* The previous Monitor's report required the State to provide youth with information that clearly described the youth's rights related to practicing their religion of choice, in particular, how they make seek accommodations for religious beliefs, practices or observance. The State revised the handbook by inserting the following language: *Every youth has the right to practice their religion. You are permitted to have the resources of your faith as long as it does not affect the safety of the facility.* The revised Handbook was put into use on January 12, 2012. Department heads and supervisors provided information to their staff on the requirement to accommodate youth's religious beliefs. As of March 15, 2012, 87% of all staff had been trained and completed a post-test about the facility's religious

	accommodations policy. During the current monitoring period, two grievances were submitted by youth who wanted the freedom to practice their religion of choice. One youth wrote that he did not want to cut his hair—that it was against his religion. In response to the youth's request, he was given an exemption to the facility's grooming policy, he was placed on a vegetarian diet, and was provided Rastafarian study materials. Another youth indicated that he wanted to convert to Rastafarianism. The Grievance Coordinator provided clear instructions for how to go about this conversion. The revised Youth Handbook clearly articulates that youth are free to practice their religion of choice and the facility has demonstrated its willingness to make religious accommodations when the issue has arisen. *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 (PU), 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 PU 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 previous Monitor's Report noted that documentation to substantiate that youth received a timely orientation to the PU could not be located. To assess whether the orientation process had become more reliable, signature pages for youth currently housed on the PU were requested for review. [Only those youth who were admitted since the previous Monitor's report was issued were reviewed, given that the facility was not aware of the problem before that time.] A total of 7 youth housed in the Progress Unit during the site visit had been admitted since January 1, 2012. Documentation was provided for all but one youth (86%) to substantiate that youth receive a complete orientation on the day of their admission to the Progress Unit. The most recent version of the PU Youth 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 Monitor provided feedback to the State on the draft version of the Handbook on February 8, 2012, but as of the drafting of this report, the Handbook had yet to be finalized. It is essential for the PU Youth Handbook to provide youth with current and accurate information about the operation of the unit, and the version currently in use omits important details. Once the Handbook has been finalized, the State will be in substantial compliance with this provision.

Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Finalize the PU Youth Handbook and policy so that they provide an accurate description of the current operation of the PROGRESS unit.
Sources of Information	• Self-assessment data and oral presentation of its interpretation for III.F.2, prepared at my request • Intake Audit Report, October 2011 through February 2012 • Scioto Youth Handbook, dated January 10, 2012 • Grievances related to religious accommodation (n=3), submitted since October 2011 • 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 since January 1, 2012 and still residing there during the site visit

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	Partial Compliance
Self Assessment	Per the SJCF self-assessment, "this provision stipulates a comprehensive screening for mental disorders within 24 hours of admission to the facility. The specific components of this screening that we perform include the MAYSI-2 and an assessment for suicide risk by nursing staff. The risk assessment conducted by nursing staff is completed within 1 hours of admission. The MAYSI-2…is completed for every youth admitted to the facility with 24 hours of admission."
Steps Taken to Assess Compliance	Per a review of ten intake packets provided for off site review revealed that all youth admitted had Reception Screening for Assaultive Behavior, Sexually Aggressive Behavior, and Risk for Sexual Victimization on the day of admission. Substance Abuse Screening was included via documents, such as the Juvenile Automated Substance Evaluation. These documents although completed, were not dated within 24 hours. It was notable however, that every assessment example provided recommended further assessment by psychology staff to complete a Behavioral Health Appraisal. The intake packets provided for review did not include documentation of the immediate screening by nursing staff, nor did include MAYSI-2 results. Per interviews performed during the monitoring visit, it was apparent that current policy and procedure regarding this process was confusing, mostly related to the multiple assessment documents and terminology utilized. In an effort to address this issue, and to simplify all Behavioral Health policies, ODYS promoted a review and revision of all policies with the involvement of central office leadership, facility administration, and facility behavioral health staff. Individuals were assigned to work groups with responsibility to review and revise policy as part of an integrated behavioral health system of care. This policy revision has been provided to the monitors in both this and the S.H. vs. Reed matter for review and comment. This policy review is currently in progress. Please note that throughout the mental health report, there are multiple references regarding the need to finalize policy and procedure. While policy and procedure is in existence and has been implemented to address processes associated with the delivery of mental health care, ODYS is currently in the process of a review and simplification of said policy. As such, the recommendation for finalizing policy is in reference to the revision and simplification process. There are existing policies in place that are fully implemented and as such the individual provisions below would

	meet the criteria for a partial compliance rating. The plan to simplify policy and via this process integrate the various mental health disciplines into a behavioral health team is positive and may result in more cohesive mental health treatment for the youth. While it is apparent that multiple assessment instruments are utilized for youth admitted to ODYS, this remains a complicated process, highlighting the need for policy and procedure revision and quality assurance monitoring. Materials provided for off site review did not clearly reveal to the monitor the response to this provision.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Fully implement 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	Partial Compliance
Self Assessment	Per the facility self-assessment, "ODYS has submitted examples…of youth identified through the initial mental health screen as needing to be referred to a mental health professional or alternative placement."
Steps Taken to Assess Compliance	This was an area of apparent improvement in the intervening period since the previous monitoring review. Discussions with behavioral health staff revealed that they felt empowered to advocate for the youth in the facility without fear of reprisal. There were examples of active advocacy noted. For example, previously, if a youth were suspected of acute mental health needs requiring transfer to the mental health unit, there was a cumbersome process to arrange this transfer. With recent shifts in process and administration, this is now reportedly a relatively painless process. For example, following the monitoring visit, a youth 999 was readmitted to the facility. Staff were familiar with this youth, and aware of his history of treatment on the mental health unit in the past. The staff wasted no time in contacting ODYS central office to request immediate transfer of this youth to the mental health unit. Following the initial contact by email, a return email was sent within ten minutes with a central office approval for transfer. Per documentation, this youth was transferred to the mental health unit the following day. In a second example, youth 111 was experiencing a deteriorating mental status. Facility behavioral health staff were noted to have made valiant efforts to address this youths increasing mental health needs; however, this youth required more intensive services than could be provided in a correctional facility. Ultimately, this youth was referred, accepted, and transferred to a residential behavioral health program. Given the review of the current behavioral health staff schedule, staff are working a flex schedule with one required evening per week and one required weekend per month. This allows for broad behavioral health coverage. One weakness of the schedule was the lack of behavioral health staff scheduled on holidays. There was an on-call schedule, and the Psychology Supervisor was responsible for this, specifically after hours telephone contact. The Psychology supervisor was also reportedly available to come to the facility for face-to-face assessments if the need arose. Given the review of documents performed for this and other paragraphs, it was apparent that there was an improvement in referral to a mental health provider,

	response from mental health providers, and access to other mental health treatment programs as needed. As such, this provision will be placed in Partial Compliance. In order to improve this level, ongoing efforts must be made to ensure that youth obtain the level of care that is necessary. In addition, quality assurance monitoring will be necessary with regard to timely response to referral and access to other behavioral health care options.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Collect data regarding the time lapse between referral and actual evaluation or assessment for quality assurance monitoring. 2. 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).
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	Partial Compliance
Self Assessment	Per the facility self-assessment, "we have provided examples…demonstrating appropriate identification of mental health needs as well as appropriate actions to transfer youth to our mental health unit and/or an alternative facility. ODYS will continue to monitor and improve the process of identifying youth with mental health needs that were not previously identified."
Steps Taken to Assess Compliance	With regard to the identification of youth previously unidentified as having mental health challenges, the facility has made changes to the facility environment in an effort to ensure that all youth requiring services are identified as such. For example, there are behavioral health staff (both psychology and social workers) housed on the units. There was also enhanced mental health presence on the Progress Units. A review of the total number of youth currently on the mental health caseload revealed that 26/27 female youth (96%) were identified. With regard to male youth 64/107 (59%) were currently identified. Additionally, via a review of the caseloads of psychology staff assigned to the Progress Units, it was apparent that 100% of the youth currently housed on those units were identified and currently receiving mental health services. Per discussions with facility staff, it was planned that all youth admitted to the Progress Units would join the mental health caseload while housed on those units. 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 was wide variability with regard to 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. 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. 4. Maintain the practice of assigning all youth admitted to the Progress Units to the mental health caseload.
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	Partial Compliance
Self Assessment	Per the facility self assessment "Our QA/QI efforts continue to evolve and develop, with increasing focus given to case conceptualization. Individual and group supervision, both clinical and administrative, are the central components of this effort…We believe the contract in regards to this provision between the treatment teams on the girl's dorms and the boy's dorms highlights a critical structural issue... The treatment teams on the girl's dorms are more mature…and function as the primary unit of identification for staff members...treatment teams on the boy's dorms are less mature, continue to have difficulty with consistent staff attendance and assignments, and do not function as the primary unit of identification for staff members… traditional divisions between the different professions and departments continue to the primary identifiers for staff members, resulting in less communication and collaboration…..We believe the shift to viewing the treatment team as one's primary unit of identification is in process on the boy's units, with our Cedar and Sycamore teams having made the most progress to date…discussions in treatment teams are more animated, detailed, clinically rich, and directed. Team members increasingly are developing more detailed and inclusive assessments and understandings of the youths with whom they are working… With continuing support from Social Work and Psychology Supervisors, clinical leadership on the team, and increased stability among unit staff, we believe we will see continuing improvement in matters related to this provision…we currently are reviewing and revising Behavioral Health Services policies and the requirements and intent of this provision will be addressed in those revisions."
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. This policy, along with others regarding Behavioral Health services have been reviewed and revised in a collaborative manner between ODYS administration and facility behavioral health staff. The policies have been submitted to the monitors for review and comment. This review is currently in process. 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. Ten examples of case formulations were provided. This included five psychological services summaries and five behavioral health appraisals. As discussed in paragraph 10, the Behavioral Health Appraisal forms have been revised, and include more pertinent information. The quality of these documents as well as the psychological services summary was variable and would likely benefit from quality assurance monitoring. For example, two of the documents provided for review were incomplete. It was noted that there are plans for training regarding case formulation in July 2012 via the subject matter expert from the S.H. vs. Reed team. For example, a good case conceptualization was authored in the case of youth 777. This youth had diagnoses including among others Posttraumatic Stress Disorder. Per the case formulation, "progress is affected by her history of complex developmental history of trauma and loss. Complex trauma involves multiple, chronic, and prolonged traumatic events, which are usually interpersonal in nature, have an early life onset, and have negative effects on normal development. The level of trauma can interfere with neurological development and the capacity to integrate sensory, emotional, and cognitive information. Someone who experiences developmental trauma often have difficulties learning how to modulate their emotions and regulate internal states, may develop disorganized and insecure attachment styles, or have trouble understanding themselves and their surroundings. [Youth name] in particular appears to have difficulties with attachment, affect regulation, self concept, and behavioral control. Secondary to the early interpersonal trauma a child will develop insecure attachments to caregivers and other people. The youth does not learn how to regulate themselves or trust and count on people to take care of them. These attachment difficulties are evident when a youth has problems with boundaries, social isolation, interpersonal difficulties, and problems with perspective taking…[Youth name] response to treatment has varied, at times she has been eager to address issues, but when she is angry she will become defiant and state she does not feel she needs to …These responses are often heard when she is non-compliant with her psychotropic medication. Her lack of maturity and social skills has interfered with her ability to integrate the things she has learned." The above conceptualization provides information regarding the developmental and psychological processes affecting the youth's ability to engage in programming.

	Other examples were less satisfactory. For example, in the case of youth 888, who had diagnoses including conduct disorder, cannabis abuse, cocaine abuse, and Dysthymic disorder, "committed to ODYS for receiving stolen property…did report episodes of low mood, loss of interest in activities that are usually enjoyable to him. He reported a subjective sense of confusion, ambivalence regarding his future- vocational interests, a life plan, or skills needs, or wants. He reported that his mother has a history of drug abuse, and that their relationship is estranged. He reported that he has an extensive history of substance abuse. His father and brother have a history of legal problems…has been in substance abuse two times [sic]; however, he continues to abuse substances he is placed on the mental health caseload to address his substance abuse, and his mood, which appears Dysthymic. It is likely that addressing these issues may assist him in clarifying a direction for his life." This case formulation was basic and written essentially from the youth's self report. There is little information here that would assist the treatment team in treatment planning, other than then need for substance abuse treatment. It is not possible to determine what premorbid risk factors contributed to his current situation. 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. The current documentation was an attempt to improve upon that process, but there is work to be done from a quality perspective. It is hoped that specific training regarding this process will be beneficial for staff. Following training, peer review and quality improvement efforts will be necessary.
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. 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	Partial Compliance
Self Assessment	Per the facility self-assessment, "The facility has begun to implement Cognitive Behavior Therapy for all Pre-Service classes during…first week the new staff is on grounds…participate in the training which includes practice with leading groups, understanding the basis for Cognitive Behavior Therapy and its effectiveness with working with youth in this type of setting…learn how to implement some of the tools…Decisional Balance Worksheet, Thinking Report and ABC Worksheet into every day practices on the unit to reinforce the use of the …concepts with the youth when they encounter problems…All three supervisors conduct ongoing clinical supervision with their staff to provide oversight and work toward improvement of clinical documentation and services in SJCF…If social services staff is going to be out for leave, they are instructed to leave the youth with packets of material to complete, and then the clinician will work with the youth when they return to review the information. In addition, we have had staff provide ongoing services if there is a vacancy on a unit either by paying overtime to cover the caseload, or the other clinician on the unit will see the youth to provide services…We monitor continually the mental health needs of youths on Progress Unit…psychology staff is housed on the units with immediate and direct access to youth…Clinical supervision with psychology staff on the Progress Units now occurs weekly…the psychology supervisor is an active participant in all meetings having to do with the Progress Units and maintains direct contact and involvement with the treatment teams on both units. Past confidently concerns have been addressed and other concerns of proper and ethical practice, as well as competent clinical practice, are primarily matters addressed in supervision meetings…We consider the question of appropriate placement on the Progress Units to be of paramount importance, and have identified and made alternative arrangements for youths in the past who were not appropriate for this unit. We have enhanced our ability to identify contraindications for placement on Progress Units. We recognize this to be an ongoing responsibility and obligation."
Steps Taken to Assess Compliance	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 observation conducted during this monitoring period, 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 (see the discussion below regarding paragraph 7 for additional information).

	Youth specialists facilitate CBT groups on the units. It appeared from the three youth specialist run groups observed during the monitoring tour that there was wide variability in the ability of individual staff and as additional training, coaching, modeling was required. Basic tenets of effective group facilitation were not utilized consistently, these included environment, review of group rules, direction of group topic, and engagement of the youth. In one group interaction led by youth specialists, youth were initially reluctant to participate. They indicated that they had heard the material before, and it wasn't helpful. Ultimately, the facilitator engaged the youth by allowing them to present a skit illustrating the day's concept. This was an excellent intervention by the youth specialist, which unfortunately, due to the youth specialist inexperience with group dynamics ended with one youth essentially taking over the group and taunting the other group members. This illustrated the need for improved coaching for staff facilitators. In the second youth specialist facilitated group observed, youth were seated haphazardly, not in a circle or semicircle conducive to engagement. The youth specialist was observed to be making sincere effort to engage the youth in the topic and the discussion. Approximately 15 minutes into the group, the unit manager entered and requested youth rearrange seating to improve the interaction. Following the rearrangement, the group facilitator was excluded from the circle, further impeding her ability to engage the youth. At this point, the unit manager began leading the discussion, with the focus on unit activities planned for the upcoming week. Ultimately, the discussion reverted to the scheduled topic, however, the youth would have benefitted from alternate modalities to promote learning (e.g. role model, skit, visual aid). This event highlights the need for routine treatment integrity checks by supervisory staff in order to ensure that staff administers the group therapeutic interactions appropriately. The above examples indicate that while there have been some improvements to the youth specialist facilitated group therapies, additional improvements are needed. Quality assurance in the form of treatment integrity checks to determine the need for increased supervision or facilitation skills for staff is necessary. Following these reviews, the training provided to youth specialists with regard to group facilitation may need to be reviewed and revised in order to ensure that principles are being appropriately addressed. In addition, staff could consider allowing youth to co-facilitate. Also the development of learning based activities for group therapies would assist in maintaining youth interest. With regard to group therapeutic interaction facilitated by behavioral health staff, a trauma treatment group co –facilitated by psychology and occupational therapy was observed. The group leaders were obviously well prepared. Unfortunately, the start of group was delayed by fifteen minutes due to a

	scheduling conflict. Administrative staff reported plans to review the schedule in an effort to reduce conflicts that impacted therapeutic interaction. This group functioned less as an interaction between staff and youth and more like a lecture or education regarding specific concepts. There were multiple opportunities for facilitators to explore specific topics with the youth; however, these were not utilized in favor of adhering to the prepared course outline. In fact, one youth attempted further discussion of a topic and was instructed by the leader to "stay on track." He was obviously upset by this. Ultimately, the occupational therapy staff sat at the table with the youth and engaged them. This was beneficial, and at the end of the scheduled group time, youth did not want to leave. A second group therapy observed with Behavioral Health staff revealed a girls trauma group where youth were actively engaged in the therapeutic process. The therapist followed the youth's lead in the discussion. The group leader was obviously more skilled, and thus led an effective group. A similar observation was made during the brief observation of a social worker facilitated group on a male general population unit. These latter two group observations revealed that there are skilled group therapy providers who could provide role modeling to other less experienced clinical staff. Additionally, they could assist with the development of activities to enhance the youth's participation in the group therapeutic process. All of the above indicate the need for quality assurance monitoring inclusive of observation and coaching for both behavioral health and youth specialist staff. With regard to the number of scheduled groups and the number of youth participating in any one group therapy encounter, this was discussed in detail in the discussion regarding paragraph 11 below. There was documentation of attendance at groups that exceed recommendations for conducting a meaningful group interaction. Review of progress notes regarding both group process and individual treatment was limited during this monitoring visit, as youth records were not provided for off site review. Rather, there were isolated examples of youth individual therapy progress notes provided as examples for other items. In review of these documents, there was 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. 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. Specific concerns were noted regarding the treatment program for youth housed in the Progress unit during the prior monitoring visit. It was noted that given the increased presence of behavioral health staff on these units with the corresponding decrease in youth census on these units that there was improvement in the overall monitoring and treatment provided for these youth. As discussed with the facility administration, facility mental health staff and DYS administration, the programming on this unit must continue to be a priority and will be the focus of future monitoring visits.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Improve documentation of group and individual therapeutic interaction and review this documentation via a quality assurance process. 2. Ensure the provision of evidence based group therapeutic interactions 3. Increase modeling and coaching for youth specialists responsible for group therapeutic interactions. This should include group therapy observation and resultant corrective action inclusive of training, supervision, etc. Administrative staff may determine that revised training for youth specialists is required. 4. Determine and ensure that appropriate numbers of youth are assigned to specific group therapy sessions. 5. Continue the integration of treatment provider disciplines in order to achieve an interdisciplinary model. 6. Continue to engage and encourage direct care staff to participate in group modalities and in the overall treatment program for the youth. 7. 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). 8. Review the Progress program, and ensure that youth are receiving appropriate mental health treatment via this program.
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	Partial Compliance
Self Assessment	Per the facility self assessment, "the OYAS system is not ready to be operationalized at this time…staff from across the agency have been using it on a trial basis…to allow them to give feedback…the facility is using a WORD document to write the youth Integrated Treatment Plans." The self-assessment also outlined process by which ODYS Behavioral Health administrative staff performed a review and training with regard to staff authorship of ITP documents (this process was discussed further in the discussion regarding Paragraph 8 below). There are also plans for additional training by the subject matter expert in the S.H. vs. Reed case scheduled for July 2012.
Steps Taken to Assess Compliance	As part of the ODYS Behavioral Health administrative review, there are plans for continuing monitoring with regard to the authorship of ITP documents. As discussed in paragraph 18 below, the facility must develop a quality assurance process to review both compliance with process and to determine outcomes associated with behavioral health treatment. 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. Develop quality assurance monitoring regarding ITP development, implementation, and progress. 3. 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	Partial Compliance
Self Assessment	Per the facility self-assessment, "The treatment team consists of a Unit Manager, Clinician(s), Providers(s), Youth Specialist(s), and staff from Mental Health Services, Psychiatry, Education, Psychology, and Recreation. Other participating staff maybe included, such as from medical services, religious services or administration. If the psychiatrist is unable to attend then he or she sends any pertinent information about a youth in his or her care to the IDT via alternate means of communication, i.e., email, telephone conversation with another team member. ODYS is continually looking at ways to increase psychiatric hours."
Steps Taken to Assess Compliance	Two treatment team meetings were observed during this monitoring visit. In both observations appropriate staff were present. In no case was a parent participating. One team, well established on the girls mental health unit, did a good job of reviewing the youth and their progress toward goals. There were challenges noted, as one youth was experiencing side effects due to her prescribed medications. This youth was reportedly experiencing sedation, and in an effort to address this, the team entered into a discussion regarding rearranging her daily schedule to accommodate her sedation. This was an instance where having the psychiatrist, as an integral part of the team would be beneficial. Rather than arranging the youth's schedule (which would not be possible in the community), the psychiatrist could adjust the medication regimen in an attempt to avoid medication side effects. The second team observed, on the Progress Unit, was not as well established. The team discussed the youth's progress toward treatment goals; however, much of the review was anecdotal and did not rely on actual behavioral data. In the case of one youth reviewed, the treatment team members had varying opinions

	on the youth's diagnosis and motivations for behavioral challenges. There was an obvious need for better integration of services and the formulation of a collaborative case conceptualization so that all team members could "be on the same page" with regard to the management of this youth. It was opined that as this team was newly formed, they would need the benefit of time to increase team cohesion and collaboration. In discussions with some team members, they were aware of the shortcomings of the team process and the need for improvement. This was encouraging, as in previous visits, Behavioral Health staff were not able to identify their own weaknesses. In previous monitoring reports, a shortcoming addressed was that in general: *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. This had improved over prior visits. Per discussions with ODYS Behavioral Health administrative staff, there were plans to move the discussion of unit issues to the end of the IDT meeting in order to minimize the "housekeeping" discussion and highlight the importance of the youth's treatment.* 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." Unfortunately, results of this QI process or other quality assurance monitoring regarding IDT meetings were not presented for review. During the two observed IDT meetings, youth specialists were present and were noted to actively participate in the discussion. This was indicative of some effort to include all disciplines in review and planning of youth treatment. Documentation regarding activities performed to integrate youth specialists with regard to mental health treatment revealed, "there have been no activities performed in the previous six months regarding efforts to integrate youth specialists with regard to mental health treatment." Reportedly due to an ongoing 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.
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. Increase efforts to include the youth's parent or guardian in the

	treatment planning process. 3. Ensure that direct care staff are included in and valued members of the IDT. 4. Begin Quality Assurance monitoring of treatment planning efforts and IDT meetings. This would include both process and outcome measures. 5. 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.
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	Partial Compliance
Self Assessment	Per the facility self-assessment, "the facility has had training from…Central Office…ITP's [Integrated Treatment Plans] that have been created by the teams reviewed and critiqued by them for quality…quality…will continue to be monitored by the clinical supervisors." In addition, there are plans for a two day training by the subject matter expert in the S.H. v. Reed case regarding case formulations and ITP writing for Behavioral Health Staff at SJCF. This is scheduled for July 2012.
Steps Taken to Assess Compliance	Document review revealed some improvement in ITP documentation. Specifically, youth strengths and measurable goals were identified on some documents. There was room for improvements with regard to ensuring goals were measurable. In the majority of examples, interventions were identified. For example in the case of youth 555, the goal was, "I will decrease my risk for violence by increasing my understanding of risk factors underlying my aggression and violence while preparing for transition back to the community." This is a multipart goal that is not measurable. There were specific interventions identified, "…completion of Understanding Yourself Workbook pages 25-33 and process with my Social Worker." This youth reportedly had strengths with regard to writing poetry, which could be utilized as a therapeutic intervention. With regard to process, "[youth name] has completed all of his assignments, but he has regressed and he has not made any progress." It would be necessary to identify other interventions that may be utilized with this youth. Review of minutes from treatment teams regarding this and other youth revealed that youth goals were documented as discussed on a regular basis. There were notations, specifically 3.8.12 stating, "he needs to decrease assaultive behavior." There was no notation of what adjustments in treatment interventions would be to assist the youth in attaining this goal. Observation of treatment teams revealed that in general youth treatment goals and their progress (or lack thereof) was being reviewed, however, as in the case outline above, identification of specific interventions for youth remained a relative weakness. What was positive was that ODYS had recognized the staff weakness with regard to development of the ITP and proactively began a training and review program for staff. As stated in multiple areas of this document, Behavioral Health policy and procedure, including policy regarding treatment planning has recently been revised and presented to monitors for review. This review is pending.

	As stated previously: *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).* It was apparent that ODYS is attempting to improve their treatment planning services in order to achieve compliance with generally accepted practices. As this process evolves, quality assurance monitoring with corrective action (inclusive of additional staff education and training) will be necessary.
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. Continue training for 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 review of revision. 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	Partial Compliance
Self Assessment	Per the Self-Assessment review "To enable youths to access mental health services directly without having to go through unit staff or another staff, locked boxes have been placed on each living unit for submission of written requests for services. However, the structure of our living units and placement of mental health staff offices on the living units has encouraged a pattern of youths asking psychology staff directly if they wish to talk or to be seen by mental health staff,. Because youths learn staff schedules within a short time of arrival on a unit, they seldom make a formal request by any other means, choosing instead to wait until their psychologist is back on grounds." Per 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 report of behavioral health staff, the above policies have been revised as part of the overall review and revision of policy. These policies have been presented to monitors/subject matter experts in both this case and the S.H. v. Reed case for review and comment. This commentary is pending.
Steps Taken to Assess Compliance	In an effort show compliance with the above provision, ten examples of youth contact with psychology staff were provided (these were for nine different youth, two examples were for the same youth). Supervisory staff indicated that currently, the practice is for psychology staff to indicate the time of the youth's request and the time that the assessment began. Of the provided examples, all were seen due to the verbal request of the youth. All of the youth were seen within minutes to one hour of their request, with seven seen immediately upon their request. Per the self-assessment and observation, 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 mental health 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. Given the Behavioral Health presence on the units, this is less of a concern, however,

	there are times (nights and weekends) where Behavioral Health staff are not immediately available, and youth must be able to make independent requests for services. One concern noted and communicated during the previous and current monitoring tours 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. There have been changes to the procedure for monitoring on the Progress Units, specifically, psychology and social work staff are required to make daily contact with youth on phase one which includes a mini mental status examination and encouraging youth to meet with and talk to the Behavioral Health staff. Per record review performed during the monitoring visit, documentation of these encounters was located. Staff interviewed indicated that in some cases, "documentation is behind…it may be handwritten." This process must be codified in policy and procedure and reviewed via quality assurance. It should be noted that in general, youth interviewed in general population and on the girls mental health units believed that they had good access to their counselor and that their needs were addressed in a timely manner. Youth housed in the Progress Units were less satisfied with their mental health treatment and contact. Interestingly, the youth interviewed on the Progress Unit were able to state their goals of treatment. Additionally, per the treatment team meeting observed during this visit, staff were more knowledgeable about the youth in general, this was opined to be indicative of the enhanced Behavioral Health presence on these units. 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 on Phase One housed on the Progress unit. 2. Determine the mental health assessment requirements for those youth on Phase Two housed on the Progress Unit. 3. Develop quality assurance monitoring to ensure timeliness and adequacy of clinical contact with those youth housed on the Progress Unit. 4. 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. 5. 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	Partial Compliance
Self Assessment	Per the facility self-assessment, "we have made changes in both the BHRP [behavioral health review panel] form and process that we believe will improve the development of treatment plans and contribute significantly to the goal of case conceptualization within the treatment teams...revised…reporting form provides a direct link from the OYAS results to the individual's ITP, and provides clear guidance and direction for identification of treatment goals and objectives…it allows for adaptation and change to address unique circumstances each youth presents…moved the process form the orientation unit directly to the treatment team that will be working with the youth throughout his program…this will enhance the team's knowledge and understanding of each youth…increase the possibility of smooth and successful transition...this change…will be included in the revised Behavioral Health Services policy…youth admitted…are screened, appraised and assessed within 30 days of admission…with the boy's population, greater than 65% are identified as being in need of mental health services, with approximately 5 – 8% of these identified at the time of admission or at some later point…as being in need of…a specialized mental health unit or life skills unit…girl's population, greater then 95% are identified as being in need of mental health services…20% identified as being in need of placement on the…mental health unit…at admission or…later in their incarceration…Monitor(s) have expressed concern…that mental health staff might be inadequately trained to identify signs and symptoms of serious mental illness in need of specialized care…supervisors…as well as…Administrative Psychiatrist…continue to monitor this…one alternative explanation of this might be that our population consists of adolescents who are in a state of rapid…changes, some of which may be related to the gradual emergence of symptoms of mental illness and/or a changing response to various psychotropic medication."
Steps Taken to Assess Compliance	During the monitoring visit, it was discussed that policy and procedure was in the process of review and revision. The revised policies have been provided to the monitors and are in the process of a detailed review. Per staff interview, a new form has been developed that is completed by the assessing clinician for presentation to the treatment team, who then functions as the Behavioral Health Review Panel making the determination regarding housing decisions. With regard to placement on the Progress Units, the census on these units had decreased substantially from the previous monitoring visit. Previously, there were 18 youth housed on each Progress Unit, currently both units together had a total population of 18 youth (11 youth housed on Cedar and seven youth housed on Sycamore). In order for youth to enter the Progress Units, a new

	referral process had been developed. Staff are now required to complete referral packets that must be presented facility administration for approval. Once placement is approved at the facility level, these admission packets must be approved by ODYS central office. For those youth with current mental health diagnoses or conditions, central office Behavioral Health staff are consulted. Unfortunately, no examples of this process were provided for off site review. As noted previously, policy and procedure is in the process of review, and this process will reportedly be included in the resultant drafts. Ten examples of intake assessment and subsequent Behavioral Health Appraisal documents were reviewed. In the sample provided, all youth were referred for a Behavioral Health Appraisal at intake. Included in the Behavioral Health Appraisal was a recommendation for placement. The monitor was not able to determine how youth who are not recommended for further assessment via the Behavioral Health Appraisal are assigned to a housing unit. Per a review of provided documents, the Behavioral Health Appraisal documents had been revised. The revision had resulted in a comprehensive document including demographic information, previous living situation, social history, developmental issues, school functioning, employment history, alcohol/drug history, mental health treatment history, history of suicidal/self injurious behavior, abuse history, problem checklist, mental status examination, assessment of cognitive functioning, diagnosis, and summary/recommendations. Recommendations included behavioral alerts, placement recommendations, treatment recommendations, recommendation for placement on the mental health caseload, considerations for specific treatment programming, and PREA recommendations. While overall there were improvements noted in the quality of documentation, variability remained. Some documents were completed; others were not. This is an area that should be monitored via quality improvement.
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 practices. 2. For those youth who require enhanced treatment following the initial placement determination, consider performing retrospective record review (e.g. QA) in order to improve assessment and placement process. 3. Begin quality assurance monitoring regarding intake and placement documentation and processes. 4. Indicate the method by which youth who are not referred for a Behavioral Health Appraisal are assessed for appropriate placement within the facility. 5. Improve documentation promulgated by the Behavioral Health Appraisal.
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	Partial Compliance
Self Assessment	The facility self-assessment for this monitoring period did not include information regarding this paragraph. Per staff interviews and a review of provided documents, it was clear that there continued to be mental health 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.
Steps Taken to Assess Compliance	Per interviews with current staff, there had been a shift with regard to their perceived ability to engage in mental health treatment. The focus of staff interviews revealed that staff felt "empowered" by facility administration to do their jobs, and believed that their opinions regarding the youth's mental health needs would be accepted and acted upon accordingly. This was a shift from the prior monitoring visits where staff did not express this sentiment. Given this shift, staff morale was obviously improved. This improvement in morale should also reflect in improved mental health treatment for the youth. A review of the provided documents revealed a spreadsheet of all mental health positions. There were a total of 18 filled social work positions (including two supervisory positions). Of these, 13 were licensed. There were two vacant social worker positions. One of these positions was noted as vacant as of 3.23.12. The second as of 5.9.12. This second vacancy date was likely a typographical error, as these documents were created in April 2012. It should be noted that of the 18 filled positions, two social work staff were out of work due to accessing family and medical leave via FMLA (Family and Medical Leave Act). There were a total of eight filled psychology positions (including one supervisor). Of these four were psychology assistants (unlicensed). Four were licensed psychology staff (inclusive of the psychology supervisor). There were two vacant psychology positions, one assistant and one psychologist. These positions were noted as vacant as of 3.11.12 and 4.1.12 respectively. There was one licensed psychiatric nurse and one psychiatric nursing vacancy. The nursing position was noted as vacant as of 12.18.11. Other mental health staff positions included two occupational therapists, a transcription service, and the facility psychiatrist. Schedules for psychology staff were provided for review. Per this document,

	psychology staff work a flex 80 hour schedule every two weeks. Regular hours are 8:30 am to 4:30 pm, and they are required to work one late night per week and one weekend per month in an effort to provide greater clinical coverage at the facility. The exception to this coverage is holidays, where per the schedule examples provided, no psychology staff is on duty. Per staff report, the psychology supervisor is on call after hours and on holidays and will present to the facility as needed. In an effort to address clinical need on the Progress Units, mental health staff resources have been shifted. Each unit now includes one psychology staff (either psychology assistant or psychologist), and two social workers (one individually licensed). Additionally, there have been efforts to assign both a psychologist and social worker to each housing unit. These shifts were the initial phase of a larger plan verbalized by ODYS to create a behavioral health team in contrast to the previous silos inherent in having artificial divisions between the departments of social work and psychology. The revision process for policy and procedure was also a step toward this integration as per staff interview, staff from various disciplines were assigned to work groups in order to provide input into the policy and procedure documents. Per the previous monitoring report, the workload for psychology staff had increased due to vacancies in social work staff positions. It was opined by the monitor that once social work positions were filled, it would be advantageous to examine the current psychology staffing pattern and required psychology workload in order to objectively determine the need for additional staff. With the planned integration of departments and creation of a behavioral health team focus, this may be premature. In addition, there has been great improvement in social work staffing since the previous monitoring visit where there were seven vacancies (as opposed to two current vacancies). 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. In previous monitoring visits, it was reported that the second mental health nurse position had been eliminated. Documentation provided for this monitoring visit revealed that the position exists and remains open. Given the severe shortage in this department, recruitment efforts must be intensified in order to fill this position. In the absence of a full time employee, the facility could consider agency or pool nursing staff. There were several examples in the provided documentation of the increased in-group therapeutic activities in the intervening period since the last monitoring visit. For example, per the document review regarding youth attendance at group: • Between 12.6.11 and 3.10.12 there were 211 male youth group units (e.g. youth attending group regarding any topic) performed by psychology or occupational therapy staff. • Between 12.15.11 and 3.17.12 there were 1171 male youth group units performed by social work staff. • Between 12.19.11 and 3.16 11 there were 232 female youth group units performed by psychology or occupational therapy staff. • Between 12.15.11 and 3.17.12 there were 786 female group units performed by social work staff. While these group therapy units are an improvement from prior contact reports, there remain issues. For example, the number of youth attending a group session was frequently noted to be excessive. This was noted more frequently with group activities led by social worker staff. For example, Core Modules provided 12.17.11 by social work staff included 22 female youth. Social worker led groups for male youth routinely included 11 or 12 male youth. This number of youth in a group interaction is not conducive to either learning or process. Behavioral health staff should determine the maximum amount of youth who may attend any one group therapy. Additionally, while the number of units has increased, there remain improvements with regard to the number of group therapy opportunities are available. For example, per the facility roster provided for this monitoring visit, there were a total of 27 female youth housed in the facility. Taking the total number of group therapy units provided to female youth (1018) and using the current female population (27), there were a total of 37 group therapies provided to each female over the three months of data provided. This would equate to 3 group encounters per week for the three month period. As all the female youth housed in the facility were engaged in treatment on a mental health unit, it is opined that this number would be higher, with daily group encounters (e.g. a minimum of 5 per week). For male youth, the total population per the facility roster was 107 on the date

	of the monitoring visit. Taking the total number of group therapy units provided to male youth (1382) and using the current male population as an average (107), there were a total of 12.9 group therapies provided to each male over the three months of data provided. This would equate to one group encounter for each male youth per week for the three month period. As the behavioral health treatment program stabilizes, increased group therapeutic encounters are expected. Please note that the above group statistics do not include those groups facilitated by youth specialits. During the monitoring visit, discussions with administrative staff revealed a focus on increasing group encounters, and holding staff accountable for group. For example, previously, groups would be cancelled frequently, the new administration requires that any group cancellation must be approved by the facility program deputy. With the current behavioral health staff, each clinician should be expected to engage in a minimum number of group therapy activities per week. Quality assurance monitoring to ensure that appropriate services with regard to both quantity (number of contact hours) and quality (with regard to fidelity to the model) are necessary. Given the serious staff shortages in psychiatry (discussed below) and mental health nursing and the need to ensure that current staff are able to provide the appropriate number of group and individual therapies to youth via a quality assurance process, this paragraph is in partial compliance.
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 via the development of the behavioral health team. 4. Ensure coverage for staff during required trainings and other absences. 5. Recruit and fill the mental health nursing vacancy. 6. Per the discussion included in provision 13 below, address the need for additional psychiatric clinical resources at the facility. 7. Begin quality assurance to review both the quantity and quality of group therapeutic interactions provided to youth.
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	Partial Compliance
Self Assessment	The facility's self-assessment did not include information on this provision.
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." A revised policy and procedure has been provided for review. This review of policy and procedure is quite extensive, as it is inclusive of all the recently revised behavioral health policies. The review is being performed in conjunction with the subject matter expert in the S.H. vs. Reed matter, and is currently in progress. 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) are reportedly provided to the youth and their parents via the psychiatric nurse for their review such that full disclosure of potential medication side effects is provided. Of the ten examples provided, eight were signed by the psychiatrist, with two unsigned documents. All examples were signed by the youth and included brief descriptions of side effect information retained by the youth following discussion with the psychiatrist. Two of the youth were over the age of eighteen, and as such, parental consent was not required. Of the eight examples where parental consent was required, six documents indicated that the parent consented to treatment with the medication. The two remaining documents included the parent's name and phone number, one indicated that despite two attempts, the

	parent was not contacted (telephone numbers disconnected) and a letter was ultimately mailed to the parent. The second document noted one attempt to contact the parent on 1.4.12; however, the results of this attempt were not noted. The second attempt occurred over two months later, 3.27.12; and the results of this attempt were not documented. Unfortunately, the facility psychiatrist was not available for interview during this monitoring visit. In an effort to determine compliance with policy and procedure as well as with generally accepted practices for informed consent, quality assurance monitoring is required. The review of the documents outlined above indicates the need for a quality assurance process. Per the facility self-assessment, given the presence of the Administrative Psychiatrist, there are plans to begin peer review with regard to this and other psychiatric treatment issues in June 2012. 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 on some level 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 and improve documentation regarding informed consent that is consistent with generally accepted practices and facility policy and procedure. 2. Finalize policy and procedure regarding informed consent in conjunction with other behavioral health policy. 3. Begin a peer review or quality assurance process for informed consent and other psychiatric documentation. 4. Ensure that medication information sheets currently available at the facility are 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	Partial Compliance
Self Assessment	Per the facility self-assessment, "the first series of revised Behavioral Health Services policies have been provided to the monitor…Administrative Psychiatrist will begin psychiatric peer review in June 20102…Administrative Psychiatrist is in the process of developing trainings on current issues in psychopharmacological treatment, including information necessary to monitor side effects."
Steps Taken to Assess Compliance	The review of this paragraph was limited as the facility psychiatrist was not available during the monitoring visit. As such, the physician was not interviewed and clinic was not observed. Psychiatric documentation was received for six youth. There was documentation with regard to psychiatric evaluation and ongoing medication management. There was psychiatric documentation with regard to the request for specific laboratory examinations. There was also documentation indicating that in some cases, the requested labs were not completed. There were flow sheets generated by the psychiatric nurse that included information such as weight, vital signs, dates of request of specific laboratory examinations, and medication compliance percentages. These forms were not complete, and had missing information on many dates. This was not surprising given the lack of psychiatric nurse resources. Given the presence of the Administrative Psychiatrist, the facility must begin the peer review/quality assurance process for psychiatric treatment. The administrative psychiatrist reported that he was in the process of revising the laboratory matrix, which designated required laboratory examinations for youth prescribed particular psychotropic medications. It is necessary that this document is revised, as there are obvious omissions. For example, for youth prescribed antipsychotic medication, there was no requirement noted for abnormal involuntary movement monitoring, however, in two cases, this documentation was located (one examination for each year for one youth). It was recognized that as only minimal documents were received, that abnormal movement monitoring documentation may exist, but was not included in the copies. Abnormal Involuntary Movement monitoring must be performed regularly (quarterly) during treatment with antipsychotic medications.

	For youth prescribed the antipsychotic medication Seroquel there was no requirement for annual eye exams, which are required due to the increased risk of cataract formation with this medication. For Lithium there was no mention of the need for an annual 24-hour urine creatinine clearance due to the risk of kidney damage inherent in treatment with this medication. For these and other noted omissions, this document must be reviewed and edited. Given continuous advances in psychiatric treatment, this document should be reviewed and updated periodically to ensure compliance with generally accepted standards of care. Once the initial review is completed and the laboratory protocol is implemented, quality assurance monitoring to determine physician compliance with the requirements, their review of the laboratory results, and their use of this information in clinical decision-making will be necessary. From the records provided, it was determined via a review of the mental health caseload document and the medication sheet for each of the youth that at the time of this monitoring visit, 71 youth were prescribed medication by the psychiatrist. This was a similar result to the previous monitoring period where 74 youth were prescribed psychotropic medication. As stated in the previous monitoring report, there had previously been over a 100% increase in the number of youth requiring psychiatric services at the facility with no corresponding increase in psychiatric clinical resources. In the previous monitoring report, inaccuracies in the tracking data for youth on the mental health caseload were discussed. Per the review of the data for this period, there were improvements. The dates of treatment plans, caseload assignments, medication start dates, medication dosage, compliance with psychotropic medications, and current diagnoses appeared to be updated. From a system perspective, it was difficult to look at trends of data (e.g. trends of prescribing, trends with regard to medication compliance) as the data were supplied for each individual youth with no compilation provided. It would be useful to determine if the data management system can be adjusted to provide reporting of data points for groups of youth over a period of time. This could also allow for some quality assurance monitoring and the identification of possible issues for further quality assurance studies. Given the manner of the data presentation, it was difficult to determine the timeliness of psychiatric treatment. Per a review of the psychiatric clinic schedule, it was apparent that clinic occurred approximately twice weekly in the previous 90 days with the exception of a 13 day gap between 1.10.12 and1.23.12. Given current contracts and the paucity of available psychiatric treatment providers, there was no clinician available to cover for the current provider in his absence. While per interviews and review of the self-assessment from previous monitoring visits 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 likely delayed. It was not possible to determine the time period between the youth's admission to the facility and their referral for a psychiatric evaluation. There were some notations in the data with regard to referral dates. In the period between 1.3.12 and 3.27.12, there were a total of 30 referrals for psychiatric treatment. Of these, eight were referrals for initial assessments. The average time lapse between referral and evaluation for these youth was 5.7 days (range 1 to 14 days). There were 22 existing patients referred to psychiatry clinic. The average time lapse between referral and evaluation for these youth was 6.6 days (range 1 to 22 days). These timelines must be addressed via policy and procedure, and they should be monitored via quality assurance. Another challenge with the data presentation was determining timeliness of psychiatry clinic follow up. In an effort to determine this, the clinic schedule was reviewed in the month of March 2012. It was noted that there were ten youth who were last seen in January 2012, indicating that they were delayed with regard to monthly assessment. Generally accepted practices and draft facility policy and procedure require that youth treated with psychotropic medications are assessed by the psychiatrist at least monthly. This was another area where quality assurance monitoring may be beneficial. 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.
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. Maintain the document regarding the current mental health caseload. Edits to this document may assist in quality assurance. 6. Begin the peer review/quality assurance monitoring for psychiatric treatment and documentation. This would include a review evaluation and diagnostics, of treatment planning for psychotropic medication, of target symptom identification for treatment with psychotropic medication, assessment for side effects with psychotropic medications, and the assessment of benefit from psychotropic medication. 7. Ensure that youth are receiving proper laboratory examinations and side effect monitoring commensurate with the psychotropic medication they are prescribed. This would require updating of the laboratory matrix and quality assurance monitoring.
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	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 had begun, however, evidence of same was not received by the monitor.
Steps Taken to Assess Compliance	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. Per the facility self-assessment, the administrative psychiatrist is collaborating with the psychology supervisor to develop training for all staff to educate them on psychiatric medications, side effects, benefits and long term concerns. This training curriculum should be provided to the monitor for review. For additional information regarding training, please see the discussion regarding paragraph 15 below.
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. Provide curriculum of newly developed training to the monitor for review. 3. Track staff compliance with training requirements and provide documentation to the monitor.
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	Partial Compliance
Self Assessment	Per the facility self-assessment, "curriculum for specific and detailed training in mental health issues and treatment has been prepared and delivered to staff assigned to mental health and other specialty programs. We will be modifying this training program for the entire facility, to be presented to staff assigned to general population units, Progress Units and specialty units alike…we will develop a continuing education component addressing mental health issues and treatment for all staff twice annually…the administrative psychiatrist, in collaboration with the psychology supervisor, are…developing a training for all staff to educate them on psychiatric medications, side effects, benefits and long term concerns…this training will be provided annually to all facility staff."
Steps Taken to Assess Compliance	Although the self-assessment indicated that curriculum for specific and detailed training in mental health issues and treatment had been prepared and delivered to staff, there was no documentation of attendance provided. Additionally, per the document request, copies of any newly developed mental health training curriculum were requested and none were received. Documentation of training provided in the six months prior to the monitoring visit was requested. This documentation noted training received by 252 staff members occurring between February 2011 and November 2011. Per a review of the positions, four were psych assistants, eight social workers, one school psychologist, two staff psychologists, and the psychology supervisor. The training topics were reviewed, and did not include those topics required by the agreement. However, the State invested considerable time and resources in training that is needed to fully comply with the Stipulation. Training topics included: meal refusal, performance based standards, safety and security policy, child abuse and neglect, youth grievance, emergency response, blood borne pathogens, ethics, prison rape elimination act, general work rules, equal employment opportunity, and cardiopulmonary resuscitation. An additional topic entitled "Managing Youth Resistance" was provided in the first and second quarter. Documentation revealed that this training was also scheduled for the fourth quarter; however, it was cancelled "due to staff shortages." In the absence of curriculum, it was not possible to determine the content or adequacy of this training, or if it was directly related to behavioral health. Additional documentation provided via the facility self-assessment included, "all

	staffs [sic] have been trained on BHS [Behavioral Health Services] policies and procedures. Staff receive a minimum of 40 hours of in-service yearly. In addition, ODYS brings in outside experts to train frontline staff as well." The self-assessment then discussed draining performed by Dr. Lisa Boesky in August 2011, with plans for an additional two-day training provided by Dr. Boesky in May 2012. The self-assessment also indicated, "staff have been trained extensively in CBT, motivational interviewing and strength based approaches." No new documentation of completed training with regard to these topics was provided for the current monitoring period. Additionally, ODYS is currently in the process of a significant review and revision of behavioral health policy and procedure, which would require review/refresher training for staff. The development of an organized, mandatory training schedule was a recommendation from the previous monitoring visits. Per the documentation provided via the self-assessment, it appears that ODYS is in the process of developing this type of program. 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 as well as the specific training topics required by the agreement. 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 noted that in the intervening period since the last monitoring visit, training regarding "Managing Youth Resistance" was cancelled in late 2011 due to staff shortages. While training is important, the facility must be able to maintain sufficient staff onsite to ensure that treatment and security services are available. Per the documents provided for the previous monitoring visit, "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 previous 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 current monitoring visit, while improved over those observed previously, indicated that further training and supervision was needed. As the monitoring visit performed to complete this report occurred in early April 2012, it was concerning that the last documented training for staff occurred in November 2011. As stated in the previous report, 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. The self-assessment indicated a more proactive approach to providing training was occurring, and this is positive, however, both

	curriculum and spreadsheets indicating completion must be provided to the monitor.
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. Provide the curriculum for behavioral health training topics and spreadsheets regarding attendance to the monitor for review. 2. Consider offering multiple trainings for each topic so that staff can schedule trainings while ensuring that their regular job duties are addressed. 3. 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	Partial Compliance
Self Assessment	According to the facility self-assessment, "the current suicide prevention and response policy, effective in November of 2011 and drafted in accordance with the guidelines set forth by Lindsay Hayes, Juvenile Suicide and Confinement: A National Survey (2004) was previously approved by federal court monitor Will Harrell. In addition, ODYS's suicide prevention and intervention process is in compliance with the Commission on Accreditation for Corrections nationally accepted performance based standards for juvenile correctional facilities."
Steps Taken to Assess Compliance	The policy and procedure entitled "Suicide Prevention and Response" revised October 3, 2011 was provided for review. Specific issues identified with this policy include: 1. Procedures a. Screening and Assessment i. Reception - There is no designated time within which the Risk Assessment Interview must be completed (as attachments were not provided with the policy received, it was not possible to review the Risk Assessment Interview document). ii. Transfer – There was no mention of the assessment or watch precautions to be provided to youth on watch status during or following a facility transfer. There is a requirement for the "immediate" completion of a Risk Assessment Interview following positive responses to questions concerning suicide ideation and self-injurious behavior during the transfer process. The time limit for the completion of this assessment was not indicated. b. Communication i. "Psychology staff are required to review psychology file information within five days of a youth's admission to a facility in order to identify possible areas of concern regarding mental status, suicide or self injury and the need for any follow up services." The policy does not designate where this review is to be documented, nor does it indicate if this review is for all youth admitted or only for those youth who have positive responses to the intake health screen. c. Precautionary Status i. This section of the policy indicates that youth placed on precautionary status must have a Risk Assessment Interview within four hours. This is the first mention

	of a time frame within which this assessment must be completed. ii. Youth placed on "watch" and who are "assessed as being at the highest risk for suicide…engaged in critical suicide attempts" are required to have "constant visual monitoring within close proximity (i.e closer than 15 feet)…line of sight shall be unencumbered." With these requirements, the staff to youth ratio is required to be "not greater than one staff to three youth. Where an adjustment pod exists the rations shall be not greater than one staff to six youth." These ratios do not allow for close monitoring of youth. For youth who are actively suicidal, one to one monitoring is required. The policy does not allow for this level of monitoring except in the case of "youth designated as making a critical suicide attempt." The level of monitoring should be determined clinically, given the results of behavioral health assessments. Regardless of a critical suicide attempt, if youth are at serious risk, there must be the ability to access one to one supervision. iii. With regard to "observation" status, there is no staff to youth ratio designated. iv. With regard to "behavioral" status, there is no staff to youth ratio designated. d. Additional comments: The policy does not designate the process by which psychiatrist is notified of a youth requiring watch status. Currently, per the document request, this is performed informally via email; however, it must be codified in policy. Per information received via the SH v. Reed action, the Suicide Prevention and Response policy was not formally approved by the monitor in that case. The policy is currently under review by the mental health subject matter expert, and there are plans to request a review of the document by Lindsay Hayes. Given the issues identified with this policy and procedure as outlined above, the review of this document by Mr. Hayes would be desirable. In addition, the agreement requires that ODYS demonstrate that interventions are implemented consistently and appropriately. In order for ODYS to ensure this, quality assurance data would be required. Per the policy review, there is a requirement for monitoring associated with this policy, "ongoing reviews shall be conducted by the designated Interdisciplinary team on a quarterly basis as part of the Departments Continuous Quality Improvement Process." Per the document request for this monitoring period, "any reviews or quality assurance data regarding suicide precautions" were requested. The response received

	indicated, "there have not been any reviews or quality assurance data regarding suicide precautions." In the previous three months, there were a total of six youth placed on suicide watch, and as such, there were youth records that could have been reviewed to assess compliance with policy. Based on the existing policy and procedure, partial compliance will be assigned.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Review and revise current policy to address timelines and ensure appropriate ratios for youth supervision. 2. Consider a review of this policy by Lindsay Hayes as recommended by the mental health subject matter expert in S.H. v. Reed. 3. Perform quality assurance monitoring to ensure compliance with policy and procedure as well as the need for corrective action.
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	Partial Compliance
Self Assessment	Review of the facility self-assessment document revealed no documentation from the facility with regard to this provision.
Steps Taken to Assess Compliance	In response to a document request for transition plans for ten youth (five of whom were prescribed psychotropic medication) discharged from the facility, the monitor was provided with the psychological services summary at discharge for ten youth, six of whom were prescribed medications at the time of discharge. The medical release summary for these youth was not provided. The medical release summary documents reviewed for previous monitoring visits contained the nursing component of transition planning inclusive of specific follow up plans (e.g. clinic contact information or appointments). The ten psychological services summary documents provided for review included a review of the youth's presenting problem; history of suicidal ideation, suicide attempts, and self injurious behavior; diagnostic impressions at intake; diagnosis history; five axis diagnosis; overall progress in treatment; goals; services provided; current medications; clients response to treatment; continuity of care/referral information; and aftercare options. The completeness of documentation was variable between documents, and would be amenable to quality assurance monitoring and corrective action. The documents provided were inconsistent in terms of specific discharge plans and lacked definitive plans with regard to referrals, support services, and parent education. Most recommendations were stated as "most likely" or "will probably." The transition plan recommendations should include concrete discharge plans for the youth and as such, should define a plan of action that the youth and their parent/guardian can follow. Again, there was marked variability in these documents. For example, youth 222 with diagnoses of Polysubstance Abuse, Conduct Disorder, and Posttraumatic Stress Disorder was documented to have "intensive substance dependency issues." The plan for discharge indicated, "upon release, youth was placed in a rehabilitation treatment facility to continue to work on her substance dependency issues." This discharge plan revealed an arrangement for ongoing treatment. Less concrete information was included in the transition plan for youth 333. This youth was diagnosed with Conduct Disorder; Polysubstance Dependence, Attention Deficit Hyperactivity Disorder, and Disruptive Behavior disorder, not otherwise specified. The discharge plan stated, "youth is likely to require follow up in the community for her history of substance abuse and possible ADHD considerations. She may also require ongoing supervision based on her history

	of criminal behaviors and current risk factors present. Youth may benefit from being released to a halfway house, residential treatment facility or day care based on the intensity of her previous substance dependence." This summary did not provide concrete referrals for treatment, nor did identify community resources that could be accessed by the youth. For youth prescribed psychotropic medication, follow up recommendations did not include the identification of clinical resources for follow up. There was no mention of a designated medical provider to perform continued monitoring of the prescribed medications on an outpatient basis. These summary documents may not be reflective of the discharge and transition planning activities performed by the behavioral health staff. During the monitoring visit, transition activities were observed with regard to youth 444. This youth was being linked with resources in the community and during the monitoring visit the youth and her psychologist travelled to the home that had been identified for her, met with the woman who will be providing personal supports for her following discharge, and visited the clinic where she will be receiving mental health services. This was an excellent example of transition planning. In reviewing existing 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. 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. It will be necessary to determine what tasks need to be completed as part of transition planning and who the responsible part will be in order to ensure youth leave the facility with appropriate scheduled follow-up services. As stated in the discussion for many of the paragraphs in this report, ODYS was in the process of a review of policy and procedure that should address these challenges. These above examples (with the exception of youth 444) 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. 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. The documentation provided for review did not include designated follow-up appointments for care following transition into the community. 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.
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. Document transition activities in the transition/discharge documents. 4. Begin quality assurance monitoring of 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	Review of the facility self-assessment document revealed no documentation from the facility with regard to this provision.
Steps Taken to Assess Compliance	As noted in the previous monitoring report, the facility had 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" outlined the process for clinical supervision and audits of clinical documentation. As noted above in this monitoring report, there was a recent effort undertaken by ODYS administration to perform a global review and rewrite of policy and procedure regarding behavioral health services. The goal of this process was to streamline policy and to promote the integration of mental health services (psychiatry, psychology, and social work) into one behavioral health program. In order to achieve this goal, ODYS designated work groups to review and edit policy and procedure. The revised policies, including policy and procedure regarding quality assurance are in the process of presentation and review by monitors (specifically monitors assigned via the S.H. v. Reed agreement). Quality assurance audits with respect to process should be developed to address specific policy and procedure requirements. Quality assurance audits were provided for review. These were performed via the clinical supervision sessions. Documents had been revised in the intervening period since the last monitoring report, and included reviews of the "first day appraisal" and "caseload review." There were challenges with this type of review. For example, the "first day appraisal" audits available for review were conducted 1.5.12, 1.19.12, 2.6.12, and 2.20.12. These four audits included reviews of a total of 14 youth. It was not possible to determine from these audits what percentage of the total number of first day appraisals performed these 14 audits represented. As data was not presented in a collated format, it was also not possible to determine trends, or the need for corrective action with regard to one particular area. Similar challenges were noted with "caseload review" audits. In the absence of tabulated data, it was not possible to determine trends or issues requiring systems review. It was noted on each individual audit that there were either compliments for the clinician's work or specific issues reviewed with the clinician under review; however documentation provided revealed that no formal corrective action had been instituted from quality assurance

	monitoring in the 90 days prior to the monitoring visit. One behavioral health peer review was provided for review. This review, including comments by six behavioral health staff occurred 2.13.12. The youth reviewed had a challenging course in the facility complicated by self-injurious behavior and frequent restraints. All documentation provided by the peer reviewers was complimentary, and offered little in the way of constructive criticism or recommendations for alternate treatment strategies. None of the reviewed documented a suggestion for behavioral health treatment in excess of what could be provided in the facility. It was notable that the monitoring team reviewed this youth's case and recommended ODYS consider a transfer to a comprehensive behavioral health facility. As noted above, the 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. Additionally, at the time of this monitoring tour, there was no formal quality assurance monitoring occurring with respect to the psychiatric physician. It will be necessary that ODYS quality assurance monitoring review four specific areas and include corrective action as needed. Additionally, a predetermined percentage of all available records should be reviewed (e.g. 10%). 1. Process measures- this type of quality assurance would determine if behavioral health services are provided in keeping with implemented policy and procedure (e.g. were evaluations performed within a specific timeline; were laboratory examinations required via laboratory parameters ordered, reviewed and addressed). For process measures regarding psychiatric evaluation and treatment, monitoring should be done via a medical model in concert with quality assurance monitoring performed for medical services. 2. Outcome measures- this type of quality assurance would determine if behavioral health services provided were of benefit to the youth. Specifically, did they result in a reduction of youth symptoms and improvement in youth functioning? This could be determined via review of youth on youth violence statistics, youth aggression statistics, and the use of segregation. Additionally, pre and post testing measures could be utilized (e.g. reduction in the scores on depression scales). It is recognized that improvements in the indices discussed above would be multifactorial and not solely the result of behavioral health services. Other outcome measures could include youth satisfaction surveys. 3. Peer review/Treatment integrity- this type of quality assurance would include a critical review of behavioral health services

	provided via a peer-review process (e.g. psychiatrists would periodically review each other's work and provide feedback). Additionally, group therapeutic process could be observed with feedback provided to the clinician or youth specialist leading group in order to ensure adherence to the model and provide opportunities for coaching and improvement of the provided services. 4. Selected studies – If a specific issue is suspected, or specific difficulties are observed with one particular unit, specific quality assurance studies could be performed with a critical analysis of the data in order to determine the need to adjust processes or treatments in order to improve efficacy. 5. Corrective action – Any comprehensive quality assurance process must include both the synthesis and review of collected data on a regular basis. Data must be collected on a continuous basis and reviewed so that issues can be addressed in a timely manner. These issues may include challenges with the practice and documentation attributed to a specific staff member or they may identify system issues. Issues that are identified must be addressed via a corrective action plan (e.g. staff training, staff supervision, policy/procedure review).
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Complete the revision of behavioral health policy and procedure. 2. Develop quality assurance monitoring based on policy and procedure. This would include process measures, outcome measures, peer review/treatment integrity, and data analysis/corrective action.
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	Partial 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 routinely evidence adequate case conceptualization information required to develop a treatment plan. Treatment plans did not routinely 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. There were noted improvements in isolated instances, as discussed in the paragraphs regarding mental health services above. As discussed during the monitoring tour, this was an area that may be amenable to quality assurance monitoring.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that case formulations are complete, outlining criteria for specific diagnoses and indicating specific youth risk factors for ongoing challenges. That treatment plans include measurable goals/objectives with targeted interventions included to address each treatment goal and that progress notes reflect interventions aimed at addressing specific treatment goals. 2. Complete the planned review and revision of policy and procedure.
Sources of Information	• Mental health records • Interviews with ODYS 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 ODYS 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 Generally. 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	Partial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) did not conduct a self-assessment for the level of medical and dental care provided at SJCF during this assessment period.
Steps Taken to Assess Compliance	An onsite visit was conducted at the Scioto Juvenile Correctional Facility on April 4-6, 2012. It was this monitor's first visit to the facility. All previous reviews of health information and other related documents had been conducted off site from records provided by ODYS. All living units were visited and procedural operations and access related to health care were observed. Locations for clinic space and pill call housed on the living unit and dining hall were inspected. The food service area was toured and staff questioned regarding access to youth special diets. Food service staff was aware of and able to verbalize the process for youth receiving special diets. There were satellite clinics and medication rooms on all the living units except Buckeye. The dining hall had a medication room. The main clinic was toured and found to be fully equipped with appropriate space, medical supplies and equipment for medical and dental care of the youth. There are three AEDs (Automated External Defibrillators) at SJCF, one each in the clinic, administration, and the progress unit. The facility areas toured appeared clean and orderly. Unit logs were checked to note whether nursing staff were conducting rounds on the units for youth in segregation. In many cases, custody staff was completing documentation that the nurse was on the unit. They often did not identify which nurse was there or the reason for the visit. The segregation room logs were not always posted on the door for the nurse to sign them after seeing youth, although multiple segregation checks were noted by nurses in the youth progress notes reviewed in the health records. A review of ten youth health records housed at the Scioto Facility was conducted. This included any Youth Injury and Assessment Forms present in the chart. 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, Dental Treatment, Oral Hygiene Instruction and Growth Chart. Admission labs were checked for completion and results within 20 days; STD screening for Gonorrhea and Chlamydia; Chronic Care and Specialty Care Consult documentation; Transfer of Health Records;

	Immunizations and Tuberculosis Screening; Medication Administration Records; Mental Health Documentation; Progress Notes and Physician Orders were checked in each health record. All records documented timely completion of intake assessments such as nurse screenings health appraisals and physical examinations usually on the same day of admission. Growth Charts were present for all youth. There was documentation of admission labs being drawn with results charted within a few days. STD screening results were documented or shown as pending with one recent admission. Immunization records were up to date except for one youth (217931). However, HPV vaccine is not being administered to all youth. HPV vaccination is generally accepted and recommended for use in males and females. I was told the HPV vaccine was not available through the free Federal Vaccines for Children Program, which is the source of all their other vaccines. All youth received tuberculosis screening with documented results. Dental examinations were completed within a week of admission with instruction given on oral hygiene. Dental treatment was provided as a result of the dental examination or as a result of a Health Request. Youth are being recalled every 6 months for dental care. All youth allergies were noted in their health record. Medication administration records and physician orders were also reviewed for accuracy and medication compliance. One female youth had complained that blood was drawn on her rather than another youth by mistake. Upon review of both female's health record, laboratory orders were found for both. There was documentation of two special diets, one activity restriction, four optometry consults and eyeglasses provided when needed. One youth failed his hearing screening and received an audiology consult. There were four youth with chronic medical conditions provided in the ten health records provided including acne, diabetes and asthma. All received appropriate assessments and treatment plans. There was one diabetic female that had complained of not receiving her insulin the night of admission. Upon review of the record, she was receiving two different types of insulin. One type of insulin was transferred with her from the sending facility and administered when due. The other, that is only required when her blood sugar is elevated, in spite of taking the first type insulin, was ordered from the local pharmacy on the day of admission. Records indicated that she did not require its use. She also complained of not having her own personal glucometer to check her blood sugar levels. The clinic provides her blood sugar monitoring with its own machine. Six 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 mental health diagnoses were not included on the youth's problem list. When nurses made isolation checks, they were documented in the progress notes. I cannot determine if all youth housed in seclusion/isolation were assessed daily by the nursing staff based on the information provided to me for review. There were some inconsistencies found for documentation of these checks on the

	unit. The only verification that seclusion rounds are occurring would be the presence of documentation. There were several "seclusion checks" noted in the youth's medical progress note, but there was not always a note on the unit by the nurses. At the next visit, I will cross check the unit logs with the seclusion list and youth medical record to be certain all youth are seen and a more extensive note is added to the medical record as to the physical status of the youth. 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. Some youth spent several days in seclusion. One youth spent 6 days in seclusion based on documentation of daily seclusion checks in the progress notes. Progress notes simply state "seclusion check" without details of the youth's health status. A more thorough review of segregation checks will be made at the next site visit. Documentation on the Youth injury and Assessment Reports were reviewed for those included in the ten health records. Youth often refused medical assessments or nurses conducted assessments through cell doors, especially after fights or the use of restraints. Internal Quality Assurance documents were reviewed that were provided by ODYS which included several Quality Assurance audit instruments. Medication Administration Record reviews for November 2011, December 2011, January 2012 and February 2012 showed a slight trend in decreasing compliance from the end of 2011 to the beginning of 2012, most likely due to some major staffing turnover that occurred during that same time period. The Medical Record Review audit instruments showed 100% compliance for November 2011, January, February, and March 2012. February 2012 Dental Services audit instrument showed 100% compliance. The documentation of vital signs audit showed non-compliance in some records on the Emergency Services instrument and the Vital Signs at Encounter Review, supporting earlier findings. The March 2012 Processing of Specialty Consults audit instrument showed 100% compliance. There was one Intra-system Transfer that occurred with review of that record with 9 out of 10 criteria met. March 2012 Nursing Health Call audit instrument was mostly compliant; also it found vital signs were not being taken at all encounters. On the last day of the site visit, I met with Dr. John Brady, Medical Director and Pamela Robbins, Director of Nursing along with Scioto Nurse Manager, Vickie Donohue to discuss the medical findings.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Expand the immunization program to include HPV vaccinations of youth as soon as available on the Vaccines for Children Program. 2. Add satellite clinic and medication room to Buckeye Units for adequate injury assessments of youth and medication administration on the unit. Youth that require restraint or use of force need to be assessed in a timely manner. It is easier to move them to a clinic on the unit for the assessment than attempting to get an already angry youth out of the unit and across campus to the medical building to be assessed. 3. Youth assessments should be done at a time that youth is cooperative enough to conduct an adequate face to face examination including vital

	signs. It is unacceptable to conduct clinical assessments on youth while they are still inside their cell. 4. Limit time of youth in seclusion and improve documentation of health status during segregation. 5. 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. This area has shown some improvement since the last review however most are still incomplete (of the ten records reviewed, none had a complete problem list including the mental health diagnoses or acute medical problems). 6. 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. Conduct Quality Assurance Program as outlined in the National Commission on Correctional Health Care Juvenile Health Standards. 7. Conduct self assessment
Sources of Information	• Site visit tour; Review of ten youth health records: ID # 217011; 218026; 217809; 217931; 217246; 217655; 217246; 217951; 217732 and 217926; Quality Assurance Documentation as outlined above.

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	Partial Compliance
Self Assessment	The Ohio Department of Youth Services (ODYS) did not conduct a self assessment for the level of medical and dental care provided at SJCF during this assessment period.
Steps Taken to Assess Compliance	Review of ten youth health records. Demonstration of Mental Health Data Base while on site at facility. Review of Policies and Procedures and Standard Operating Procedures (SOP) effective 3/1/12 provided by ODYS. All health records reviewed contained some health information transferred from the county probation offices or other facilities. I do have a concern that the offense data contained within the Disposition Investigative Report is included in some of the health records along with the medical information on the youth. The offense information is irrelevant to the provision of the youth's health care and should not be included in the health record. The health record is still fragmented due to the psychological and counseling notes being housed separately on the housing units. However, after the site visit and observation of the facility layout, it would be impractical to have a combined physical health record. It is imperative that an electronic health record is established for the sharing of the mental health and medical information. SJCF currently has a Mental Health Database that I observed during the April 2012 visit. Although not all inclusive, this database includes diagnosis, medication information and medication compliance. Psychology staff that are 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. This existing database could be expanded to include other medical information, if the cost of a new EMR is cost prohibitive.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Continue to improve process for sharing of health information between medical and mental health to include psychologists, by expansion of the existing mental health database to include pertinent health data, if not purchase of a new electronic medical record. 2. Continue to review and update policies and procedures annually. 3. Correct Effective Dates on new policies (see below).
Sources of Information	• Site visit tour; Review of ten youth health records: ID # 217011; 218026; 217809; 217931; 217246; 217655; 217246; 217951; 217732 and 217926.

	• Review of Policies and Procedures with supporting forms supplied to me by ODYS effective March 1, 2012 to include: Dental Services; Dental Record Form; Environmental Health and Radiation Safety Form; Dental Radiology SOP effective date 3/31/10; Dental Sterilization and Infection Control; Dental Tracking Form; Dental Examination (03/31/10 effective date); Dental Treatment Plan; Dental Tracking; Nursing Protocols for Screening Assessment and Stabilization of Dental Conditions (effective date 3/31/10); Removal of Precious Metal (effective date 03/31/10); Youth Dental Appliance and Precious Metal Receipt and Routing Form; Health Care Treatment Plans for Youth with Special Needs; Medical Problem List; Chronic Care; Chronic Care Management Forms for Asthma, Diabetes, Hepatitis, Hypertension, Seizures, Tuberculosis +PPD, Generic Chronic Care Condition; Chronic Care Monitoring Tool; Consent for Medications for Youth with Mental Health Diagnoses; Chronic Care Management Mental Health Treatment with Antipsychotics; Dietary Consultation Form; and Food Consumption Form.

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	The Ohio Department of Youth Services (ODYS) did not conduct a self assessment for the level of medical and dental care provided at SJCF during this assessment period.
Steps Taken to Assess Compliance	Health Request call drop boxes were present on all the living units. Only one housing unit had to locate Health Request slips when asked, rather than having them readily available near the drop box. When I asked for one, the staff immediately replaced them and explained that youth sometimes will take them down and they had not been replaced. Health Request Slips were out and accessible to youth on every other unit. Progress Notes and Nurse Health Requests were reviewed in 10 health records, five selected by the monitor on site and 5 provided electronically by ODYS for youth at the Scioto Facility. Health requests included in these health records were responded to adequately and documented by medical staff 100% of the time. 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. As a result of conducting the site visit, I discovered a separate notebook of Health Call Requests that were not stored in the health record. This explains why there are more nursing notes addressing youth complaints in the progress notes than there were health request slips in the record. Additional progress notes documented responses to health call requests that may have been kept in the Health Request Binder. A few examples of Nurse Health Requests included, a youth that complained of a chipped tooth that was seen by the dentist the following day with coat and bonding treatment provided; youth complaint of difficulty sleeping triggering a sleep log and mental health referral; youth minor complaints of acne, constipation, lip sores, and soap irritation that were addressed by nurses the following day. One youth with Asthma that complained of chest tightness received an appropriate assessment and treatment with follow up by the physician. During the site visit in April 2012, youth interviewed by Dr. Dedel did not express any complaints regarding health requests not being addressed by health care staff.
Recommendations	In order to continue substantial compliance with this provision, the State must: 1. Ensure Health Request slips are readily available to youth on the all housing units in proximity to the drop boxes. Youth should not have to rely on custody staff to request forms. 2. Conduct self assessment to correlate health call requests from youth stored in notebook binder with documentation of the health call request assessment in the progress notes.
Sources of Information	• Site visit tour; Review of ten youth health records: ID # 217011;

	218026; 217809; 217931; 217246; 217655; 217246; 217951; 217732 and 217926.

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	Partial 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. More recently, education and direct care staff shortages have interfered with the ability to provide consistent services to the general population and have caused a major disruption to the PROGRESS Unit's (PU) educational program. *Staffing Issues* Shortly after the facility converted to a long-term placement for medium and close custody youth, the rates of youth violence increased significantly. The school addressed this problem by separating the housing units during the school day (previously, the units were comingled and medium custody boys were thought to be threatened, intimidated and victimized by the close custody boys). During the current monitoring period, the schedules were shifted so that medium custody and close custody boys attended school in different buildings, and the girls attending school separately as well. This appears to have created a safer environment that is much more conducive to learning. In addition, the education program was seriously disrupted by teacher vacancies. The facility appears to have an adequate number of funded teachers' positions. However, due to teacher resignations and disability leave toward the end of the monitoring period, the school was short two special education teachers, one math teacher and one science teacher. School Administrators reported that class cancellations occurred a few times per month since January 2012, but more frequently in March 2012 because the attendance person went out on maternity leave and the facility's only substitute teacher had to fill that position. Lacking additional substitute teacher resources, many classes could not be covered and youth had to remain on their housing units. These education staffing problems were compounded by direct care staffing problems. In the general population, units often did not have sufficient Youth Specialists to transport youth to school so the teachers had to travel to the units to deliver services. The logistics were challenging and in general, this strategy did not work well to deliver quality educational services. In the Spring grading period, units were rotated in and out of the school so that everyone got a half-day in the school building. This occurred on about 5 occasions during the 2.5 month

	grading period. School was cancelled altogether on three days in March 2012, and while some youth received instruction on their units, some youth did not. On the PROGRESS Unit (PU), the direct care staff shortages were particularly dire. Without 3 Youth Specialists on duty, PU youth cannot move to the designated classrooms. A review of March 2012 attendance records for the PU revealed that on 17 days, youth did not attend school in the classrooms. Instead, they received worksheets under their doors for most of the four academic periods. *ABC Room* 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 October 2011 and March 2012, 180 youth were referred to the ABC room. This rate of referral is significantly lower than the previous monitoring period, when 262 youth were referred. The reasons for this decrease are discussed below. Youth were referred to the ABC room for rule violations pertaining to offensive or threatening conduct, being disruptive, distracting other students or being outside an authorized area. Of these, approximately 90% satisfactorily completed the requirements of the ABC room and were returned to their classrooms. *Unit Instruction* Previously, the Parties to the *S.H.* lawsuit negotiated an agreement regarding the delivery of education services to youth who are confined to the living units for disciplinary reasons. Students in seclusion must receive instruction from a certified teacher four times per day, for at least 30 minutes per visit (i.e., Unit Instruction). The State submitted documentation for Unit Instruction provided during the October-December 2011 and January-March 2012 grading periods. A total of 16 students reportedly required Unit Instruction for the October-December 2011 period; and 33 students reportedly required it for the following grading period. Documentation verified that all of these students received some level of service, but comparisons to other data submitted by the State bring these numbers into question. Recall that in Provision III.A.3, a total of 217 uses of Intervention Seclusion were recorded for the October-December 2011 period, and 88 were recorded for the January-March 2012 period. While only a subset of these youth would meet the criteria for Unit Instruction (i.e., have been in Intervention Seclusion for at least 72 hours), the number of students served by the school still appears to be too small. The State will need to confirm the number of students in Intervention

	Seclusion at the 72-hour threshold, and then verify that all of these students received Unit Instruction. This cross-referencing should be submitted during the next monitoring period, particularly as the data entry problems with Unit Instruction (discussed below) are resolved. The Unit Instruction recordkeeping had improved somewhat compared to the previous monitoring period, but was still fraught with problems. The attendance clerk position was unfilled for the entire monitoring period, and various individuals have filled the position on a temporary basis. As a result, attendance codes were not used consistently and the time thresholds for Unit Instruction were sometimes confused. Second, teachers misunderstood the requirements for Unit Instruction and were only providing coursework in the four academic subjects, when they should have been providing coursework for students' two elective subjects as well. The Education Administrators were well aware of the on-going problems and quite candid about the areas in need of improvement.
Steps Taken to Assess Compliance	*Staffing Issues* The School Administrators were completely candid about the obstacles they faced during the current monitoring period, and thus no additional data collection was needed to assess compliance. From all reports, the situation should improve dramatically during the upcoming grading period. Nine new Youth Specialists have completed pre-service training, the school received three new substitute teachers and the teachers on maternity and disability leave are schedule to return to work. Clearly, compliance cannot be achieved if youth do not have dependable access to the school program. Furthermore, for some youth on the PU, attending school is the nearly the only time they are permitted to leave their rooms, and many youth have treatment goals tied to school attendance. Staffing problems that cause these youth to spend the entire day locked in their cells can have very grave consequences in terms of the youth's mental health and ability to transition off the PU. *Absenteeism* For some students, disruption in access to school caused by staff shortages is compounded by their own absenteeism. A sample of IEP Progress Reports was reviewed for the purpose of determining compliance with the provision related to IEPs. (III.E.7). This review suggested that a number of youth have serious attendance problems. At least 5 of the 26 students (20%) reviewed had such significant absenteeism that progress on their IEP goals could not be measured. These students were not listed on the Unit Instruction rosters so it is unclear how their time out of the classroom is categorized and recorded, and whether services were provided to them some other way. As noted with the staffing issue discussed above, if students do not have dependable access to educational services, the State cannot demonstrate its compliance with this provision. *ABC Room*

	While youth who actually serve their ABC sanction appear to adjust their behavior so that they can return to the classroom in a relatively short period of time, several problems plagued the implementation of the ABC room. First, the aforementioned teacher resignations required the ABC teacher to be pulled into the main school to cover classes. As a result, teachers and students in the main school often did not have access to the ABC classroom. Further, close custody boys were served in the Fitness Center's classrooms and the Fitness Center does not have sufficient classroom space to operate an ABC room, meaning the ABC option was unavailable to this segment of the population as well. As a result, students were supposed to serve their ABC time on the housing units. However, there were many logistical problems associated with this strategy, so youth did not always serve their ABC time and even when they did, they were not required to do the assignment, the work was not returned to the teacher, and/or the documentation was not completed properly. A review of the existing ABC documentation suggests that staff need to exercise more care in completing the ABC form. The descriptions of the student's behavior from the referring teacher were often blank or overly vague (e.g., "disruptive," "disrespect," or "creating distraction"). More precise behavioral descriptions would allow school administrators to identify teachers who may need additional help with classroom behavior management and would also allow the youth's treatment teams to identify the precise situations that are interfering with the student's ability to fully engage in school. Further, the documentation often lacked exact start/stop times and the time credits were not always tracked. In the past, the ABC room has proved to be a useful tool to intervene with disruptive youth so that the learning environment of the classrooms can be preserved. While space and staffing shortages caused a major disruption in this service during the current monitoring period, several teachers have been hired and space has been reallocated so that teachers and students will have dependable access in the upcoming grading period. *Unit Instruction* Without a list of youth who spent time in Intervention Seclusion, it is impossible to know whether the Unit Instruction practices are sufficient to identify and serve all of the youth who do not report to school for that reason. These data will be requested and reviewed for the next monitoring period. Hopefully, the existing problems with coding and data entry will be resolved so that the cross-referencing will be both accurate and reliable.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Ensure that sufficient direct care staff and education staff are available to provide students with dependable access to education services. 2. Address students' chronic absenteeism with individualized plans to improve attendance and by delivering services to youth in alternative

	settings as needed. 3. Provide dependable staffing and space to ensure that the ABC room is available to teachers and students each school day. 4. Improve the consistency with which Unit Instruction data are recorded and entered so that compliance with this policy can be demonstrated. Toward this end, cross-referencing with the list of youth on Disciplinary Seclusion will be necessary to demonstrate that all eligible youth receive services. 5. 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	Partial Compliance
Self Assessment	The State provided data on the 57 special education students in custody as of March 15, 2012 (approximately 55% of the total population). Of these youth, three student's IEPs were expired. The other 54 youth (95%) had current IEPs. Historically, the State has struggled ensure that IEPs include measurable goals and objectives. Training and technical assistance has been on-going, with both the Special Education Administrator and Intervention Specialist reviewing draft IEP documents prior to the meetings' being held. Only when the IEP goals and objectives are clearly stated can meaningful progress reporting be accomplished. 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 53 students (100%) who were at Scioto at the end of the January-March 2012 grading period. Of these, 32 youth were still working toward mastering the IEP goals and thus no IEP revision was required. The other 21 students required IEP meetings to revise goals (student met the goal, goals needed to be better articulated, a Behavior Intervention Plan was required, etc.). This focus on whether students are actually acquiring the skills and competencies prescribed by the IEP is very positive.
Steps Taken to Assess Compliance	A sample of 10 IEPs (the last 10 IEPs written by Scioto prior to the Monitor's April site visit; 18% of the total special education population) were reviewed to assess the quality of goal articulation and the extent to which progress monitoring and reporting facilitated student progress. Eight of the 10 students qualified under the Emotional Disability category and 2 had Specific Learning Disabilities. In terms of the prescribed level of service, six students (60%) were served entirely in the regular education classrooms (with consultation from the Intervention Specialist), 3 students (30%) were served in the Resource Room for one or two periods per day, and 1 student (10%) was placed in the self-contained classroom on the mental health unit. Two students (20%) received services from the Occupational

	Therapist and 3 students (30%) received services from the Speech and Language pathologist. These placements seemed appropriate given the description of the youth's academic and functional performance contained in the IEPs. *IEP Goal Development* The question of whether progress can be accurately measured rests on the quality of articulation of the IEP goals and objectives, which depends, in turn, on clear descriptions of the students' skill deficits. While a few of the IEPs' Student Profiles contained excellent descriptions of the youth's strengths and weaknesses, overall, the Profiles tended to focus heavily on the students' classroom behavior. While all of the Profiles featured input from the students' teachers (an excellent practice), teachers' input was often overly focused on the youth's behavior and did not specify the specific skill deficits that inhibited the student's progress in the curriculum. Similarly, the Present Level of Performance section used to set up each IEP goal, was often non-specific, generally limited to the youth's recent scores on the relevant achievement test. While the goals were indeed measurable (nearly all of them identified an increase in achievement test scores), about half of the students' objectives were not anchored to the specific skills the youth needed to acquire in order to achieve the goal (e.g., "satisfactorily complete assignments requiring reading fluency, comprehension, and writing activities to earn 60% each quarter"). Math objectives tended to be better articulated than Language Arts objectives, as they identified the specific skills needed to accomplish the goal (e.g., subtracting and multiplying fractions; multiplication problems involving one-digit numbers; etc.). Further, behavior goals tended to be overly general and not individualized. While the description of students' behavioral challenges was usually comprehensive and multi-faceted, the goals and objectives were nearly identical across students. Some students did not have a clearly articulated basis for the behavior goal (i.e., the Student Profile indicated that the youth had regular attendance, had only a few negative behavior reports, and generally remained on-task in class). Other students had behavioral objectives that did not reflect the nature of their particular challenges (e.g., objectives would set attendance thresholds or a reduction in YBIRs when the youth had neither attendance problems nor YBIRs but instead could not stay on task, was distracted, talked excessively to peers, and did not follow directions well). Greater specificity in the language used to construct objectives would surely make progress reporting easier and more meaningful. While transition goals were nearly identical for all students, the similarities in tasks to be accomplished make these similarities reasonable. However, from there, goals need to be further developed for each student so that they reflect the likely

post-secondary education and post-release path of the student. Unfortunately, students will be challenged in pursuit of these goals given the very limited vocational training and job opportunities available at the facility (see III.E.8, below).

Progress Reporting

Past Monitor's reports have voiced concern about the frequency and quality of progress reporting on IEP goals. Progress reports specific to each goal on the IEP must be compiled and mailed to parents at the conclusion of each grading period. The facility has made significant progress in sending these reports (reports were sent for 100% of special education students for both the October-December 2011 and January-March 2012 grading periods).

While still not at the level required to reach substantial compliance with this provision, the quality of content in the Progress Reports is improving. For the October-December 2011 grading period, a random sample of 14 Progress Reports were reviewed from the 72 that were created (19%). In just under half of the cases (42%), the reports included clear, specific information about the student's acquisition of necessary skills or their persistent problems in mastering the required material. Reports on behavior goals were multi-faceted and included behavior in a variety of settings.

However, over half (58%) of the Progress Reports had significant problems, such as:

- The goal was not measurable to begin with, so the progress report was vague and non-specific.
- The data reported did not respond to the way the goal was supposed to be measured (e.g., teachers reported a course grade when they were supposed to be tracking a variety of problem behaviors; teachers gave behavioral descriptions when they were supposed to report grades on a set of assignments). If a student was supposed to receive 80% or better on a series of reading assignments and tests, those specific results should be reported.
- The report did not give any sense of the skills that needed to be mastered in order to achieve the goal, or which skills had been acquired. This was particularly obvious when the goal related to increasing the student's grade equivalence score on an achievement test—the following discussion stated only whether the youth took the test or not, but did not discuss the skill areas in which deficits remained.

For the January-March 2012 grading period, the Monitor altered the methodology upon recognizing that the progress reporting had improved. Rather than assessing a student's progress report as a whole, the student's goals were assessed individually so that more incremental progress could be detected. Across the 12 Progress Reports reviewed, a total of 38 goals were assessed.

	Among these, approximately 70% of the reports clearly stated whether the student had acquired the necessary skills to achieve the goal and with what types of tasks the student continued to struggle. In so doing, these reports gave a much clearer sense of the distance the student needed to travel to achieve the goal and how instruction could be better focused in the subsequent grading period. This is very encouraging. The remaining 30% of goals did not have sufficiently detailed reports. [It is worth noting that many of these were Transition goals, which have been newly added to the Progress Reporting process. Their inclusion is very positive, but also reinforces the importance of these goals being clearly articulated, measurable and attainable during the period the youth will be housed at the facility.] Particularly now that youth 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. Of course, the problems pertaining to access to education services described in III.E.1, above, preclude the reliable delivery of special education services, particularly for youth on the PROGRESS Unit, where services were delivered through the youth's door approximately 80% of the time.
Recommendations	In order to reach substantial compliance with this provision, the State must: 1. Improve the specificity of a) Student Profiles and b) Present Levels of Academic and Functional Performance in IEP documents to ensure that the skills students need to acquire in order to progress through the curriculum are clearly articulated in the IEP goals. Develop objectives that address these skill deficits. 2. Ensure that Progress Reports are skill-specific and provide a clear description of what the student has mastered and what still needs to be addressed in order for the student to meet the goal. 3. Ensure that sufficient direct care staff and education staff are available to provide youth with dependable access to education services.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.7, prepared at my request • Review of n=10 IEPs of current Scioto students' IEPs (18% of the total population) • Review of n=14 Progress Reports from the October-December 2011 grading period (19% sample) and n=12 Progress Reports from the January-March 2012 grading period (21% sample)

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	In its self-assessment, the State discussed data on student enrollment in the three currently available vocational classes. Of the 88 students at Scioto: • 9 students (6 boys, 3 girls; 10% of the population) are enrolled in Administrative Office Technology (a course that teaches students how to use various computer applications to prepare them for clerical, data entry, graphics, or other office-based jobs); • 10 students (7 boys, 3 girls; 11% of the population) are enrolled in Career-Based Intervention (i.e., a campus job; students get credit); and • 13 students (15% of the population) are enrolled in Transition Skills (students must take this course prior to release; includes job skills, resume building, interview skills). So, course offerings continue to be quite limited and only about one-third of Scioto's students are involved in semester-long vocational courses. [During the most recent intersession, seven students participated in a 16-hour ServeSafe program in which students could earn a certificate in safe food handling.]
Steps Taken to Assess Compliance	Students who have graduated or obtained a GED are not protected by this provision since they are no longer eligible for special education. The dearth of available programming for these youth is discussed in III.F.1, above. Although not directly relevant to this provision, fully developed programs for graduates and a robust array of vocational opportunities for students would be mutually beneficial. The DYS is urged to take responsibility for the post-secondary educational opportunities for graduates. 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 DYS has had several loosely conceptualized plans for developing the vocational program since the inception of the Stipulation, and yet none of them has gained any traction. This is the least well-developed of all of the Stipulation's provisions that are currently overseen by the Monitor. Immediate and significant attention is required.
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. The choice among the vocational options should be tailored to the risks and needs of the youth at Scioto.
Sources of Information	• Oral presentation and underlying documentation for provision III.E.8, prepared at my request • Interview with Bonnie Sweeny, newly appointed Education Superintendent