PROGRESS Unit at the Scioto Juvenile Correctional Facility

1st Status Report
Civil Actions 2:08-cv-00475 and 2:04-cv-01206

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INTRODUCTION

In October and November 2012, pursuant to the *United States v. Ohio* and *S.H. v. Reed* Stipulations, the U.S. Department of Justice (DOJ) and the *S.H.* plaintiff class each initiated a process for dispute resolution to address concerns regarding the purpose, structure, and operation of the PROGRESS and Transition Units at the Scioto Juvenile Correctional Facility (the PU). The Monitors and Plaintiffs in both cases have expressed on-going concerns about DYS' operation of special management units since at least 2007. The Ohio Department of Youth Services (DYS) and DOJ negotiated and agreed upon a proposed Consent Order, filed with the Court on December 19, 2012. The Court did not sign the Order until January 18, 2013 when it was also incorporated into a broader settlement between DYS and the *S.H.* plaintiff class. The Consent Order sets standards related to PU policies, admissions screening, programming, out-of-room time, staffing, treatment planning, length of stay, and promotion and demotion between phases. The *S.H.* settlement supplements the Consent Order with additional standards related to PU behavioral health staffing and quality assurance.

PURPOSE AND STRUCTURE OF THE REPORT

Although the DOJ monitoring team issues reports every six months, Drs. Dedel and Glindmeyer feel strongly that progress can be facilitated by more frequent feedback to the Parties. The PU program is changing quickly, and more frequent feedback will both recognize the State's progress and also provide sufficient guidance to keep the program development on track with what is required in the Order. The Parties and Monitors agreed that Drs. Dedel and Glindmeyer would write this first status report, covering the period January 18, 2013 (the date the order was signed) through February 28, 2013. While January 18, 2013 is the official "start date," it is important to recognize that the PU reform effort predates the Order. The State, DOJ and Monitors began sketching out a new vision for the PU in early November 2012, and the State began submitting data documenting these changes in late November 2012. Status Reports will be issued every three months hereafter. The next one will cover the period March 1 through May 31, 2013 and will be issued sometime in June 2013.

In order to facilitate progress, this report is formatted as a Quality Assurance (QA) report. When the Order was incorporated into the *S.H.* settlement, a requirement for a QA plan to be developed and implemented was imposed. While there are many ways to accomplish this task, Drs. Dedel and Glindmeyer believe that structuring feedback using a QA model will provide a clearer sense of our expectations of the State toward this end, and will advance the State's understanding of Quality Assurance and Quality Improvement (QA/QI) by using concrete, real-time examples. We hope that this format is helpful to the Plaintiffs in their effort to assess the current conditions of the PU and to the State in their efforts to adopt a QA/QI system that creates the internal capacity to identify and solve problems.

Technical assistance notes are offered throughout the report. These are designed to improve the DYS' ability to monitor program performance (and, concurrently, assist the Monitors in providing a comprehensive review of the program). Generally, these issues cluster around data collection issues and documentation needed to substantiate program performance.

For each of the seven substantive areas in the Order [identified by the Consent Order's paragraph number in brackets], the report includes the following:

- *Standard*: A statement of what the State is trying to achieve in the particular substantive area. Multiple standards may apply to a single substantive area. The standards are based on the requirements of the Court Order. However, they are a statement of what "should be," not necessarily a description of what currently exists at this point in time.

- *Status*: For the purpose of the status report, the Monitors use a two-level system for each substantive area: the area is either in substantial compliance or it is not. [Once the DYS adopts a comprehensive QA program, it is encouraged to adopt non-legal language for these categories. For example, "Exemplary Performance," "Adequate Performance" and "Performance Needs Remediation." Further, under the QA program, each standard within the substantive area should be rated individually to provide a more precise measure of the PU's performance.]

- *Methodology*: The data that should be used to assess performance toward the standard. In some cases, this goes beyond the data that have been sent to the Monitors.

- *Analysis and Interpretation*: A presentation of the data collected for the timeframe, January 18-February 28, 2013, and an interpretation of what it says about the extent to which the standard is being achieved. [At times, this report relies on older data to provide a better context for the discussion or to better illustrate patterns that have emerged.]

- *Recommendations*: Statements regarding what must occur in order for the standard to be achieved. The Monitors also provide technical assistance throughout this document, intended to solidify quality assurance procedures or ensure the integrity of the program design.

The recommendations refer to a Quality Improvement Plan (QIP). This structure is utilized to shift responsibility for the ongoing monitoring of the PU to the DYS, in order to make external monitoring unnecessary. A QIP is recommended for each area in which the Monitors have identified areas of concern. A multidisciplinary team should be involved in analyzing the problems to understand the reasons they occur, and then drafting a QIP to address the underlying causes of the problem.

Subsequent status reports will ask for the State's analysis and interpretation of current data, which will be validated by the Monitors. From there, the Monitors will review the progress made on QIPs developed in response to this report. As substantial compliance is reached with all of the standards, the State should begin to produce both the QA and QI portions of the report.

Although DYS is not yet in substantial compliance with any of the standards, it is essential to recognize that less than two months have elapsed since the Order was signed. In several cases, DYS has addressed most of the requirements of the subsection and must refine only a small part of the required procedures.

The Order is very specific. Dissecting the PU at this level risks "missing the forest for the trees." The PU is a radically different program than it was a year ago, when the Plaintiffs for both lawsuits raised serious concerns about the amount of isolation and lack of treatment that characterized the youths' experience. Today, all youth on the PU are out of their rooms during waking hours and are engaged in a full range of education and rehabilitative programming. This change represents a massive cultural shift for DYS and the PU staff. From here, DYS must tie up some procedural loose ends and must advance the substance and quality of the treatment offered to youth on the PU so that they can return to the general population more quickly. Even in the short time since the PU reform effort began, the DYS has made significant positive changes to the quality of the youth's living conditions.

Furthermore, DYS has been dutiful in its submission of required data and information and has supported the monitoring team's efforts to obtain current, accurate descriptions of the PU's functioning. In late February 2013, the *S.H.* Lead Monitor and his Assistant made an unannounced visit to the PU. DYS cooperated fully and the Monitors' observations largely validated the data that DYS had been submitting. Not only were all youth out of their rooms during waking hours, but they also remained out of their rooms even after a youth engaged in a serious incident. Such observations are very encouraging.

While there has been significant progress, much work remains. One of the key findings of this status report is the frequency with which youth are recycled back through the phases, resulting in prolonged lengths of stay on the PU for most youth. While most of the procedures designed to ensure prompt promotion have been properly implemented, many youth continue to engage in problematic behaviors even after they are promoted toward the general population. While some of these youth may persist in problem behaviors no matter what treatment interventions and behavior management strategies are attempted, the deficits in treatment planning suggest that improvements in this area may produce better outcomes, and shorter lengths of stay, for many of the PU youth. DYS is strongly encouraged to focus on the reasons that youth are not moving through the program back to the general population within the basic prescribed timelines (i.e., not the behavior, but rather the skill deficits). Questions about whether youth are receiving the type and intensity of treatment prescribed by their treatment plans are also still pending, given the difficulties experienced in matching current ITPs to the *CaseNotes* data.

The monitoring team sincerely hopes that this report brings greater clarity to the work that lies ahead and provides a useful template for the DYS Quality Assurance/Quality Improvement program.

Technical Assistance Note: Data Analysis and Interpretation
The Court Order requires DYS to provide a broad range of data to substantiate compliance with the various requirements. Simply providing the data is only the first step—these data must demonstrate that the PU is functioning in a manner that cures concerns about the program's design, the treatment and services provided to youth, whether youth develop the skills necessary to meet behavioral expectations and treatment goals, and the youth's length of stay on the unit. In order to do so, the data must be specific and must be structured to reveal the dynamics of the care provided to youth. *Toward that end, the Monitors provided feedback to DYS designed to improve the quality of the data. DYS began submitting data to the Monitors well before the Order was signed. Since early December 2012, the*

Monitors provided feedback to address the following issues:

- *Categorization and completeness of data contained in the CaseNotes database to accurately depict the amount of CBT group therapy, other treatment, and various contacts with youth.*
- *Accuracy of the data contained in the Youth Activity Tracking data to ensure that it can be used to troubleshoot issues that became evident with leisure time, delivery of MAV groups by the Youth Specialists, meals being eaten in rooms, and opportunities for recreation.*
- *Methods for validating the activities categorized as "Structured Programming."*
- *Functioning of the Central Office Review Board.*
- *Tracking youth's progress toward behavioral expectations and treatment goals and how these could be captured in the IDT minutes rather than continuing to utilize the Behavioral Tracking Sheets that were originally designed for this purpose.*
- *Capturing the youth's length of stay on each phase, and cycling back through the phases when it occurred.*
- *Analyzing and interpreting the data in-house so that program modifications can be made more quickly and without needing the Monitors to direct these improvements.*

In mid-February, DYS requested a hiatus in providing data so that the bugs in the various databases could be addressed and an internal effort to review and interpret data could be launched. As of the writing of this report, fixes to the databases are underway but the facility has yet to undertake the task of analyzing and interpreting the large volume of data submitted. The Monitors requested that the data submission resume in order to ensure that current data are immediately available and to ensure that progress toward meeting the performance objectives envisioned in the Order does not stall. All historical data, albeit unanalyzed was submitted prior to the drafting of this report. Hopefully, the format of this report will help DYS to conceptualize the type of internal review that is still needed to demonstrate that this type of intensive, external oversight is no longer necessary.

[II.14] Policies, Procedures and Handbooks [monitored by Dr. Dedel]
Status: Not in Substantial Compliance

(1) Standard: Policies and Procedures
Policies and procedural manuals are current, accurately describe the operation of the PU, and provide guidance to staff in implementing the standards for the Unit. The Youth Handbook accurately describes the operation of the PU so youth know what to expect from the program and what is expected of them.

Methodology.
The following information is used to determine compliance with the standard:

- PU Policy
- PU Procedural Manuals
- PU Youth Handbook

Analysis and Interpretation.
The Court Order grants DYS 60 days from the day of signing to submit policies, procedures and Handbooks that accurately describe the operation of the PU. DYS submitted these materials to the Monitor within the required timelines. Because the timeline fell outside of the review period and because both documents will require some revision to ensure they capture all of the information required by the Court Order, the adequacy of the documents will be discussed in the next Status Report.

Recommendations.
In order to meet the standard associated with Policies and Procedures, the DYS should develop a Quality Improvement Plan to address the following issues:

1. Creating written policies, procedures and a Youth Handbook that accurately describe the operation of the PU. Reviewing and revising the documents as needed to keep pace with the evolution of the program.

II.9 Admission Screening [monitored by Dr. Glindmeyer]
Status: Not in Substantial Compliance

(1) Standard: Admissions Screening.
The PU accepts only those youth who can be reasonably expected to respond positively to the type of program and treatment services on the Unit. As such, their behavior and mental health history is reviewed to ensure that the behaviors are not the symptoms of mental illness (including undiagnosed or untreated mental illness). Youth with the following DSM-IV diagnoses or conditions are excluded from placement on the PU:

- Thought Disorders
- Mood Disorders
- Developmental Disorders
- Recurring self-injurious behavior or suicidal ideation.

Methodology: The following information is used to determine compliance with the standard:

- "Requests for PROGRESS Placement" table

Technical Assistance Note: Admissions Screening
The methodology for auditing the PU admissions process needs to be fortified in order to gain a more complete picture of the characteristics of youth who are admitted to the PU and the screening process itself (e.g., whether the admissions protocol was followed, whether youth with disqualifying diagnoses were denied admission). This information would also be useful to determine whether certain diagnoses may be harbingers for poor adjustment to the PU. Future submissions to the Monitor should include: • *Notes from the Administrative Psychiatrists' documenting the pre-admission review* • *Mental health files of youth who are admitted to the PU. [Note: During a conference call in February 2013, Dr. Glindmeyer requested mental health files for all youth admitted to the PU, but was directed to request them individually. Only three youth had been admitted at that point and so it was unclear why this request could not be fulfilled.]* *The DYS QA team should review these same documents, once comprehensive internal audits of the PU are established.*

Analysis and Interpretation.
The "Requests for PROGRESS Placement" grid included the following information: youth's name; identification number; facility; date the PU packet was received; adjudicated offense; mental health caseload status; educational program (e.g. regular or special education); DSM diagnoses; reason for request for PU placement; outcome of request (e.g. either approved or denied); the rationale for the approval/denial of placement; and the date of transfer to the unit.

Per a review of the grids for December 2012 and January 2013, there were a total of five youth referred for PU placement. Of those five youth, two were declined for PU placement. The first, JH, was declined, as "youth had not been placed on any special management plans to address his behavior." TH, the second youth, was declined as "the youth's ITP had not been updated to reflect the youth's current behaviors so that they could be addressed…the youth had not been placed on a behavior contract." Both of these cases revealed the recognition of the need for the

implementation of intermediate steps to address the youth's behavioral challenges prior to resorting to PU placement.

Of the remaining three youth approved for PU placement, all had DSM-IV-TR diagnoses listed; however, only two youth were assigned to the mental health caseload. The third youth, KD, had diagnoses including ADHD and Borderline Intellectual Functioning. There was a notation of previous diagnoses including Conduct Disorder; Bipolar Mood Disorder, not otherwise specified; Alcohol Abuse; Cannabis Abuse; and Antisocial Personality Disorder. Given these significant mental health diagnoses, it would be expected that this youth would be assigned to the mental health caseload. It is also concerning that this youth had a previous diagnosis of a mood disorder, which would be an automatic exclusion to PU acceptance. It is recognized that this diagnosis may have been revised prior to his PU referral; however, a review of medical records would be necessary to determine this.

There was a notation in the "Central Office Progress/Transition Unit Review Board" documentation dated 1.30.13 that youth KD "requested to see the psychiatrist and restart his medication." It was noted that Depakote ER (a mood stabilizing medication) was prescribed, with the dosage increased on January 23, 2013 to a total of 1000 mg daily. This document indicated that KD's diagnosis included "rule out Bipolar Disorder, not otherwise specified;" however, the utilization of this medication was suspicious for an actual diagnosis of Bipolar Mood Disorder. There was also documentation of this youth engaging in assaultive behaviors and sexually inappropriate behaviors. Moreover, the document provided recommendations to the Interdisciplinary Team (IDT) which included, "the youth's psychological services summary does not include a case formulation, treatment progress, or the youth's response to treatment" indicating the likelihood that the youth's diagnoses had not been formulated in a collaborative manner prior to his referral to the PU or for the period between his acceptance to the PU on 12.31.12 and the review board documentation dated 1.30.13 and signed 2.5.13. Regardless, this youth's record, inclusive of the documentation of the Administrative Psychiatrist's review, should be reviewed closely given his admission to the PU with a potential mood disorder, which should have been ruled out prior to admission.

Of the three youth accepted for the PU, two were receiving special education services. One youth, TB, was noted as receiving special education services due to "ED" indicating "emotional disturbance." This youth also had mental health diagnoses including Cannabis Dependence; Oppositional Defiant Disorder; Conduct Disorder; and rule out Psychotic Disorder, not otherwise specified. This youth was accepted to the PU "due to the youth's continued assaultive behaviors despite staff's efforts." This case is concerning as the potential presence of a thought disorder is an automatic exclusion to PU acceptance. At the time this report was authored, documentation indicated that this youth had transferred to the PU on 2/1/13 and remained on Phase 1 as of 3/8/13. Over time, ODYS should monitor the length of stay on the phases for youth with mental health disorders. Regardless, this youth's record, inclusive of the Administrative Psychiatrist's review, should be reviewed closely given his admission to the PU with a potential thought disorder, which should have been ruled out prior to admission.

Youth	Diagnoses	Phase One	Phase Two
TB	Rule out psychotic disorder, NOS; Conduct Disorder; Oppositional Defiant Disorder; Cannabis Dependence	Transfer 2.1.13 Per roster of 3.8.13 youth remains on P1 35 days	
KD	Current Diagnoses: ADHD and BIF. Prior diagnoses: Rule out Bipolar Mood disorder, NOS; Conduct Disorder; Oppositional Defiant Disorder; Alcohol Abuse; Cannabis Abuse; Antisocial Personality Disorder	Transfer 12.31.12 Last documentation on unit 2.16.13 and youth remained on P1 47 days (minimum, stay may have been longer, do not have record of date of transfer to another facility)	
DG	Adjustment Disorder; PTSD; Conduct Disorder; Cannabis Abuse	Transfer 2.1.13. Promoted 2.20.13 19 days	Promoted 2.20.13

The table above suggests that youth with certain mental health diagnoses (e.g., TB and KD) require an increased amount of time to progress through the phases. This should be reviewed by ODYS on a continuous basis.

While the facility has a process for reviewing and screening youth prior to admission, a few youth were admitted with “rule out” diagnoses. If these diagnoses were finalized and “ruled in,” they would have precluded the youth from admission. Youth should not be admitted to the PU with these pending diagnoses.

Recommendations.
In order to meet the standard associated with Admissions Screening, a Quality Improvement Plan should be developed to address the following issues:

1. Expanding the scope of data that are available for review by the QA auditor (e.g., youth’s complete mental health record; Administrative Psychiatrist’s notes).
2. Ensuring that youth referred for admission to the PU are screened with regard to the presence or absence of a mental health condition that would preclude admission. For these youth, alternate placements should be considered (e.g., a referral to the mental health unit).
3. For youth with mental health conditions who are accepted to the PU, reviewing their length of stay on each level to determine whether youth with mental health conditions experience difficulty progressing through the stages on the PU, further informing the referral and screening process.

[II.10] Daily Schedule [reviewed by Dr. Dedel]

Status: Not in Substantial Compliance [Note: see issues regarding large muscle activity while in restraints and a written plan for graduate programming during school hours.]

***(1) Standard: Out-of-Room Time*.**

Youth on the PU have as much out-of-room time as youth in the general population, which ensures their access to the rehabilitative treatment necessary to address the behaviors and skill deficits that resulted in their placement on the PU. In general, PU youth are out of their rooms from 7am to 7pm, except during shift change (40 minutes daily), medication pass (30 minutes daily), Treatment Team (3 to 4 hours per week), and seclusion time that is ordered as a sanction for major rule violations. The PU is not a lock-down unit that relies on isolation to suppress youth behaviors.

Methodology.

The following information is used to determine compliance with the standard:

- Youth Activity Tracking sheets that indicate the youth's activities throughout each day, separated according to whether the youth is in his room or out of his room.
- Youth and staff interviews

Analysis and Interpretation.

The DYS provided *Youth Activity Tracking (YAT)* logs for the 4-week period from January 20 through February 16, 2013. Each week, a random sample of 4 youth was selected for a total of 16 youth and 107 days. Of the 107 days reviewed, youth were in seclusion for 8 of them. In other words, on 92% of the days reviewed, the youth were out of their rooms and engaged in the program. About half of the youth spent one day in seclusion during the week reviewed.

The Order requires youth to be out of their rooms on non-IDT days for at least 10 hours and 50 minutes (allowing 70 minutes for shift change and med passes during the 12 waking hours). This minimum was exceeded for approximately 90% of the non-IDT days in the sample. On 11 of the 107 days (10%), times in excess of 70 minutes were recorded for shift change/med pass. This is a reasonable rate of exception.

Technical Assistance Note: Activity Tracking
Until very recently, the days on which IDT meetings were held were not identified in the YAT. While there are other ways to verify that IDT meetings are held as required (and the data confirm that they are), it is of concern that the YAT data reflected that youth were out of their rooms during times when they were not.

It is worth highlighting the significant change in practice that has occurred over the past few months. Previously, youth spent most of their waking hours locked inside their rooms. Now, they have similar out-of-cell time to the general population, which creates the opportunity to provide the intensive programing that these youth sorely need.

Recommendations.

A Quality Improvement Plan is not necessary to meet the standard regarding out-of-room time on the Daily Schedule.

***(2) Standard: Daily Activities*.**

Each day, youth on the PU participate in the following activities, out of their rooms:

- Meals;
- 330 minutes of education, except during intersession;
- One hour of large muscle activity (without restraints);
- Individual and group treatment conducted by Behavioral Health Staff;
- Structured activities led by Youth Specialists or Volunteers;
- Leisure time (one hour on school days, two hours on non-school days).

Methodology.

The following information is used to determine compliance with the standard:

- Youth Activity Tracking sheets that indicate the youth's activities throughout each day, separated according to whether the youth is in his room or out of his room.
- Observations of PU activities
- Youth and staff interviews

Analysis and Interpretation.

The DYS provided *Youth Activity Tracking (YAT)* logs for the 4-week period from January 20 through February 16, 2013. Each week, a random sample of 4 youth was selected for a total of 16 youth and 107 days. Across the days:

- Three meals were provided to each youth, each day (100%). Youth who were not in seclusion ate outside of their rooms.
- A full day of education was provided to youth who were not in seclusion (100%) [*Chancery* attendance records should be used to verify these data.].
- Recreation was provided on all but 12 days (89%; 4 non-seclusion and 8 seclusion days). Although recreation was provided consistently, the PU practice continues to require P1 youth to attend recreation while wearing restraints if they choose to go to the gymnasium or the outdoor recreation area. True large muscle activity is nearly impossible while wearing these devices, particularly for taller youth. Furthermore, youth in seclusion do not receive recreation, which goes against the generally accepted practice in the field.
- Group and individual treatment was recorded for all but 12 of the 99 non-seclusion days (88%). It is likely that IDTs were held on these days but were not recorded. On most days, multiple treatment activities were recorded.
- Structured activities were recorded on all of the non-seclusion days (100%).
- Leisure time was recorded for only 6 of the 99 non-seclusion days (6%).

Technical Assistance Note: Activity Tracking
"Structured activity" and "leisure time" appear to be used somewhat interchangeably. In November 2012, youth had a large amount of leisure time recorded, about which the Monitor expressed concern. Since then, the pattern in the data has shifted to register a high volume of "structured activity" and relatively no "leisure time." This issue should not be one of semantics; the distinguishing feature should be one of interaction with staff. The precise term used does not concern the Monitor, but DYS should construct a way to verify that staff and youth are interacting during the majority of time when youth are not in school or participating in a treatment activity. Experience has shown that excessive, unstructured leisure time leads to increases in misconduct.

Overall, the Monitor is concerned that the amount of staff time and effort used to construct the daily activity records may be overkill and thus not sustainable for the purposes of QA. There may be a simpler way to verify that youth are out of their rooms and engaged in the required activities. Some combination of tracking in-room time (which is far less voluminous), structured questioning during IDT meetings (e.g., "did you get meals/shower/rec every day this week?"), and a targeted effort to document structured programming and leisure time activities may be more practical.

Finally, the on-site visit conducted by the S.H. Lead Monitor and his Assistant reinforced the importance of posting a current daily schedule on each Unit. The schedule for the Transition Unit was outdated, which led to complaints from youth that staff were not following the program with regard to bedtime. Not only are current schedules essential to inform youth expectations, but are also important to ensure that relief staff properly implement the program. On a positive note, both youth and staff were very cognizant of the schedule—they know what should be happening at all times and youth could recite the schedule without looking at it.

Recommendations.
In order to meet the standard associated with activity component of the Daily Schedule, a Quality Improvement Plan should be constructed to address the following issues:

1. Identifying ways to engage youth in large muscle activities without the use of restraints. DYS contends that youth are offered indoor recreational opportunities that do not require restraints, but that youth choose options in which DYS has determined restraints must be worn. Setting up situations in which youth cannot actually participate in meaningful activity seems contrary to the agency's commitment to recreation.
2. Providing daily large muscle recreation to youth in seclusion.
3. Efficient methods for tracking out of room time, receipt of basic services (meals, showers, recreation) and engagement in structured activities. Any new methods should provide sufficient details to substantiate compliance with the standard, but should also be simple enough to ensure DYS continues to utilize them for the purpose of Quality Assurance.

***(3) Standard: Graduate Programming*.**
Youth on the PU who have graduated from high school participate in out-of-room structured activities throughout the time that non-graduates are in school.

Methodology.
The following information is used to determine compliance with the standard:

- List of youth who have graduated from high school
- Youth Activity Tracking sheets that indicate the youth's activities throughout each day, separated according to whether the youth is in his room or out of his room.
- Youth and staff interviews

Analysis and Interpretation.
The DYS submits weekly *Youth Activity Tracking* logs that record how youth spend their waking hours. A specific data collection and analysis protocol has not been established for youth who have graduated from high school or obtained their GEDs. One such youth was identified via the

IDT minutes, and his *YAT* consistently revealed that he spent the hours when other youth were in school outside of his room in "structured activities." The specific activities in which the youth engaged are unknown. Youth in the general population have access to college courses, vocational programming and campus jobs. Given that PU youth cannot travel around campus, the traditional options are not available. However, a plan should be developed to advance the youth's career interest and job readiness while on the PU, but that also addresses the legitimate safety concerns posed by these youth. The Order allows DYS 60 days from the date of signing to develop such a plan, which expires on March 18, 2013. DYS submitted the Unit Handbook within the required timeline, but outside of the period of review for this report. The substance and outcomes associated with graduate programming will be discussed in the next status report.

Recommendations.
In order to meet the standard associated with graduate programming on the Daily Schedule, a Quality Improvement Plan should be developed to address the following issue:

1. Occupying graduates' time when other youth are in school. While they are currently able to spend this time outside their rooms, structured activities that promote career interest or job readiness should be considered. At a minimum, the plan should include a mechanism to identify graduates housed on the PU and should indicate how the hours that other youth spend in school will be occupied.

[II.11] Staffing [monitored by Dr. Dedel]

Status: Not in Substantial Compliance [see issues related to identifying which staff are permanent versus relief and staff training]

***(1) Standard: Staff Numbers and Training*.**

A sufficient number of adequately trained supervisory and line staff are available to implement the PU program as designed.

- A Unit Manager (UM) works during all waking hours, seven days per week.
- All assigned PU Youth Specialists have completed required training within three months of their assignment.
- All Youth Specialists (whether assigned or relief) read and sign the relevant Post Orders.

Methodology.

The following information should be used to determine compliance with the standard:

- Average daily populations for Sycamore, Cedar and Buckeye
- UM schedule
- Youth Specialist staffing reports
- Youth Specialist training records
- PU Post Orders and signature pages
- Staff interviews

Analysis and Interpretation.

The DYS submitted work schedules for the four Unit Mangers (UM) assigned to the PU for the months of January and February 2013. Throughout the two-month period, UM coverage met the requirements of the Order (i.e., UM available during all waking hours, 7 days per week). On Monday, Tuesday and Thursday, all four UMs were on duty with staggered start times which provided extensive UM coverage throughout waking hours. On Wednesdays, Fridays and weekend days, two unit managers were on duty with staggered schedules that provided for overlap between 11a and 3:30p and one UM on duty during the remaining waking hours.

Technical Assistance Note: Unit Manager Schedules
A review of each individual UM's schedule indicated that all of the UMs rotate days off (either Sunday/Friday or Wednesday/Saturday). While this provides everyone with one weekend day off per week, the UMs never have two days off in a row. This may be entirely to the preference of currently assigned UMs. But, if problems with morale or retention develop, re-examining the schedule is advised. Experience with other positions at DYS (e.g., social workers) indicates that scheduling is an essential component of the ability to attract and retain highly qualified staff.

The Youth Specialists' (YS) schedule was provided at the end of February 2013 for the Sycamore and Cedar Units. [Staffing data were not provided for the Transition Unit.] The YS shift assignments are as follows: 5 staff on 1st shift, 4 staff on 2nd shift, and 3 staff on 3rd shift on each unit, for a total of 24 positions. There is currently one vacancy on Cedar, 1st shift. Each of the 24 staff is assigned to 1st, 2nd, or 3rd shift and has two days off per week. In all cases, the staff have two days off in a row. As stated in the *Technical Assistance Note*, above, this may be preferable

to currently assigned staff, but DYS should consider how the staff's days off are sequenced if problems with morale or retention are encountered.

DYS also provided weekly staffing reports for November and December 2012, which show the number of staff who actually reported to work each day. [YS staffing data were not submitted for January 2013.] This report does not list the names of the staff, so it was not possible to determine whether the staff who reported were those who were regularly assigned to the PU, or if relief staff were utilized.

The Order requires staff assigned to the PU to complete training "specifically relating to working with youth on the PU and implementing the PU as designed" within 3-months of their assignment. DYS is required to submit training records for staff assigned to the PU within three months of the date the Order was signed. These records are due on April 18, 2013 and will be discussed in the subsequent Status Report.

Staff who are not regularly assigned to the unit (i.e., relief staff) are required to read and initial the PU Post Orders whenever they are scheduled to work the unit. The PU's Post Orders are severely outdated (last revised in March 2012, prior to the significant program changes described in this report). In order to maintain the integrity of the reforms, even when regular staff are on vacation, out sick or otherwise unavailable to work, these Post Orders need to be updated to accurately reflect the job responsibilities of a YS assigned to the PU.

Determining whether staffing levels are "adequate" requires knowledge of the size of the population the staff are supervising on any given day. Average daily populations (ADP) are normally calculated by adding the number of youth on a unit each day, and dividing the sum by the number of days in the month. Daily population levels were not available to the Monitor, but weekly unit rosters provided a snapshot of population levels that could be used to estimate the ADP.

Population Averages, per unit			
Unit	**Nov/Dec**	**Jan/Feb**	**Average**
Sycamore (P1)	7.0	5.75	6.375
Cedar (P2)	8.0*	4.5	6.25
Buckeye (Transition)	6.4	8.25	7.325
Total PU	21.4	18.5	19.95
**Note: There were several days in December when P2 boys were housed on Buckeye with the Transition youth. They are included in the P2 count.*			

As shown in the table above, the average number of youth assigned to the PU decreased by approximately 14% over the 4-month period. Within the PU as a whole, the population across the three units fluctuated (decreasing on Sycamore and Cedar, but increasing on Buckeye). In real numbers, the average PU population decreased by about 3 youth over the 4-month period.

The weekly staffing reports, coupled with the estimated ADP permit an assessment of the typical staff—youth ratio on Sycamore and Cedar. 1st and 2nd shifts normally had 3 staff on each unit, while 3rd shift normally had 2 staff. About 10% of the time, 1st and 2nd shifts had 4 or 5 staff and 3rd shift had 3 staff.

A staff-youth ratio was calculated for all three shifts on each unit for each of the 66 days reviewed. On Sycamore, 1st and 2nd shifts were staffed at 1:2.33 or better every day, and 3rd shift was staffed at 1:3.5 or better every day. On Cedar, 1st and 2nd shifts were staffed at 1:2.66 or better every day, and 3rd shift was staffed at 1:4 or better every day. These staffing levels are appropriate for an intensive programming unit with high-risk youth, such as the PU. As noted, staffing data were not submitted for the Transition Unit, so staff—youth ratios could not be calculated.

Technical Assistance Note: Staffing
DYS data submissions have not included staffing levels on the Transition Unit. Being as the Transition Unit is part of the PU, these data are required by the Court Order. Furthermore, staffing data for January and February has not yet been submitted.

Recommendations.
While the DYS meets some of the requirements related to staffing (e.g., UM scheduling, staff—youth ratio) a few issues remain. The DYS should develop a Quality Improvement Plan related to the following issues:

1. Calculating a monthly ADP for each unit so that staff ratios can be tracked easily.
2. Including Transition staff in the Quality Assurance process surrounding staffing (e.g., schedules, daily staffing levels, training, etc.).
3. Amending staffing reports to identify whether any of the staff who worked on a given day/shift were relief staff.
4. Developing a mechanism to certify that all assigned staff have completed PU-specific training within 3 months of their assignment.
5. Updating the Post Orders for the PU to reflect current procedures.

***(2) Standard: Impact on Safety*.**
Recognizing there are many contributing factors to youth violence, staffing levels on the PU are sufficient to ensure that a lack of supervision does not contribute to the opportunity for youth to commit violence against other youth or staff.

Methodology.
The following information should be used to determine compliance with the standard:

- Rate of youth-on-youth violence for past 12 months
- Rate of youth-on-staff violence for past 12 months
- Disaggregated list of AOVs committed by youth that includes the youth's name, date and type of violence.

Analysis and Interpretation.
The DYS has provided a spreadsheet each month since November 2012 listing the youth who have been involved in AOV during the month. Spreadsheets from November 2012 through January 2013 (the last month for which data are available) were analyzed to identify the number of youth involved in AOV against staff and other youth. The table below presents the number of youth-staff assaults and youth-youth assaults. In the future, the DYS should include data on the ADP each month and calculate a rate for each type of violence (rate = number of incidents/ADP). Using a rate will neutralize the impact of the fluctuating population on the units and will permit long-term comparisons. While it appears that the rate of violence is decreasing in the PU, the population of the PU has also decreased during this same time period. This makes the need to use a rate particularly pronounced.

The estimated unit-level ADP used in the staffing discussion above is not sensitive enough for these calculations given that a complete set of weekly data were not available for each month. However, ADPs of 21 (Nov), 20 (Dec) and 19 (Jan) are reasonable estimates and are used for illustrative purposes. These rates should be recalculated when the actual ADP is known.

Rates of Violence on the PU						
Month	Youth—Staff			Youth—Youth		
	Number	ADP	Rate	Number	ADP	Rate
Nov 12	8	21	.381	5	21	.238
Dec 12	6	20	.285	1	21	.048
Jan 12	5	19	.263	1	19	.053

The same youth was involved in early all of the youth-youth assaults. This youth's treatment plan should be reviewed to determine whether there are sufficient therapeutic and environmental supports to help him to refrain from violent behavior.

Clearly, the rate of youth-staff assaults is much higher than the rate of youth-youth assaults. In order to ensure a safe environment for the staff posted to the PU, the types of violence and the underlying causes of these assaults should be further analyzed and addressed. As noted in subsequent sections of this report, reducing the rate of youth-staff assaults will also shorten youth's length of stay and shrink the PU's population, as youth-staff assault is one of the main reasons why youth are recycled through the phases.

Technical Assistance Note: Rates of Violence
While DYS has invested considerable resources in creating a robust staffing plan for the PU, the ability to demonstrate that the enhanced staffing levels translate to a safer environment for youth and staff (as required by the Order) is hampered by the lack of unit-specific data on AOV and ADPs. The safe environment may be easy to substantiate once the data are in order.

Recommendations.
In order to meet the standard associated with the Impact of Staffing on Safety, the DYS should create a Quality Improvement Plan to address the following issues:

1. Developing the ability to track *rates* of violence by collecting the number of AOVs and the ADP each month for the PU, specifically.
2. Analyzing the incidents involving violence against youth to identify any patterns in unit, location, youth involved, etc. Enact specific strategies to address these patterns.
3. Analyzing the types of violence perpetrated against staff, their underlying causes and any environmental conditions that create the opportunity for violence to occur (e.g., sufficient staff support during restraints? Ability to collect liquids and throw them? Tensions between individuals that should be mitigated?). Develop and implement specific strategies to address these issues.

[II.12] Treatment Planning [monitored by Dr. Glindmeyer]
Status: Not in Substantial Compliance

(1) Standard: Clinical Staffing [this standard is derived from paragraph II.C.3 of the *SH* Order]
Clinical staffing is sufficient to implement youth's treatment plans and to conduct Inter-Disciplinary Team (IDT) meetings (e.g., with 20 youth on the PU, "sufficient staffing" is three psychologists, one psychiatrist, one psychiatric nurse and three social workers). The staffing levels are adjusted when the population fluctuates or upon reasonable professional judgment.

Methodology.
The following information should be used to determine compliance with the standard:
- PU clinical staffing plan

Analysis and Interpretation.
Sufficient data were not submitted in order to demonstrate compliance with this standard.

Technical Assistance Note: Clinical Staffing
The clinical staffing plan was not submitted for review at the time this report was authored. DYS needs to develop a mechanism to track the number and type of clinical staff and the ratio to the PU population for each position.

Recommendations.
In order to meet the standard associated with Clinical Staffing, a Quality Improvement Plan should be created to address the following issues:
1. Reporting the clinical staffing levels and hours of clinical activity on a periodic basis.
2. If ratios are found to be insufficient once the data have been assembled, ensuring appropriate staff to meet the clinical needs of youth on the PU.

(2) Standard: Treatment Planning**.**
Treatment plans are individualized and include concrete, realistic, measurable goals and objectives that are designed to address the specific behaviors that led to the youth's placement on the PU. Specific interventions are prescribed in order to assist youth in accomplishing treatment goals. Progress toward treatment goals results in promotion through the PU's phases and, ultimately, back to the general population.
- Phase 1 (P1) goals focus on acquiring skills to move safely about the unit without the use of restraints once promoted. Skill acquisition is demonstrated by meeting behavioral expectations.
- Phase 2 (P2) goals focus on acquiring skills needed to refrain from aggressive behavior once returned to the general population.

Methodology.
The following information should be used to determine compliance with the standard:

- Content analysis of Treatment Plans for youth on P1 and P2 including the presence of measurable goals and objectives with targeted interventions.
- Data on the frequency and type of treatment services provided, via the *CaseNotes* database.
- Progress notes to demonstrate how treatment goals are addressed within each treatment activity.

Analysis and Interpretation.
ITP documents were available for five youth (AE, DS, DS2, BD, and WH). These ITP documents were provided in early January 2013. More recent documents were not made available for review, so, in the interest of providing guidance and feedback, the early January documents were audited. Improvements were noted in the goals and objectives recorded in the ITPs compared to those reviewed in October 2012 during the most recent DOJ site visit, but the lack of focus on skill building continues to be problematic (and, encouragingly, has been a focus of the feedback from the Central Office Review Board).

Furthermore, the prescribed type and frequency of treatment was not always clear in the description of the intervention. This lack of specificity precluded an assessment of the extent to which treatment services were provided (per the *CaseNotes* data) as prescribed on the ITP.

Technical Assistance Note: Treatment Planning
The Court Order requires ITP documents to be provided within 30 days of the youth's admission to the facility and subsequently upon any changes to the ITP. Documentation showed that a number of youth were admitted to the unit in late December 2012 and early February 2013; however, initial ITP documentation was not received. In the future, timely submission of initial and subsequent ITPs is essential for comprehensive monitoring and quality assurance. *CaseNotes data are regularly submitted and, despite some mis-categorization of activities, appear sufficient to identify the type and amount of treatment youth receive. However, without current ITPs, the CaseNotes data cannot be cross-referenced with the ITP prescription. Finally, the QA process should also include a review of Progress Notes to ascertain whether treatment sessions are appropriately anchored to the youth's treatment goals. These data should all be submitted to the Monitor.* *ODYS has conducted several audits to improve the quality of treatment planning. These reviews provided excellent feedback and will be an essential component of DYS' Quality Improvement Plan.*

Whether youth were prescribed psychotropic medication was difficult to determine given the content of the treatment plans. Youth who are prescribed medication must have an ITP goal referring to this treatment intervention.

Other goals, while appropriate, were variable with regard to appropriate interventions indicated. Two specific examples are discussed here, but the pattern was evident throughout the IDT documents. In the case of BD, one of his treatment goals was "I will not expose my penis to any female for the next 14 days. This will be monitored by not receiving any YBIR's for sexual

conduct within that 14 days." The intervention indicated, "If I feel the urge to expose myself or masturbate in front of a female…I will complete a Decisional Balance worksheet and process the information with my social worker during individual sessions. I will talk to my behavioral health [staff] at least one time per week regarding my sexual misconduct urges." This youth had diagnoses documented as ADHD and Conduct Disorder. There was no IDT goal regarding psychotropic medication, and therefore, it was unclear if he was prescribed medication at the time this ITP was authored.

In this case, a more appropriate treatment protocol would be to consider the youth's motivation for exposing himself (e.g. anxiety, sexual aggression, impulsivity, to repel others, hypersexuality, control of his environment, attention seeking, etc.) or specific triggers, which precipitated his self-exposure. Then, treatment interventions should be developed focusing on specific skills the youth will need to acquire in order to address the underlying cause of the maladaptive behavior.

Documentation provided revealed a review of this youth's treatment plan performed by ODYS central office 2/15/13. There were excellent suggestions provided via this review document. Unfortunately, the ITP revisions performed as a result of this review were not provided prior to the completion of this status report.

Other examples included the case of RB. Per the IDT minutes dated 2.26.12, his treatment goals included, "I will reduce acts of violence or cruelty towards people." IDT documentation indicated, "this is…weakest area…he earned two primary YBIR's for fighting…peers target him and taunt him…he appeared to allow these insults to fester to the point where he would fight…shows an increased ability to ignore and control his temper, but he is still fighting…not meeting this behavioral requirement." The document further stated, "in light of the fights, there may be a recommendation to return to the PU where he does well because of the structure on the unit and in school…another option is that …earn his way to general population and possibly transfer to another facility. Youth Specialists expressed concern for…safety because of the behaviors of his peers."

This documentation is concerning as there are apparently concerns for this youth's safety, he is being targeted and taunted, and then penalized for fighting. The IDT must explore ways to ensure this youth is safe and not provoked by other youth. In addition, there were no notations regarding skills he may need to develop. The document indicated, "team members encouraged him to stop fighting, continue to work on expressing his anger differently and asked if they could assist him to reach these goals. [He] did not identify any needs from the team. It was considered that the youth's primary need is safety."

Recommendations.
In order to meet the standard associated with Treatment Planning, a Quality Improvement Plan should be developed to address the following issues:

1. Ensuring that ITP goals and objectives are measurable, strength-based and include the specific skill development needed.
2. Ensuring that ITP interventions are documented and appropriate to the stated goals and objectives, via clinicians' Progress Notes.
3. Verifying that youth receive the type and intensity of the services prescribed on the ITP.

***(3) Standard: Progress Reporting and Promotion*.**

Progress toward treatment goals and behavioral expectations is assessed on a weekly basis. Youth are promoted to the next higher phase when they have met their treatment goals and behavioral expectations. Behavior not related to AOV, serious STG activity, possession of major contraband, or repeated verbal threats to cause serious harm are not used as a basis to withhold promotion.

Methodology.

The following information should be used to determine compliance with the standard:

- Behavior Expectation Tracking Sheets
- Treatment Plans, and updates
- Progress Note entries in the CaseNotes database
- IDT Minutes

Analysis and Interpretation.

IDT minutes were received throughout the monitoring period, clearly demonstrating that the IDTs on all three units meet weekly as required. Youth are regularly promoted when they have accomplished the behavioral objectives. However, the discussion surrounding why Phase 1 youth did not or could not meet the behavioral objectives often lacked substance. Furthermore, progress toward treatment goals was not discussed with enough detail to determine which objectives may have been met and which remained incomplete.

In general, the discussion surrounding treatment plans (ITPs) during the 2/26/13 IDT meetings were much improved over previous submissions. The revised format reviews the youth's ITP goals and a brief summary of his progress toward said goals. However, it was difficult to discern the skills that the team believed were necessary for the youth to develop in order to meet their goals.

For example, in the case of youth CC, the IDT minutes revealed the youth "received a primary violation for sexual misconduct…last week…since this, he has had three secondary violations…has not met his behavioral expectations…team members reported youth's positive participation in group and in school…[but] he continues to sit alone in the corner…observing unit activity. [Psychology staff]…continues to process his feelings of dissonance." This IDT case summary lacks clarity with regard to specific skills this youth needs to develop in order to avoid behavioral challenges, including sexual misconduct. This youth was noted to have strengths with regard to participation in group and in school, but was reported to isolate on the unit. While it was suggested that the youth's observation served a purpose, it is unclear what this purpose is and how it will be addressed with regard to skill acquisition. This discussion was not anchored to the youth's treatment goals, and thus the youth's progress toward them was never quite articulated.

In the case of youth RB, it was noted that acts of violence toward others was this youth's "weakest area." There was information that "peers target him and taunt him…shows an increased ability to ignore and control his temper, but he is still fighting…not meeting this behavioral requirement." There was a notation that the team encouraged this youth to "stop fighting" but it was unclear what skills this youth needed to develop in order to achieve this goal.

With regard to youth TB, the lack of progress toward treatment goals may be due to a potential psychiatric illness. This youth had diagnoses on admission to the PU of: Rule out psychotic disorder, NOS; Conduct Disorder; Oppositional Defiant Disorder; Cannabis Dependence. His family reportedly refuses to consent to psychotropic medication, and his behavior has been "odd" and included the requirement for suicide watch due to his tying " jumpsuit around his neck" covering "himself with his mattress and was unresponsive to staff." This youth has reportedly not met any of his treatment goals and has not been promoted. Given what appear to be significant mental health symptoms, consideration of a transfer to the mental health unit would be expected.

Recommendations.
In order to meet the standard associated with Progress Reporting and Promotion, a Quality Improvement Plan should be developed to address the following issues:

1. Ensuring that ITP and IDT documentation clearly outlines the skills that the youth needs to develop in order to meet identified treatment goals.
2. Ensure that the ITP clearly outlines the steps that will be utilized to assist the youth in skill development.
3. Documenting the progress, or the lack thereof, on the ITP goals and how the interventions will be adjusted in order to assist the youth in achieving said goals (note: this may be documented in weekly IDT minutes).

***(4) Standard: Inter-Disciplinary Team*.** [Note: this standard applies only to the *S.H.* Agreement.] A psychiatrist or psychologist facilitates an Inter-Disciplinary Team (IDT) meeting. Attendees include social workers, psychologists, occupational therapists, medical staff, educators, recreation staff, Unit Managers and Youth Specialists. If a member of the IDT cannot attend, written input is provided to the IDT Chair.

Methodology.
The following information should used to determine compliance with the standard:

- IDT Minutes

Technical Assistance Note: IDT
While the Monitors have not yet engaged in this type of monitoring, any Quality Assurance protocol should include direct observation of IDT meetings in order to form conclusions about whether they meet the relevant standards.

Analysis and Interpretation.
The IDT minutes available for the majority of the monitoring period did not include the names or positions of the staff members present. The one exception to this was the IDT documentation from 2/26/13. These minutes revealed an improvement in documentation surrounding the participants in the meetings, although it did not always specify the individual's role. The contract psychiatrist was present for IDT on Phase 1 and Phase 2, and the psychologist was present for the IDT on the Transition Unit. Prior to these minutes, it was not possible to verify whether the

required participants attended or not, and it did not appear that non-attending members submitted written input for consideration by the team.

Recommendations.
In order to meet the standard associated with the Inter-Disciplinary Team, a Quality Improvement Plan should be created to address the following issues:

1. Documenting staff attendance (i.e., name and role) at IDT via the IDT minutes.
2. Ensuring an appropriate complement of staff at the IDT meetings.
3. If staff are not in attendance, providing written input to the IDT chair for review.

***(5) Standard: IDT Substance*.**
Youth appear before an Inter-Disciplinary Team (IDT) at least bi-weekly. IDT meetings for each youth involve a structured and specific discussion of each youth's goals and objectives, behavioral expectations and progress toward meeting them.

- When goals and expectations are met, the youth is promoted.
- If goals and expectations are not met, the IDT identifies the areas in need of improvement so the youth know what is required for promotion. The IDT also revises the treatment plan or its implementation to better address the underlying causes of the youth's unwanted behaviors.

Methodology.
The following information should be used to determine compliance with the standard:

- IDT Minutes
- Treatment Plans, and updates

Technical Assistance Note: IDT
While the Monitors have not yet engaged in this type of monitoring, any Quality Assurance protocol should include direct observation of IDT meetings in order to form conclusions about whether they meet the relevant standards.

Analysis and Interpretation.
IDT minutes reviewed for this status report revealed documentation that youth meet with the IDT bi-weekly as required. There was notation that the youth were engaged in the treatment planning process and that treatment interventions were discussed with them. As noted in the discussions above, there needs to be increased attention to skill development with regard to those skills needed to meet specific treatment goals. Furthermore, only some of the youth reviewed in the most recent set of IDT Minutes includes a structured review of the youth's ITP goals and objectives.

Technical Assistance Note: IDT
The Court Order requires youth to attend the IDT only every other week. It is likely that feedback on the youth's performance is more powerful when delivered to the youth by the team. In order to facilitate

progress through the program, as is the goal, DYS should consider reviewing each youth in person every week. This may be feasible given that the PU population is lower than it has been in the past.

There was documentation of the IDT's awareness of the need to be clear and consistent with youth when discussing promotions (or retention on a specific level). For example, in the case of DS reviewed in IDT on 2/26/13, "it was suggested that in the future, the team needs to be clear with youth that they need to complete all ITP goals for a youth on Phase 2 to qualify for transition, and if behavioral expectations need to be carried over from Phase 1, that they need to be put in the form of a measurable objective on their ITP…Phase 2 youth move to transition based strictly on their ITP goals."

Recommendations.
In order to meet the standard associated with the IDT Substance, a Quality Improvement Plan should be crafted to address the following issues:

1. Ensuring that IDT documentation reveals a structured and specific discussion of each youth's goals and objectives.
2. Ensuring that IDT documentation includes discussion of behavioral expectations and progress toward meeting expectations.
3. If goals and expectations are not met, identifying the areas in need of improvement so the youth know what is required for promotion.

(6) Standard: Length of Stay [this standard is monitored by Dr. Dedel; the other standards in the Treatment Planning section are monitored by Dr. Glindmeyer]

A Length of Stay (LOS) record is maintained for each youth to document the date placed on Phase 1, promoted to Phase 2, promoted to Transition, and transferred to the general population. Youth are expected to promote to the next phase within 30 days (or be referred for review, as described by Standards 7-8, below). Across the three phases, the outer limit is 90 days.

Methodology.
The following information should be used to determine compliance with the standard:

- LOS Records which are currently captured on the *Youth Activity Tracking* form

Although 21 youth spent time on the PU during the period of review, LOS data were available for only the 17 youth housed on the unit as of February 25, 2013 (see Technical Assistance note, below). Each youth's *Youth Activity Tracking* (YAT) record begins with a synopsis of their movement across the phases. [Note: DYS began capturing LOS data on October 1, 2012. As a result, LOS data for youth who entered the PU prior to that date will underestimate their actual LOS.] Data on overall LOS and LOS within each phase were calculated for each youth, and then aggregated across the 17 youth in the sample.

Technical Assistance Note:
Given that DYS does not capture YAT data for youth on in Transition, it may not be prudent to house LOS data within these records. End dates for Transition are not included among the data provided to the Monitor and so the LOS could not be calculated for the four youth who returned to the general population during the sampling timeframe. DYS should develop the ability to compile stand-alone LOS records that capture the beginning and end date for all phases.

Analysis and Interpretation.
The youth housed on the PU as of February 25, 2013 had been there for an average of 118 days (about 4 months). Because outliers (i.e., youth who have a very short LOS or a very long LOS) distort a mathematical average, the median was also calculated. The median was 142 days (about 5 months), which means 50% of the youth on the PU had been there for less than 142 days and 50% of the youth on the PU had been there for more than 142 days. Put simply, the average youth currently on the PU has been there for about 4 or 5 months. Note that these youth have not yet completed the program—this statistic refers only to the length of time they have currently been on the PU.

The LOS on Phases 1 (P1) and 2 (P2) were also calculated. These calculations used only stays that had been completed—if a youth is currently on a phase, that data was not used because there is no end date. Across the 20 P1 stays, the average LOS was 35 days, and the median was 19.5 days. For the 17 stays on P2, the average was 22 days and the median was 16 days. The median for both P1 and P2 was significantly shorter than the average, which means that the average was distorted by a small number of youth who spent an extraordinarily long time on the phase (e.g. one youth spent 134 days on P1, another spent 64 days on P2).

The number of times the 30-day benchmark for external review was exceeded was also calculated. Across the 20 completed stays on P1, 7 exceeded the 30-day maximum limit (35%). Across the 17 completed stays on P2, 3 exceeded the 30-day maximum limit (18%). In other words, 65% of the P1 episodes were completed within 30 days and 82% of the P2 episodes were completed within 30 days.

Finally, the frequency with which youth recycled through the phases was calculated. Across the 17 youth, all but 5 youth had repeated the P1-P2-T cycle (or part of it) at least once. In other words, 70% of the youth currently on the PU have not progressed cleanly from P1 to P2 to Transition, but rather have recycled through the phases, sometimes more than once.

Thus, while many of the individual LOS on P1 (65%) and P2 (82%) fall within the 30-day maximum limit, the fact that youth often cycle back through the phases accounts for the significantly longer LOS than these data would suggest. In fact, all but three of the 17 youth currently housed on the unit (82%) have already exceeded the 90-day maximum limit, and they have yet to complete the PU program.

Recommendations.
In order to meet the standard associated with Length of Stay, the DYS should develop a Quality Improvement Plan to address the following issues:

1. Develop stand-alone LOS records that provide definitive end dates for all phases, including the Transition phase. Consider divorcing the LOS record from the *YAT* records.
2. Investigate the reasons that youth are being returned to lower phases at such high frequencies. While the obvious reason is that they have displayed behavior that warrants demotion (i.e., AOV, using STG to direct the harm of another person, major contraband, repeated verbal threats), the QIP should look for the underlying reason that these youth have not adopted or are not displaying the skills needed to control their impulses, manage anger, improve decision-making etc.

***(7) Standard: Central Office Review Board Composition and Timelines*.**

A Central Office Review Board (CORB) conducts a review of any youth who has been on any phase of the PU for more than 28 days. At a minimum, the CORB consists of an Administrative Psychiatrist, the Bureau Chief of Facility Programs, and Behavioral Health Administrator. The CORB review is completed by the 42nd /35th day on the phase.

Methodology.

The following information should be used to determine compliance with the standard:

- CORB review packets

Analysis and Interpretation.

Of a total of seven CORB review documents, six included signatures of a minimum of three staff members, including the Administrative Psychiatrist. One did not include the signature of the Administrative Psychiatrist. For other members present, it was difficult to determine the individual and their role, as in some cases, the signatures were illegible, and there was no notation included.

A review of the documents revealed inconsistencies with regard to the required timelines for review. For example, BD was admitted to the PU 11/9/12, he was placed on his current phase 1/2/13, and the date of the review was 2/15/13, however two board members signatures were dated 2/19/13. There was notation of a previous review 12/21/12, but documentation of this meeting was not reviewed given the timeframe for this status report. This timeline was confusing: this youth had a period of 56 days between the first and second review; however, documentation did not clarify the reason for this delay. Review of other cases revealed similar issues with regard to timelines. Documentation should provide a clear history of the youth's PU stay including the number of days on a particular level, promotions and demotions. Special attention should be given to youth who "recycle" through the system.

Recommendations.

In order to meet the standard associated with the CORB Composition and Timelines, a Quality Improvement Plan should be developed to address the following issues:

1. Ensuring that the full complement of CORB staff participate in the review and sign the document. Clearly indicate the individual's title.
2. Ensuring documentation of the youth's history on the PU including the number of days on a particular level, promotions and demotions, and ensuring that the CORB review is performed within the required timelines.

***(8) Standard: Central Office Review Board Substance*.**

The CORB utilizes a comprehensive summary of the youth's clinical formulation, treatment, progress and challenges to date. The summary is reviewed by each CORB team member prior to the case review. The CORB issues specific recommendations for refocusing the youth's treatment and sets specific timelines for subsequent reviews. Recommendations are communicated to the IDT, which notifies the youth if the treatment plan has been modified.

Methodology.

The following information should be used to determine compliance with the standard:

- CORB review packets
- IDT Minutes

Analysis and Interpretation.

A review of seven examples of CORB documentation revealed that in most cases, all of the required documentation was not reviewed. For example, in the case of BD, the psychological services summary and the IDT monthly progress report were not reviewed. In the case of RB, the IDT monthly progress report was not reviewed. In the case of DH, the psychological summary was not reviewed, nor were behavioral health assessments. In the case of KD, the IDT monthly progress report was not reviewed. In the case of JC, behavioral health assessments were not reviewed. In only two cases was there indication that all data were reviewed.

Technical Assistance Note:
The CORB review should not proceed without a comprehensive packet of information for the youth. Reviewing a youth's progress with incomplete information is counterproductive. Furthermore, the fact that treatment has been ongoing without some of these essential treatment documents raises serious concern about the quality of treatment provided.

It was concerning that in some cases, there was a failure on the part of the IDT to follow through with recommendations in a timely manner. For example, in the case of KA, documentation indicated that during a previous review dated 11/19/12, the CORB recommended an increase in the frequency of sessions to focus on the youth's anger management and plans for additional psychological testing. With regard to the increase in frequency of sessions, there was documentation of the sessions with the youth, specifically, four individual psychotherapy sessions in January 2013, but overall, this was a decrease over the number of individual sessions in the month of December 2012, where there were six noted.

It was noted that although the focus of the sessions was "to explore the youth becoming more open with the psychologist and to exercise better methods of self control" and the CORB had recommended anger management, it was not documented that anger management techniques were being addressed with this youth. Moreover, psychological testing remained pending, almost three months after it was recommended.

In general, documentation did not indicate specific skills that the youth would need to develop in order to progress. For example, in the case of KA, the CORB noted, "will connect his thoughts regarding being aggressive towards others by completing a decisional balance worksheet." Assaultive behavior has been a significant issue for this youth. The CORB document does not opine regarding the reason the youth has not been able to acquire the necessary skills to address his impulsivity (outside of the recent prescription of psychotropic medication).

In the case of RB, the CORB indicated that the youth had routine contact with social work, psychology, OT, nursing, and psychiatry. Information regarding the content of these contacts and the need to alter treatment modalities in order for this youth meet his treatment goals was not included. In addition, recommendations to the IDT were vague, for example, "continue to focus on managing anger and teaching positive coping skills." As this youth apparently cycled from P1 to P2 on several occasions, more focus should have been placed on what skills the youth needed to progress and the manner in which these skills were being taught/modeled/reinforced with the youth.

Recommendations.

In order to meet the standard associated with the CORB Substance, a Quality Improvement Plan should be developed to address the following issues:

1. Ensuring that all information is available to the CORB so that the members can perform a quality review and make appropriate recommendations.
2. Ensuring that specific recommendations for refocusing the youth's treatment are provided. Consider soliciting feedback from the IDT on the utility of the CORB document.
3. Ensuring that ITP documentation addresses specific recommendations of the CORB.

[II.13] Phase Demotions [monitored by Dr. Dedel]
Status: Not in Substantial Compliance

***(1) Standard: Phase Demotion*.**
A deliberative process is utilized to demote youth to a lower phase. Demotions are imposed only for the following reasons: an act of violence, STG activity that promotes or directs an individual to carry out an act of violence, possession of major contraband, repeated verbal threats to cause serious physical harm to staff or other youth. All demotions are approved by the facility Superintendent.

Methodology.
The following information should be used to determine compliance with the standard:

- AMS reports
- IDT Meeting minutes
- IH documentation, including appeals
- Interviews with youth, DYS and Scioto administrators
- Phase Demotion Summary Form (currently under development)

DYS submitted a list of four youth in response to a request for "a list of youth who were demoted between January 18 and February 28, 2013." Three of these demotions were overturned just before this report was issued. Four additional demotions (one of which was overturned) were identified via the IDT minutes.

IDT minutes and other documents were reviewed to ascertain the reason for demotion and how the decision to demote was deliberated. IDT Minutes were also reviewed to ascertain whether the teams use alternative consequences to sanction youth, even when their behavior may have qualified them for a demotion.

Technical Assistance Note:
Although the Monitor was provided with data regarding youth who were demoted, the data were often incomplete and required additional follow-up questions, memos and conference calls. Moving forward, DYS should develop a form for the Superintendent's signature that clearly delineates 1) whether the youth's behavior fits into the four criteria listed in the standard; 2) the evidence that is available to support that conclusion; and 3) why phase demotion is considered the best response (i.e., why a less severe sanction is considered to be inadequate; why Phase 1 and not Phase 2; what skills the youth needs in order to prevent similar behavior from re-occurring and how to best teach him those skills). Such a document would likely reduce the need for DYS to respond to follow-up questions from Monitors, public defenders, and other interested parties. At the time this report was drafted, DYS had begun to create this form. It should be completed for all youth who are demoted, whether or not their demotions are later rescinded or overturned. The extent to which this form provides the required information will be discussed in subsequent Status Reports.

Analysis and Interpretation.
During the period of review, eight youth were slated for demotion to a lower phase. The demotion was overturned for one of these youth due to a technical violation of his due process

rights (the YBIR was not served within 24 hours; he was accused of using his position within an STG to direct other members to harm a female staff if she refused to bring in contraband). Among the other seven youth, one assaulted a Unit Manager on the Transition Unit; one engaged in an AOV (details were not provided); one had a promotion rescinded because he was found in possession of tobacco during the unit transfer; one sexually assaulted a Youth Specialist by grabbing her crotch; and the other three allegedly engaged in verbal threatening and intimidation of medical staff during an emergency response (although this was reported by medical staff only after the fact, not in their written witness statements). After several weeks, the phase demotions for these last three youth were overturned via the IH Appeal process, just prior to this report being issued. The IH ruling stated that "the youth's behavior did not amount to a primary rule violation."

While on the surface, some of these youths' behaviors may meet the requirements of the Court Order, documentation of the deliberative process (whether an Intervention Hearing, IDT meeting or other group decision-making process) was not provided to identify the relevant facts and whether they supported the youth's eligibility for demotion. The youth's perspective is also not represented anywhere. Similarly, no information was provided to indicate why the group believed demotion to Phase 1 to be the most appropriate response. In one case, the IDT had recommended a demotion from Transition to P2, but the Superintendent overrode the IDT decision and demoted the youth to P1. The reason for this override was not provided. The Court Order requires active deliberation to ensure that phase demotions are used only in response to egregious behavior and to ensure that other, less severe sanctions have been considered.

IDT minutes from January 18 through February 28, 2013 were reviewed to identify instances in which alternative sanctions were imposed, even when a youth's behavior may have met the demotion criteria. During the review period, three instances were noted where youth engaged in behavior that appeared to qualify them for demotion, but a less punitive sanction was imposed. These included: two Transition youth who engaged in a fight in school (both were put on extended Behavior Contracts on the Transition Unit) and a youth who was put on a Behavior Contract for serious threatening behavior (although he was later demoted for an AOV).

Moving forward, DYS needs to provide additional information regarding the nature of the youth's misconduct and evidence of a deliberative process to determine the most appropriate sanction. Though not required by the Court Order, it would be helpful for the DYS to assess the extent to which youth who engage in serious misconduct are sanctioned *without* the use of phase demotion.

Recommendations.
In order to meet the standard associated with Phase Demotions, a Quality Improvement Plan should be developed to address the following issues:

1. Ensuring that documentation supports the requirement that a deliberative process was used to determine whether the facts of the incident support the youth's eligibility for demotion and why phase demotion was selected from among the other available sanctions.

[II.C.3] Quality Assurance [monitored by both Dr. Dedel and Dr. Glindmeyer; this standard applies only to the *S.H.* Agreement]

Status: Not in Substantial Compliance

***(1) Standard: Quality Assurance Process*.**

The Quality Assurance (QA) program establishes specific standards for the operation of the unit and a specific methodology for measuring the level of performance on each standard. When deficits are identified, a Quality Improvement (QI) plan is created to identify the underlying causes of the problem and to construct specific strategies designed to remediate the deficit. The QI plan's effectiveness is measure on a monthly basis. Findings from the QA/QI process are articulated in a written document at least twice per year.

Methodology.

The following information should be used to determine compliance with the standard:

- Written reports that include QA standards, methodologies and results
- Written QI plans and monthly progress reports

Analysis and Interpretation.

While the DYS has amassed a large volume of data relevant to the daily operation of the unit and the substance of the treatment delivered on the PU, it has yet to organize these data in any meaningful way. To date, the Monitors have borne the responsibility of analyzing and interpreting the data, and making recommendations for program improvements. While this ensures that the Monitors are fully informed about the PU's operation, it comes at significant expense to the State. Perhaps more importantly, it does not carry an exit strategy. DYS needs to develop a rigorous Quality Assurance/Quality Improvement process that is capable of identifying, analyzing and solving problems that will inevitably occur in the operation of a complicated program with very challenging youth. Only when this occurs will external monitoring by the Monitors become unnecessary.

Recommendations.

In order to meet the standard associated with Quality Assurance, a Quality Improvement Plan should be developed to address the following issues:

1. Developing a set of standards or performance objectives that describe what each component of the program aspires to do. To assist in this effort, the Monitors drafted the standards used in this report to reflect the various subsections of the Court Order. These should be considered, modified if necessary, and supplemented with standards that address important issues that may not be adequately addressed in the Court Order (e.g., SBBMS).
2. Developing an audit methodology for each standard. Identify existing data that speak to the performance on each standard. DYS appears to possess most of the data it needs to assess the unit's performance (exceptions are noted throughout this status report). Develop a schedule for audits (e.g., quarterly, semi-annually) and a sampling strategy (i.e., what proportion of the cases/days/occurrences/incidents will be reviewed? For things that don't happen often (e.g., phase demotions), all cases should be reviewed. For things that occur regularly (e.g., daily activities), a random sample should be identified).

3. Analyzing and interpreting the data that is produced by the audits. Identify patterns that speak to the challenges in meeting a particular standard. Memorialize these efforts in writing, in the form of a written Quality Assurance Report that includes the standard, the methodology used to audit performance, and the analysis and interpretation of the data that was collected.
4. Developing a Quality Improvement Plan for each area in which the standard is not met. An interdisciplinary team of staff who can dissect the problem to determine its underlying causes should develop this plan. Once known, specific strategies to address the underlying causes need to be developed. The strategies should be fleshed out into specific tasks, responsible parties, and timelines.
5. Conducting targeted reviews for each QIP to determine whether the strategies are working to improve performance toward a specific standard. These should be in addition to regularly scheduled, comprehensive audits. Document the results of the targeted reviews on the QIP and make adjustments to the strategies if the desired results are not being obtained.