2012

S.H. v. Reed Fourth Annual Report

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S.H. v. Reed 2012 Annual Report

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Table of Contents

Introduction 2
I. Use of force / investigations / restraints / seclusion / discipline / grievances 5
II. Safety / gang intervention / programming / unit staffing 8
III. Education 10
IV. Medical care 14
V. Mental health care and psychiatry 19
VI. Dental care 28
Comprehensive Compliance Chart, December 2012 29

Introduction

What follows is the Monitor's 2012 Annual Report on compliance with the *S.H. v. Reed* Stipulation for Injunctive Relief. Over the course of 2012, we have reported comprehensively on the requirements of the Stipulation at each remaining facility operated by the Ohio Department of Youth Services (DYS). We have also monitored the Stipulation's requirements with regard to DYS's central office and Release Authority. This report is filed in the context of Defendant's December 7th motion to terminate the Stipulation under the Prison Litigation Reform Act (PLRA). Defendant's motion has triggered a short timeline under which plaintiffs have the burden to demonstrate current and ongoing systemic violations of their rights under federal and constitutional law. This report has, therefore, been ordered by the Court to serve as a roadmap for the parties' impending litigation.

In this report, we summarize the recent fact-findings of the *S.H.* monitoring team that identify ongoing systemic deficiencies. We have limited the issues to those that may, by themselves or in combination, amount to violations of plaintiffs' rights under federal and constitutional law. We do not presume to make findings regarding the constitutionality of conditions in this report; but rather focus entirely on the facts and expert opinions that have been requested by the Court to guide its decision regarding termination. The PLRA provides a very short period for the Court to consider the ongoing need for relief before the current Stipulation becomes unenforceable. Given this timeline and the PLRA standard that must be met for new relief to be ordered, this Annual Report is significantly stripped down. We do not discuss the areas with which DYS has achieved substantial compliance or significant progress toward compliance – though there are many. This timeline and the holidays also make it impossible for us to follow our usual protocol for seeking input from the parties on our reports before they become final.

We regret that the abruptness of termination proceedings has not allowed us the time to thoroughly applaud DYS for its accomplishments over the last five years. Suffice it to say, in all subject areas there have been commendable reforms. In some areas, like reducing the youth population in secure confinement and regionalizing services, Ohio has truly become a model to the nation. These reforms have come about because of hard work on the part of DYS's staff and administrators. As the lead Monitor over the remedial stage of the *S.H.* case, I want to personally thank those staff members and administrators for their commitment to protecting and serving the youth who have been committed to their care. I also want to recognize the monitoring team members whose coaching and vast expertise have helped make these reforms possible. Although I believe there are ongoing deficiencies with regard to the Stipulation's requirements, I take great pride in the work we have done together to improve conditions in Ohio's juvenile correctional facilities. When the litigation has concluded, we will issue a final report on compliance with the original Stipulation, highlighting DYS's significant achievements over the previous five years.

In order to reduce the cost and burden of our monitoring we agreed to limit our 2012 on-site monitoring to one site visit and one report per facility. Because our visits to Scioto and Circleville

Juvenile Correctional Facilities were back in January and February 2012, our findings are somewhat stale with regard to the PLRA standard of current and ongoing violations of plaintiffs' rights. For that reason, the Court has ordered us to make expedited visits to Scioto and Circleville and to file expert fact-finding reports by or before February 8th, 2013. We recognize the imposition our visits and corresponding document review will cause on such short notice; but again emphasize that it is the PLRA, and not whim, that has exacted such a short timeline on the Court and monitoring team.

Since being appointed two years ago, I have always worked toward a collaborative resolution to this case. Following a March 2012 conference with the Judge and parties, I initiated a fifth year planning process. I asked the subject matter experts on the monitoring team to work with their counterparts at DYS to identify the issues not yet in compliance, agree upon strategies to achieve compliance within the presumptive final year of *S.H.* monitoring, and memorialize them into Fifth Year Plans. This process was collaborative and showed terrific promise for winding down the case; however, it was derailed by an important, but lengthy, dispute resolution process and now the litigation. As the parties review the findings in this report as well as those in the forthcoming reports from our expedited visits, I remain open to a collaborative process. I do not believe that litigation is the best or only way to address the findings. As I have said in the past, if the parties are willing, I would be more than happy to mediate an amicable termination of certain areas of monitoring, and a limited continuation of other agreed-upon areas.

This report is divided into six sections, corresponding to subject areas in which we believe there are ongoing deficiencies. Every deficiency identified here has been identified in previous monitoring reports. The discussions in each section summarize the findings of the Monitor and subject matter experts, and are intentionally concise. For more detailed discussions, see the underlying reports that are cited to in footnotes throughout this Annual Report. Because the oversight of the Court will at some point be replaced by DYS's own internal quality assurance (QA) mechanisms, we have also identified deficiencies in the QA system within each section of the report that must be addressed in order to prevent and correct violations of plaintiffs' rights. We have not included a section in this report on the Release Authority or on regionalization of service delivery. We anticipate a compliance report from monitoring team member Vince Nathan on the Release Authority by January 31st, and from Shay Bilchik on regionalization of service delivery by January 4th.

At the end of the report is a chart showing comprehensive compliance ratings for every Stipulation paragraph. This chart is based on the compliance ratings in our various site visit reports and other expert reports, and includes some updates based on interviews with monitoring team members. There are three areas – classification, seclusion, and grievances – for which we have left the compliance ratings pending. With regard to classification and seclusion, we anticipate imminent policy changes that should help bring DYS into compliance. With regard to grievances, the Chief Inspector's Office (CIO) will soon complete another youth grievance survey to gauge youth confidence in the grievance system; and we look forward to reviewing those survey results. Once the policy changes have been made and the survey results shared, we will supplement this report with compliance ratings for those Stipulation paragraphs. If the survey results show significant improvement in youth perceptions of fairness, our compliance rating will date back to the CIO's implementation of remedial measures.

The chart lists every Stipulation paragraph and distinguishes those that require compliance ratings from those that do not. The rows that are colored gray are guiding principle paragraphs and

other paragraphs that do not require compliance ratings. The rows that are colored blue are those that we have found in sustained substantial compliance. We have asked that DYS continue to monitor compliance with the paragraphs highlighted in blue through their internal quality assurance process. Each substantive paragraph is either rated for compliance generally or at each of the four juvenile correctional facilities. Those that are rated in the 'General' column, are for the most part responsibilities of the Department's central office. Those that are rated at each facility are based on fact findings from our site visits. Our compliance ratings include SC (in substantial compliance), NC (not in compliance), and PC (in partial compliance). For purposes of the constitutional standard, we do not believe that a rating of PC in all cases defeats an allegation of deliberate indifference. While there are some paragraphs for which PC denotes significant progress overall, there are other paragraphs that require improvements in multiple areas, and PC may simply denote progress in one of those areas.

The following subject matter experts contributed to this report:

Shay Bilchik, J.D.
Ava Crow, J.D.
Kelly Dedel, Ph.D
Anne Flynn, M.Ed
Daphne Glindmeyer, MD
Steve Martin, J.D.
Orlando Martinez
Vince Nathan, J.D.
Barbara Peterson, RN
David Roush, Ph.D
Don Sauter, DDS, MPA
Ronald Shansky, MD
Andrea Weisman, Ph.D

I. Use of force / investigations / restraints / seclusion / discipline / grievances

Subject matter expert: Steve Martin, J.D.

Paragraphs 70-71: use of force

- **Indian River:** Too many incidents of inappropriate force continue to occur, and a sustained record of compliance has not yet been established. From January-September 2012, the Chief Inspector's Office has sustained use of force violations in ten separate investigations. Several of these incidents have involved malicious conduct by staff. While Indian River staff with support by central office personnel, have been addressing these compliance issues, a sustained record of compliance has not yet been established; nor can it be concluded that incidents of inappropriate force have become rare or isolated at the facility. Also, as previously reported, a relatively small number of youth assigned to the Mental Health Units are repeatedly subject to staff use of force.[1]

  Of the 60 incidents reviewed for May-June 2012 that required immediate corrective action, two involved the use of the Emergency Restraint Belt (ERB), in which youth were transported across facility grounds in face-down positions. In both instances, the youth experienced impaired breathing problems. Since these two incidents, facility officials have developed and implemented transport protocols that require use of a transport gurney in such situations; and the central office Facility Resource Administrator has taken action to ensure adoption of such protocols at other DYS facilities.[2]

- **Circleville:** During the reporting period preceding our last visit to Circleville, supervisors had become directly and unnecessarily involved in use of force applications; levels and intensity of force applied had not been minimal; and incidents that should have been referred to investigation were not. The increased level of force was related to the use of the Emergency Response Belt (ERB) at the facility. While this restraint device can offer staff a means to more quickly restrain violent/resisting youth while minimizing risks associated with prone restraints, it should only be employed when necessary to fully immobilize a seriously violent/resisting youth. It certainly should not be routinely employed as a precautionary restraint. We reviewed too many instances in which its application was questionable. Moreover, there was at least one instance in which a youth was left in his cell in the ERB. Additionally, there were too many planned use of force incidents for the reporting period in which video recordings were not available for review. Most of the incidents had been taped, but the tapes had not been preserved in a fashion that made them accessible for review.[3]

[1] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 28-29; Indian River, expert report by Steve Martin (Sept. 2012), pp. 3-5.
[2] Id.
[3] Cirlceville, Monitor's comprehensive site visit report (Feb. 2012), pp. 25-26.

- **Scioto:** While facility officials were in most instances utilizing planned use-of-force tactics (including verbal strategies), a number of incidents were identified in which planned tactics could have been employed, but were not. Facility personnel were not utilizing the hand-held video in all instances in which they should, and there were instances in which they were unable to retrieve hand-held video tapes for review. We found again that the administrative review process was problematic. Reviewing officials in too many instances failed to identify and address critical issues, and in some instances failed to conduct and/or document appropriate follow-up. This follow-up is especially important, because many of the incidents reviewed reflected security lapses that directly precipitated or caused the need to use force.[4]

Paragraph 76: seclusion

- **Indian River:** Pre-hearing seclusion hours have been reduced from an average of 3500 hours per months to 2500 hours per month. These hours are driven by the number of rule infractions and the scores on the IRAV instrument, which limits the discretion of facility officials to make release decisions. The monitoring teams for both the *S.H.* and DOJ cases are currently working with DYS to revise the IRAV procedure in order to incrementally reduce the length of time youth spend in pre-hearing seclusion.[5]

- **Circleville:** At our last visit to Circleville, we reported disturbing patterns of inconsistent and excessive use of seclusion. Pre-hearing seclusion totaled 20,000 hours for July-September 2011, and 6,500 hours for October-December 2011. Sanctioned seclusion totaled 7,500 hours for July-September 2011, and 13,500 hours for October-December 2011. We reported dramatic increases in the application of the maximum 120-hour seclusion sanction, and noted that the 120-hour sanction was often employed on youth who had contra-indications for such lengths of stay in seclusion, related to their mental health status. The use of seclusion not related to Acts of Violence was also substantial at the facility, averaging over 3000 hours per month for October-December 2011, and approximately 1,400 hours for January 2012. Facility officials needed to improve their documentation for justifying extensions of this type of seclusion beyond three hours. Too often, an uninformed stock statement of "safety and security" served as the basis for extensions.[6]

- **Scioto:** At our last visit to Scioto, we found that the monthly average disciplinary seclusion hours for male youth had increased from approximately 2,300 in June-August 2011 to approximately 6000 in September-November 2011. The majority of these hours were pre-hearing seclusion for Acts of Violence. Many of these pre-hearing seclusion hours involved a relatively small number of youth, often those on the PROGRESS Units, who were held for the maximum 72 hours.[7]

[4] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 28-29.
[5] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 32-33.
[6] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 28-30.
[7] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 31-33.

- **Observations of plaintiffs' counsel and the Court:** Plaintiffs' counsel have repeatedly objected to the compliance ratings in our reports, arguing that the current rates at which youth are secluded remains a very significant concern; and that the monitoring team's incremental approach to reform in this area does not go far enough to reduce the Department's reliance on seclusion as a correctional measure.[8] The Court also expressed concerns about the duration of pre-hearing seclusion during an October 2012 visit to Scioto Juvenile Correctional Facility.[9]

Paragraph 235-238: discipline

- **Circleville:** For the months November 2011 through January 2012, on a population of approximately 85 youth, Circleville hearing officers imposed approximately 7,600 days of intervention time and 12,600 hours of sanctioned seclusion. For sixty-three of these hearings during the three month period, Hearing Officers imposed the maximum period of sanctioned seclusion (120 hours) for a total of 7,650 hours. We found that such excessive use of these punitive sanctions on a youth population of 85 provided ample evidence that facility officials were too often failing to "impose appropriate consequences for youth rule violations with the purpose of encouraging change in behavior and not solely for punishment," as required by DYS Standard Operating Procedure 303.01.02. Very often such punitive sanctions were imposed on youth on the mental health caseload without proper consideration of their mental impairments.[10] (For an extended discussion of this concern, see Steve Martin's expert report for Circleville at pp. 10-12.)

Paragraph 232-234: grievances

- **All facilities:** Monitoring team member Steve Martin reported timely and appropriate processing of youth grievances at all facilities, and repeatedly recommended a rating of substantial compliance. The Monitor, however, continues to be troubled by the findings of the youth grievance survey conducted by the Chief Inspector's Office. System-wide, 43% of youth reported that the grievance process did not work; 53% of youth reported that they had been told by staff that if they file a grievance, nothing will happen; 18% of youth reported that staff had treated them badly after filing a grievance; and 15% of youth reported that they had been told by staff that they cannot use the grievance process to report staff misconduct. In response to these survey results, the Chief Inspector's Office put several remedial measures in place, and has committed to conduct another follow-up survey by January 2013.[11]

[8] Id.; Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 32-33.
[9] Remarks of District Judge Algenon Marbley before Department of Youth Services administrative staff and Scioto Juvenile Correctional Facility administrative and line staff (Oct. 16, 2012).
[10] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 80-81.
[11] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 91-92; Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 80; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 83-84; Ohio Department of Youth Services, Chief Inspector's Office, Quarterly Cumulative Summary Report (Jan. 2012), pp. 16-19.

II. Safety / gang intervention / programming / unit staffing

Subject matter experts: Orlando Martinez & David Roush Ph.D (now Orlando Martinez & Kelly Dedel, Ph.D)

Paragraphs 48, 49, and 66: unit staffing

- **Scioto:** At our last site visit to Scioto, we found that service delivery was significantly hampered by staffing shortages. Units were short-staffed as many as 2-3 times per week, and Youth Specialists regularly took leave under the Family Medical Leave Act (FMLA) in order to avoid mandated overtime on the weekends. Staff shortages caused lockdowns throughout the facility, and programs and recreation had been cancelled on at least one day each weekend in the months preceding our visit. The staffing situation was aggravated by the extremely long time it took to get a new Youth Specialist working the shift. We found that Unit Managers and social workers regularly covered Youth Specialist shifts, detracting from their own job duties, and further diminishing the capacity to provide structured programs and rehabilitative services on the units. Scioto at the time had 9 Youth Specialist vacancies and extraordinarily high levels of staff on leave.[12] During a December 11, 2012 conference call, DYS reported 18 current vacancies for Youth Specialist positions at Scioto, 23 Youth Specialists off work, and 3 on leave. While lockdowns are no longer occurring, the monitoring team continues to express concerns over the 28% of the workforce at Scioto who are currently unavailable for work.[13]

  Kelly Dedel, who serves on both the *S.H.* and DOJ monitoring teams, reports that between April and October 2012, minimum staffing levels could be achieved through the use of mandated overtime. While this has improved access to programming, it is not a practical or durable solution to ensure the proper functioning of the facility.[14] DYS's staffing formulation for Scioto must include a site-specific replacement factor that accounts for vacancies and leave; and must be based on the numbers of staff needed for consistent application of the treatment models on the general population and specialty units.[15]

  Units are also staffed as though Youth Specialists were interchangeable, due in large part to the "pick-a-post" provision in their collective bargaining agreement. Youth Specialist staff choose their own posts in order of seniority, which often results in the least-experienced direct care staff working on the highest needs units, without consideration given to the particular qualifications needed to work with special populations (e.g., on the girls' unit, the Mental Health Units, and the PROGRESS Units).[16] The impending agreement between DYS and DOJ will require PROGRESS Unit staff to be adequately trained before they are permitted to be permanently

[12] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 13-14, 18-19, 26-27.
[13] Comments of Rochelle Jones and Kelly Dedel, conference call regarding staffing concerns at DYS (Dec. 11, 2012).
[14] Email conversation with Kelly Dedel (Dec. 14, 2012); *see* DOJ Monitor's October 2012 site visit report for Scioto (forthcoming).
[15] Email conversation with Orlando Martinez, David Roush, and Kelly Dedel (Dec. 14, 2012).
[16] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 26-27.

assigned. Relief staff without this training will not be permitted to work on the unit independently.[17]

Paragraph 65: safe living conditions

- **Indian River:** Changes in programs, youth population, and the addition of the Mental Health Units have resulted in fluctuations in violence reflected through assaults, fights, physical restraints, and incidents of seclusion. Youth gangs still exert a powerful negative influence at Indian River, and concerns remain about the high rate of fights and physical restraints. Trends confirm progress toward a safer environment, but it may take some time for the gang intervention efforts and other programming to produce sustainable positive outcomes.[18] (For an extended discussion and charts regarding safety indicators, see Martinez and Roush's expert report for Indian River at pp. 19-21.)

- **Scioto:** Sexual misconduct and assaults significantly increased in September and October 2011, corresponding with the transfer of more aggressive youth from Ohio River Valley Juvenile Correctional Facility, and the creation of the PROGRESS Units at Scioto. Levels of fear among Youth Specialists were unacceptably high, largely related to staffing shortages, and youth perceptions of safety were mixed, depending on which housing units they were assigned to.[19] Kelly Dedel, who serves on both the *S.H.* and DOJ monitoring teams, reports that while youth-on-youth violence has decreased considerably; youth-on-staff violence has continued to increase. Youth consistently reported frustration with certain staff members who were described as antagonizing, provoking, and otherwise speaking and behaving in ways that could increase youths' propensity for violence toward them.[20]

- **All facilities:** DYS has no usable definition of direct and continuous supervision in its policies, procedures, and training. Direct supervision and continuous interaction with youth, as opposed to staff congregating at the security desk, increases safety by facilitating officers' ability to de-escalate situations before an incident occurs, and respond more quickly to incidents that do occur. It also reduces the area of the facility that is *de facto* inmate controlled. Because direct supervision is not clearly defined in policy and training, the Department's investigation of incidents does not always identify corrective action needed to improve staff performance with regard to preventable fights and assaults.[21]

[17] Draft Consent Order between United States of America and The State of Ohio (Nov. 28, 2012), p. 7; Email conversation with Kelly Dedel (Dec. 14, 2012).
[18] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 25-26.
[19] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 25.
[20] Email conversation with Kelly Dedel (Dec. 14, 2012); *see* DOJ Monitor's October 2012 site visit report for Scioto (forthcoming).
[21] David Roush, Memorandum to Amy Ast re: Direct Supervision in the Ohio Department of Youth Services (Aug. 15, 2012).

Quality Assurance for unit staffing

Paragraph 68: Youth Specialist performance evaluation

- **All facilities:** In 2009, DYS changed the title of its direct care workers from Juvenile Correctional Officers to Youth Specialists, and in 2011 identified the core competencies and responsibilities of the new Youth Specialist. The core competencies and responsibilities contain a new emphasis on positive interactions with youth, and participation in youth programming and activities. Since changing the position description for direct care staff, DYS has not implemented a performance evaluation to measure staff members' job performance in relation to the new core competencies and duties (as opposed to the job duties of the previous "Juvenile Correctional Officer" position). We have repeatedly recommended implementation of the comprehensive performance evaluations that have been developed by the DYS Bureau for Professional and Organizational Excellence; however, they are still not implemented at the facilities.[22]

III. Education

Subject matter experts: Ava Crow, J.D. & Anne Flynn, M.Ed

Paragraph 189: All youth receive a full school day

- **Scioto and Circleville:** Unit instruction for students who were secluded due to Acts of Violence did not comply with the parties' agreement. These students must receive 2 hours (four 30-minute sessions) of direct instruction on the unit with a teacher, and must receive an additional 3.5 hours of educational activities with a teacher roving throughout the affected units.[23]

- **Scioto:** Safety and security issues requiring students to be moved and educated separately made it difficult to provide a full school day. Movement times and meals cut into instructional time. There were frequent occasions when Youth Specialist staffing shortages meant there were not sufficient staff to bring students to school. The school was short seven teachers for a period preceding our last site visit, causing over 500 classes to be cancelled.[24] On a December 11, 2012 conference call, DYS reported the staffing concerns have largely been resolved due to a smaller student population.[25] DYS also reports significant changes with regard to educational services provided on the PROGRESS Units.[26] We will report findings regarding current conditions following our expedited site visits.

[22] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 27; Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 24; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 27.
[23] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 63-64; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 66-67.
[24] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 66-67.
[25] Statements of Bonnie Sweeney and Ava Crow, conference call re: staffing concerns at DYS (Dec. 11, 2012).
[26] Defendant's Motion to Terminate the Stipulation for Injunctive Relief, Motion for Stay and Response to Plaintiffs' Motion for Specific Performance, pp. 14-15, 30 (Dec. 7, 2012).

- **Indian River:** Interviews with a Unit Manager and Youth Specialist revealed youth being educated "under the door" without regard to DYS policy and the parties' agreement. Training issues remained regarding which secluded students were to be educated in their cells and how to properly document various types of unit instruction.[27]

Paragraphs 194-195: Education staffing

- **Indian River:** Significant numbers of students (107 students at our last site visit) were eligible for, but were not receiving, Title I math remediation. Indian River must develop a systematic strategy to address the math needs of the students who function at the lowest math levels.[28] Teacher absences have contributed to significant numbers of cancelled classes (147 classes at our last site visit). Indian River should recruit additional substitute teachers and develop additional strategies to address days when teachers are absent.[29]

- **Scioto:** The school was short seven teachers for a period of time preceding our last site visit. This sometimes meant that classes were cancelled because they could not be covered. Special education teachers were substantially over state mandated caps due to vacancies and teachers on extended leave. Approximately 40 students who needed a science credit during our last visit did not have a science class available to them due to teacher vacancies. Because of the multiple schools-within-a-school, Scioto / Willis High School is the most difficult school in DYS to staff, and may require a separate staffing analysis.[30] On a December 11, 2012 conference call, DYS reported that education space has been consolidated and is now less compartmentalized.[31] We will update our findings in this area following our expedited site visits.

Paragraph 207: School discipline

- **Scioto:** At the time of our last site visit, the school's progressive discipline policy was not being followed. Students were sent out of various classrooms without regard to procedure, and students in the ABC room were sleeping and walking around rather than doing school work. Because of the multiple schools-within-a-school, some students did not have access to the ABC room at all, and were instead were being sent to their housing unit without a teacher.[32]

Paragraph 219: Illiteracy / Title I reading teachers

- **Scioto:** Title I reading was offered with a reading specialist through the Read 180 program and with a Title I teacher through My Reading Coach (MRC). Security concerns, however, prevented certain housing units from being scheduled in the same building together, which limited access for some units to MRC. Additionally, only one to two youth received instruction on MRC each

[27] Ava Crow & Anne Flynn, Cuyahoga Hills & Indian River site visit report (Sept. 2012), p. 11.
[28] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 76-77.
[29] Id.
[30] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 71.
[31] Statements of Bonnie Sweeney and Ava Crow, conference call re: staffing concerns at DYS (Dec. 11, 2012).
[32] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 64, 74-75.

day, when at least ten youth at any given time were non-readers who would benefit from the program.[33]

Paragraphs 221-222, 225: Special education / compliance with IDEA

- **Circleville:** IEP team meetings are not held "as needed" to address lack of student progress. No occupational therapy (OT) services were available for two students who required it at Circleville / Starkey, and no system was in place to ensure services pending completion of a long-term contract for OT services. There was only limited documentation of the special education services that had been provided. Specifically, there was no systematic documentation that specially designed instruction, assistive technology, accommodations, and modifications or support for school personnel were actually delivered.[34] Additionally, special education students in science classes were not served by Highly Qualified Teachers (HQT) as required by the IDEA.[35]

- **Scioto:** With limited exceptions, almost no inclusion services were offered to special education students. During school quarters preceding our site visit, the 12-student caseload cap was regularly exceeded, and staffing levels, when factoring in long-term absences and vacancies, had not been sufficient to provide adequate special education services. PROGRESS Unit teachers were not systematically referring students with substantial behavioral problems during school to the Intervention Assistance Team. Although special education services were generally provided, they were not sufficiently documented in progress notes or intervention specialist case notes. IEP team meetings were not held "as needed" to address lack of progress in IEP goals. Students' individualized needs were addressed in the IEPs, but some had goals which were not quantified or could not be measured.[36]

The Court's March 28, 2011 Order: Integration of educational services and plan with treatment and reentry plans; Unit instruction for youth secluded for Acts of Violence

- **All facilities:** During our visits to Scioto and Circleville, students' education plans were not integrated with the Individualized Treatment Plans and reentry plans, in accordance with the Court's March 28, 2011 Order. Although there was some joint discussion between unit staff and teachers at treatment team meetings, there was not a system in place to ensure coordination of these plans, including special education plans.[37] During our visits to Indian River and Cuyahoga Hills, DYS's efforts to integrate educational services and plans with treatment and reentry plans had begun, but were not yet fully implemented. The plans did not reflect seamless, cohesive services across environments.[38]

  The Court's Order included a presumption "that students will be educated outside of their cells unless there is an individualized determination that providing educational services outside the

[33] Id., at pp. 77-78.
[34] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 75-77.
[35] Circleville, education site visit report by Ava Crow & Anne Flynn (Feb. 2012), p. 13.
[36] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 78-80.
[37] Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 83; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 86.
[38] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 96-97.

cells is too dangerous".[39] This is also supported by the IDEA's requirement of educational services in the least restrictive environment. However, at all facilities except for Cuyahoga Hills, students held in pre-hearing seclusion were not permitted out of their cells for one-on-one education with a teacher.[40]

- **Circleville:** During our February site visit, no students who were secluded for Acts of Violence were permitted outside of their rooms for educational instruction. This was in violation of the Court's March 2011 Order. This problem reflected a communication breakdown between central office and the facility.[41]

Quality Assurance for education

Paragraphs 182, 204, 205, and 217: Classroom management

- **Circleville:** A significant number of classroom observations revealed ineffective teachers who did not use differentiated instruction strategies, and did not engage students. The assistance and resources provided to teachers had been insufficient to embed the necessary skills. Teachers were routinely observed to passively sit while some students "guessed their way" through the computerized curriculum tests. Instruction was not systematic and was randomly delivered. Poorly performing teachers must be identified and held accountable for improved performance.[42]

- **Scioto:** Substantial additional training was needed in classroom management practices. Although there was good cooperation among teachers and Youth Specialists, some staff demonstrated an inability to effectively maintain order, and youth in several classrooms slept, walked around, or engaged in conversations unrelated to school.[43] Students worked on CSLS with little or no teacher input, and the system acted simply as computerized worksheets. Teacher evaluations reflected this problem, but did not reflect improvement in teacher performance.[44]

Paragraphs 221-222, 227, 229: Compliance with IDEA / monitoring progress toward IEP goals / teacher evaluations

- **All facilities:** Although training had been provided, special education principles were not embedded with many teachers. Effective collaborative teaching and teaching to students' IEP goals remained problematic. At all four facilities, co-teaching and teaching to IEP goals must be incorporated into the teacher evaluation system. Additionally, progress monitoring must

[39] Order of the District Court, Southern District of Ohio, Eastern Division (Doc. 249) (March 28, 2011), p. 7; Agreement of the *S.H.* parties (April 22, 2011).
[40] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 73-74; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 62-64; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 66-69.
[41] Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 60.
[42] Id., at pp. 67-69, 73; Circleville, education site visit report by Ava Crow & Anne Flynn (Feb. 2012), pp. 11-12.
[43] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 63, 73-74.
[44] Id., at p. 76.

improve and should be incorporated into the teacher evaluation systems at Scioto, Circleville, and Cuyahoga Hills.[45]

IV. Medical care

Subject matter experts: Ron Shansky, MD & Barb Peterson, RN

Paragraph 124: Injury assessments following fights or applications of force

- **Scioto and Circleville:** Following altercations or uses of force, youth who were assessed for injuries did not have vital signs or an adequate history taken, and did not receive a professional assessment in a clinically appropriate space. The histories did not include questions as to what happened during the incident, and nurses concluded without proper assessment that there were no injuries and that no immediate treatment was needed. Youth were seen in the housing units, usually through a solid door with a small window, rather than in a clinical setting.[46]

- **Indian River:** Assessments were generally being performed at the clinic. However, nurses made treatment decisions without eliciting relevant information from the youth or from a Youth Specialist regarding what occurred. For example, some of the injury assessment forms reviewed noted that the youth complaint was "I got jumped," without follow-up questions or a more detailed explanation of areas on the body where trauma may have occurred.[47]

- **Cuyahoga Hills:** Some injury assessment forms concluded that no treatment was needed even though no vital signs, description of the complaint, or assessment were completed. The physical assessment must address the likely areas of injury in significant detail, and only after the complaint is adequate, the vital signs have been performed, and an appropriate physical assessment is performed, can a decision be made with regard to recommended treatment.[48]

Paragraphs 135-136, 239: Medical records

- **All facilities:** Medical records are not integrated to provide an overall view of the youth, his/her needs, specific treatment goals, and the methods to be used by all staff to accomplish the stated goals. Medical files are not easily accessible to other disciplines involved in treatment planning for youth, and psychology and social work files are not readily available to medical personnel.

[45] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 88; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 77-78; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 81; Cuyahoga Hills & Indian River, education site visit report by Ava Crow & Anne Flynn (Sept. 2012), p. 44; Circleville, education site visit report by Ava Crow & Anne Flynn (Feb. 2012), p. 17; Scioto, education site visit report by Ava Crow & Anne Flynn (Jan. 2012), p. 22.
[46] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 49-50; Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 46.
[47] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 52-53.
[48] Id.

Given the multiple locations where information is located, the information system itself is a barrier to the provision of adequate care. DYS has decided to participate with the adult corrections system in the implementation of an integrated electronic medical record (EMR). Implementation of this EMR may take several years.[49]

- **Cuyahoga Hills:** Care for acute illness was documented in the majority of cases, but the outcome or results of the care and treatment provided were not documented. Monitoring and assessment of treatment outcomes is particularly important for youth with frequent, recurring acute illnesses.[50]

Paragraphs 147-148, 153: Health care staffing

- **All facilities:** There are often lengthy delays in receiving permission to post, recruit, and fill vacant positions. There is no relief factor for 24/7 nursing staff, resulting in the routine use of overtime and agency staff to fill planned absences and other vacancies that occur. The purpose of the relief factor is to have adequate numbers of personnel prepared to work with the identified population to cover routine vacation, sick leave, and educational leave.[51]

Paragraphs 127-128: Administration of medicine

- **Cuyahoga Hills:** Physician orders were generally consistent with professional and community standards of care for youth and adolescents. There was no documentation, however, that the physician had assessed the effectiveness of the care as ordered. There was also no documentation that repeated episodes of the same/similar complaints were assessed for patterns or relationship to the youth's health status.[52]

- **Circleville:** Nursing practice standards for the administration of medications were not consistently met. Medications received from the pharmacy were checked against the pharmacy manifest, but were not checked against the original physician order. There was a need for development of a secure medication room to eliminate the practice of nurses repackaging medications for transport across the campus. DYS policy and procedure for the recording and assessment of medication errors had also not been fully implemented.[53]

- **Scioto:** The medication administration record (MAR) was not an accurate record of medications as ordered by the physician or administered by the nurse. Omissions and other medications errors were not reported as required by policy. The MAR was not always available at the time of

[49] Id., at p. 61; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 51-52; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 55-56.
[50] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 62-63.
[51] Id., at pp. 70-71; Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 58; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 60.
[52] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 54.
[53] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 47-48.

administration, and when it was, documentation was not completed at the time of administration, but later or not at all. Certain medications were "floated" (dissolved in water) rather than crushed as ordered (neither practice is recommended). Medication containers delivered to housing units did not have the required information included (name of medication, dosage, expiration date, special instructions, etc.).[54]

Paragraph 140: Face-to-face appointment for acute illness or hospitalization

- **Cuyahoga Hills:** Scheduled and unscheduled off-site medical services were generally provided in a timely manner; however, follow-up with the patient upon his return was not.[55] (For a more detailed accounting of this finding with examples, see Peterson and Shansky's expert report for Cuyahoga Hills at pp. 9-10.)

- **Scioto:** With regard to off-site emergency room visits, there were problems with inadequate history during a nurse injury assessment, inconsistency between the cover and problem list in the medical record, and significant problems with patient follow-up.[56] (See Peterson and Shansky's expert report for Scioto at pp. 11-12 for examples.)

Paragraph 133: Medication storage

- **Scioto:** Because the PROGRESS Units are closed, self-contained units, clinic space should be provided on those units with adequate equipment and security provisions for storing and administering medications. This will enhance safety; enhance the potential for medication compliance among youth on those units; and bring nursing practice in line with current standards.[57]

Paragraphs 111, 122, 127-128, and 141: Physician performance generally

- **Cuyahoga Hills:** The physician's documentation and treatment provided were not consistent with standards of care for adolescent practice with regard to chronic care patients and patients transferred to the facility. For these and other patients, there was also no documentation that the physician had assessed the effectiveness of medications as ordered, and no documentation that repeated episodes of the same/similar complaints were assessed for patterns or relationship to the youth's health status. We recommended that the Health Services Administrator develop performance improvement strategies for the physician and that the Medical Director provide frequent peer review and counseling until the physician's performance is satisfactory.[58]

[54] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 51.
[55] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 66.
[56] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 57.
[57] Id., at p. 55.
[58] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 44-45, 51, 54-58, 67.

Quality Assurance for medical care

Paragraphs 112, 115, and 152: Performance assessments

- **All facilities:** The Medical Director has not conducted peer reviews to evaluate and improve the performance of facility-based physicians. Additionally, the Medical Director's own performance is not evaluated for the clinical adequacy of the medical services provided in facilities.[59]

Paragraph 116: Review of policy and procedures

- **Central office:** All of the required medical policies have been promulgated and the majority implemented. However, there is no routine review/revision/approval of policies and procedures by the central office quality improvement committee.[60]

Paragraphs 118-121: Initial patient health appraisals and assessments

- **All facilities:** We found problems at all facilities related to initial health assessments for youth entering DYS for the first time. We consistently recommended routine monitoring of nursing and clinician performance with regard to the completion and accuracy of health appraisals at both the Scioto reception center and the parent institutions; as well as peer review with the physicians to ensure that all significant positives on the initial nurse screen are addressed during the physical exam, and to ensure that the physician summary and plan are comprehensive and appropriate. The systemic problems we identified in our record review included immunization decisions that were inconsistent with Centers for Disease Control recommendations; physicians' failure to review the history taken at the reception center; and physicians' failure to elaborate on positive findings identified during the nurse intake screen. These issues are critical for risk management and good medical care.[61]

Paragraph 131: Laboratory services

- **All facilities:** We found problems at all facilities related to laboratory services, and consistently recommended quality improvement monitoring of the dates of lab orders and draws; completion of the draw; access to and timely retrieval of lab results; and utilization of lab levels in the provision of care. The systemic problems we identified in our record review included failure to complete admission labs for females; untimely lab draws and/or delays in providing lab results, so that physicians saw youth during scheduled appointments without the test

[59] Id., at pp. 45-46, 71; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 41-42, 58; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 45-46, 61-62.
[60] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 46-47.
[61] Id., at pp. 47-50; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 43-45; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 46-49.

results; failure to review the lab results with the youth when the levels were available; and failure to utilize available lab results in the provision of care for youth.[62]

Paragraph 132: Tracking infectious diseases

- **All facilities:** Diagnosed infectious diseases of all types are not routinely monitored. There is no certified infection control nurse at the central office level or at any facility. The Health Services Administrator reports monthly statistical data, but there is no use of the data to establish trends within or across facilities. We have repeatedly recommended monitoring and tracking of infectious diseases and trends.[63]

Paragraphs 137-138: Review of records

- **All facilities:** We found problems with medical records at all facilities, and have consistently recommended monitoring of quantitative (names, titles, dates, format and frequency of notes, legibility, etc.) and qualitative information (is information relevant, accurate, and utilized in provision of services); use of this data in performance evaluations; and identification of facility and agency-wide trends. The systemic problems we identified in our record reviews included problem lists not being complete, accurate, or up-to-date; documents being out of order or in the wrong location; physician and nursing notes failing to utilize patient history or information from similar events in reaching treatment conclusions; physician notes failing to include the history and testing used to reach a diagnosis, and failing to note the outcome of treatment provided.[64]

Paragraph 139: Vital signs

- **All facilities:** Nurse and physician review of abnormal vital signs is not monitored as part of the quality improvement program. Our record review at one facility revealed several youth injury assessment forms in which nursing staff did not recognize abnormal vital signs or repeat /re-monitor signs the next day. At another facility, we found an example of a youth whose abnormal blood pressure was not re-monitored upon return from the emergency room for head trauma. Now that guidelines have been posted and training has been provided, the quality improvement program should monitor compliance with DYS protocol on vital signs.[65]

[62] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 59-60; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 50-51; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 54.
[63] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 60; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 54.
[64] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 63-65; Circleville, Monitor's comprehensive site visit report (Feb. 2012), p. 53; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 56.
[65] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 65-66; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 53-54; Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 57.

Paragraph 141: Using quality improvement data to improve performance

- **All facilities:** The quality improvement monitoring tools that DYS has created are used on a regular basis, but use of these tools is not yet demonstrably linked to improvement in performance. All facilities need to demonstrate the use of monitoring data to implement improvement strategies and achieve improved performance. When performance measured by the monitoring tools is consistently at an excellent level, the program should begin using other open methodologies to identify opportunities for improvement. This can be done by thoroughly reviewing records of patients who have received services, and identifying other areas where problems with timeliness, continuity, or professional performance exist. The goal is to find problems, understand the causes, and implement strategies to improve.[66]

V. Mental health care and psychiatry

Subject matter experts: Andrea Weisman, Ph.D & Daphne Glindmeyer, MD

Paragraph 17: Equitable treatment of youth

- **All facilities:** At site visits in December 2011, January 2012, and September 2012, we noted racial disparities with regard to placement on the Mental Health Units and PROGRESS Units. In December 2011, we noted that African American youth represented 65-75% of the population on general population units at Indian River, but only 35-45% of the population on the Mental Health Units. In September 2012, we made similar findings, noting that African American youth represented 57% of the population on general population units, but only 26% of the population on the Mental Health Units. This was cause for concern that African American youth were under-represented on the Mental Health Units. At Scioto, we noted that 84% of the youth on the PROGRESS Units were African American, and all had significant mental health disorders. Comparing the PROGRESS Unit population with the population on the Mental Health Units, we raised concerns again that there may be a racial bias in the identification of mental health disorders as opposed to behavioral disorders; and that race may affect perceptions of a youth's dangerousness and/or need for treatment among decision-makers, and among staff at all facilities referring youth for specialized placement. We recommended that DYS collect data at various decision points, particularly related to referral for mental health treatment and discipline, and analyze it through a "racial lens". We also recommended clinical supervision and peer review with regard to racially disparate treatment.[67]

[66] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 67.
[67] Id., at p. 13; Indian River, psychiatry report by Glindmeyer (Sept. 2012), p. 2; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 17-18; Scioto, mental health and psychiatry report by Weisman and Glindmeyer (Jan. 2012), p. 16; Indian River, Monitor's comprehensive site visit report (Dec. 2011), pp. 11-13; Indian River, report by Martinez and Roush (Dec. 2011), pp. 5-7.

- **Cuyahoga Hills:** We raised concerns that African American youth were under-represented among those prescribed psychotropic medications, and suggested a possible treatment bias that the facility should further investigate. The facility population was comprised of 61% African American youth and 35% Caucasian youth. Youth on the mental health caseload were represented proportionately. However, 50% of the youth prescribed psychotropic medication were Caucasian.[68]

Paragraphs 51, 136 and 240: Mental health and psychiatry records

- **All facilities:** As we have stated in numerous previous reports, behavioral health records are stored in multiple locations, and are not easily available to other members of the interdisciplinary treatment team. While medical files, including psychiatric notes, are largely paper records, both social work and psychology notes are stored electronically. This non-integrated health services record management system is not conducive to collaboration and continuity of care across disciplines.[69]

  In order to obtain information and prepare for psychiatry clinic, psychiatrists at all institutions must gather information from paper medication documents; psychology information from a computer database search; separate information from the mental health records, which is present at IDT or behavioral health staff meetings; and email and phone messages from various clinicians. This process is unnecessarily time consuming, with a high potential for error. Given the multiple locations where information is located, the information system itself is a barrier to the provision of adequate care.[70]

  Additionally, progress notes and interventions from psychologists, social workers, and psychiatrists do not generally reference the youth's treatment plan. Each note appears as a distinct entry, and each intervention appears to cover only what happened in the immediate moment, so there is little evidence of continuity of care over time. Providers also do not generally review notes from other disciplines. DYS has committed to purchasing an electronic medical record (EMR) in which all health service providers – somatic and mental health – will document their interventions in one location. We have repeatedly recommended developing a timeline for transition to the EMR, and, until that time, to implement a system of centralized recordkeeping.[71]

- **Cuyahoga Hills and Indian River:** DYS intends to implement integrated treatment plans in all facilities, but at both Cuyahoga Hills and Indian River, there continue to be multiple treatment

[68] Cuyahoga Hills, psychiatry report by Glindmeyer (Sept. 2012), p. 2.
[69] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 19, 62-63, and 95-96; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 51-52; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 55-56, and 85-86.
[70] Id.
[71] Id.

plans being developed. Social work develops the Unified Case Plan and psychology develops a separate, sometimes inconsistent, mental health treatment plan.[72]

- **Cuyahoga Hills:** Just prior to our monitoring visit, the paper medical records had been "thinned" without a protocol in place for such a process, leaving random psychiatric clinical documentation in the charts. If paper medical records are to be thinned, it must be done according to a policy and procedure developed in consultation with the psychiatrist and other medical staff.[73]

Paragraphs 58 and 88: Special needs youth / exacerbation of mental health symptoms

- **All facilities:** At each facility, the monitoring team reported case studies following interviews and extensive document review, demonstrating problems with the care provided to seriously mentally ill youth. The examples highlight our concerns that mental health symptoms presented by some youth in DYS facilities may go undiagnosed or untreated due to deficiencies in clinical competency. The case studies include one youth who was hospitalized and diagnosed with Schizophrenia. In the two months prior to his hospitalization, he was taken off of medication by the psychiatrist. He engaged in almost daily assaultive and self-injurious behavior; and was at one point observed eating soap and body wash. He was discharged from the Mental Health Unit, and was not considered for an acute mental health intervention until he committed a serious assault on a staff member. Another case study involved a youth with a history of significant abuse and trauma as well as psychosis, who was held in near-continuous seclusion due to repeated acts of violence. While there is no question that this youth was difficult to manage, the mental health progress notes contained no working clinical formulation to contextualize his behavior. It is unacceptable for such a youth to spend the majority of his time in seclusion, particularly given the fact that he experienced hallucinations while confined.[74]

  Another case study involved a youth with a history of treatment with psychotropic medications, who was not referred to the psychiatrist until a month after his admission. The process for his mental health intake and evaluation was also unreasonably lengthy. From the time he was admitted until he was finally seen by the psychiatrist and put on medication, he engaged in repeated violent behavior and was subjected to repeated periods of seclusion. Although there were copious notes from mental health staff, none included a clinical formulation of what was going on with the youth. Additional case study examples involved an acutely psychotic youth whose behavior over a five-month period resulted in his inappropriate transfer to the PROGRESS Unit rather than a DYS Mental Health Unit or a residential treatment facility; and a youth whose documented challenges and behavior clearly suggest a diagnosis in the autistic spectrum, who was instead diagnosed with Conduct Disorder and other diagnoses.[75]

[72] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 19.
[73] Id., at pp. 62-63.
[74] Id., at pp. 34-35; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 17-19; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 19-20; Cuyahoga Hills & Indian River, mental health report by Andrea Weisman (Sept. 2012), pp. 27-29;
[75] Id.

Paragraphs 74-75: Crisis management

- **All facilities:** Behavior contracts, as currently written, are not likely to bring about the desired behaviors. The behavior contracts we reviewed listed too many behaviors to be modified, were too vague, and provided inadequate incentives and consequences. (For examples, see Andrea Weisman's expert report for Cuyahoga Hills and Indian River at pp. 24-26 and 41.) The guiding principle of behavior contracts is to engage youth in successive approximations toward the desired behaviors, increasing expectations and rewards as the youth is successful in the contract's requirements. The plans that we reviewed did not collect adequate data and use that data to construct a plan aimed at gradually reducing the occurrence of a problem behavior; they were not adequately targeted at the one or two behaviors that were keeping youth from being successful in the program; and rewards and incentives were not meaningful, immediate, and individualized.[76]

- **Scioto:** DYS's maximum security PROGRESS Units have been the focus of a lengthy dispute resolution process. When the monitoring team visited as a group in January 2012, we found 1) that staff were ill-equipped to provide custody and treatment for violent youth with serious mental health disorders; 2) that the environment on the units did not help stabilize behavior; 3) that treatment and services provided to youth were profoundly inadequate; and 4) that the degree of seclusion and restraints was excessive and ineffective at improving youths' behavior and critical thinking skills.[77] In accordance with the Court's December 11, 2012 Order, various monitoring team members will be visiting the PROGRESS Units on an expedited schedule to make findings regarding the current conditions of confinement. Our findings from January 2012 remain useful as an historical reference point.

Paragraph 91: Adequate trained personnel, space, and time

- **All facilities:** Psychiatric services and hours at all facilities were insufficient to meet the needs of the youth population. At Cuyahoga Hills, there were multiple inefficiencies that interfered with or prevented youth from receiving appropriate psychiatry services. Youth were often scheduled for clinic at or after their bedtimes; there were difficulties with timely and efficient transport of youth to the clinic; and a significant portion of the psychiatrist's time was unaccounted for by seeing patients or by reviewing charts. At Indian River, although the psychiatrist was generally accessible, consistent, and reliable, she was not able to regularly attend the treatment team meetings for youth in the general population (as opposed to the Mental Health Units). Sixty-nine percent of the youth on the psychiatrist's caseload at Indian River were housed in the general population; therefore the large majority of youth on psychotropic medications did not have the psychiatrist participate in their treatment team meetings. At Circleville and Scioto, the weekly allotments of hours for psychiatric coverage were not adequate to provide clinical

[76] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 31.
[77] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 30-31.

services, participate in treatment team meetings for youth who were prescribed psychotropic medications, respond to crisis situations, and provide on-call / after-hours consultations.[78]

Paragraphs 98 and 106: Treatment planning and design

- **All facilities:** Throughout DYS facilities, with the exception of Cuyahoga Hills, the various behavioral health disciplines did not operate as a unified mental health department. Psychology and social work held separate meetings, and maintained separate, inconsistent treatment plans. Treatment plans at all facilities, in addition to not being integrated, were not clinically adequate. Information gathered about youth was not distilled into clinical formulations; goals on the plans were too vague; and objectives were often not measurable. Treatment plans inappropriately listed completion of worksheets or attendance at groups as the desired objectives. (Worksheets and groups are therapeutic modalities designed to address objectives; they are not objectives in and of themselves.) Few treatment plans reviewed by the monitoring team contained documentation of the youth's progress toward achieving goals and objectives. Treatment planning was also organized around a formulaic, predetermined number of treatment doses. This does not comport with standard practice in the field. The clinical program should be individualized, and based on youth progress toward meeting well-articulated goals.[79]

  Treatment plans were also inadequate with regard to psychiatric goals and objectives. When present, they focused exclusively on medication compliance, rather than on the efficacy of the medication; and the youth's knowledge of the medication's purpose, dosage, and potential side effects.[80]

  DYS could have identified and corrected these systemic treatment planning deficiencies with a system for quality improvement monitoring. DYS did invite monitoring team member Andrea Weisman to conduct a training on treatment planning for behavioral health staff at Scioto and Circleville, and we will report updated findings regarding the quality of treatment plans at those two facilities following our expedited site visits.

Paragraph 107: Suicide prevention

- **All facilities:** In December 2011, we raised significant concerns regarding DYS's suicide prevention policy, and following an objection from DYS, we agreed to seek guidance from national expert Lindsey Hayes, at no cost to the State.[81] In an August 3, 2012 email, Mr. Hayes

[78] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 35-37; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 32-33; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 51-53.
[79] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 42-44; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 34-35, 38-40; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 43-44.
[80] Id.
[81] Indian River, Monitor's comprehensive site visit report (Dec. 2011), pp. 50-52.

recommended revisions to DYS's suicide prevention policy, highlighting the same concerns we highlighted in our December 2011 report. These included: mental health staff assessing youth within 24-72 hours rather than within 7 days; placing youth at the highest risk for suicide on 1:1 staff-to-youth observation, not 1:3 observation; expanding the criteria for the highest risk category; ensuring that youth on any level of suicide precautions is seen daily, not every 72 hours, by mental health staff; and a more explicit provision regarding follow-up with youth after discharge from suicide precautions.[82]

Paragraphs 121-122: Initial assessments / transfers

- **Scioto:** In the mental health appraisals conducted at the Scioto reception center, clinical summaries were minimal, and did not identify specific diagnostic criteria. It was unclear how the appraisal tool was utilized to formulate diagnoses and case conceptualization.[83]

- **Cuyahoga Hills:** The psychiatrist's documentation made no notation of a review of intake documents or historical information. Although the psychiatrist had a computer in his office, he indicated that he did not know the password, and did not regularly review historical data. This finding requires immediate corrective measures, and could have been prevented if the psychiatrist's review of historical data had been monitored through quality assurance and peer review processes.[84]

Paragraph 127: Psychotropic medication

- **All facilities:** We made repeated findings over the course of the year that laboratory parameters were missing from DYS's clinical standing orders, and required immediate review by the Administrative Psychiatrist to ensure that the lab testing and monitoring requirements were consistent with generally accepted practices. For example, required monitoring for treatment with the atypical antipsychotic medication Seroquel did not include an annual eye examination. This is required due to the potential for this medication to precipitate vision changes and cataract formation. Another example was the absence of creatinine clearance or 24-hour urine creatinine clearance monitoring during treatment with the mood stabilizing medication Lithium due to this medication's potential for negative effects on the kidneys.

- **Cuyahoga Hills:** A local protocol at Cuyahoga Hills required all psychotropic medications to be crushed or provided in liquid form, with the exception of those medications designated as extended release. This protocol was not medically appropriate. Youth are likely to refuse crushed medication because of the taste or because they don't recognize the medication by color and shape when it is not in pill form. Crushed or liquid medications should be provided only following an individual assessment that such an intervention is clinically indicated. Otherwise, initiating routine oral checks following administration of pills is a more appropriate

[82] Email from Lindsey Hayes to Andrea Weisman (Aug. 3, 2012)(forwarded to Laura Dolan on Aug. 20, 2012).
[83] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 48-49.
[84] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 50-51.

practice. This practice would also reduce the capacity for clinical errors.[85] (For an extended discussion of the facility's need to individualize treatment with regard to crushing medications, including case examples, see Daphne Glindmeyer's expert report for Cuyahoga Hills at pp. 2-4, and 10-12.)

- **Scioto:** Psychotropic medication orders did not appear to be updated consistently; prescriptions appeared to be outdated; and the written report of medication adjustments did not consistently match the medication log. Although the number of youth at Scioto who were prescribed medication by the psychiatrist had more than doubled, there had not been an increase in psychiatric clinical resources. Routine evaluations for 33 youth who were treated with psychotropic medications were not conducted by the psychiatrist in a timely manner. Additionally, laboratory examinations were not always provided (or not documented) for treatment with specific medications.[86] (See Daphne Glindmeyer & Andrea Weisman's expert report for Scioto at pp. 55-56 for examples.) DYS could have identified and corrected these systemic problems if it had in place quality improvement monitoring regarding psychiatric documentation and clinical decision-making.

Paragraph 238: Discipline for youth on mental health caseload

- **All facilities:** The performance of clinicians was inadequate with regard to 1) recognizing when problem behavior was related to underlying mental health disorders; and 2) taking appropriate action with regard to discipline and treatment. When a youth is determined to have a mental health disorder or developmental disability that contributed to the occurrence of a rule infraction, and the infraction is referred to the Intervention Hearing process, the clinician filling out the Capacity Assessment form should recommend mitigation of the potential sanctions. Most of these cases should be referred to the treatment team rather than the formal hearing process. In the event that the infraction is referred to the Intervention Hearing process, mental health staff should be expected to attend the hearing, and offer guidance to the Hearing Officer on clinically appropriate interventions.[87]

  At all facilities, the monitoring team found examples of punitive sanctions imposed on youth who were on the mental health caseload without proper consideration of their mental impairments. At Cuyahoga Hills, for example, the psychologist noted in two assessments that the youth had an underlying mental health disorder that likely contributed to the commission of the rule infraction; however, the psychologist neither attended the Intervention Hearings, nor recommended any mitigation to the sanctions.[88] (For additional examples, see Steve Martin's

[85] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 54-56.
[86] Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 51-53.
[87] Id., at p. 85; Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 93-95; Circleville, Monitor's comprehensive site visit report (Feb. 2012), 80-83.
[88] Id.

expert report for Circleville at pp. 10-12; Andrea Weisman's expert report for Circleville at pp. 30-34; and the Monitor's comprehensive reports for all four facilities.)

Quality Assurance for mental health care and psychiatry

Paragraph 62: Sex offender programming

- **All facilities:** The provision of sexual behavior treatment is not uniform across facilities. Some psychologists meet with youth in groups; others meet individually with youth. We have found practices that have limited clinical utility, such as giving youth multiple packets at a time to complete on their own; and a formulaic curriculum that allows little room for thoughtful input from the individual clinicians working with youth. There are currently no quality improvement processes in place, or outcome measures collected, to assess the quality and efficacy of the sex offender programming.[89]

Paragraphs 102-103, 152: Mental health quality assurance and peer review

- **All facilities (w/r/t psychiatry):** With regard to quality assurance for psychiatric practice and treatment, the first psychiatric peer reviews recently occurred at each DYS facility. Although deficiencies were noted, the peer reviews did not include information regarding corrective action or how the noted deficiencies were going to be addressed. Outside of peer review, there was no formal process at any facility for psychiatric quality improvement to monitor the physician's documentation, prescribing practices, and laboratory monitoring. There was also no process in place to identify systemic issues affecting psychiatric practice. Quality improvement programs must be based in the defined standard of care, a review of adherence to those standards, and measured with regard to a review of youth outcomes. (For a discussion on the ways in which youth outcomes can be measured, see Daphne Glindmeyer's expert report for Cuyahoga Hills at pp. 8-9, and for Indian River at pp. 7-8.)[90]

- **All facilities (w/r/t mental health):** Although quality assurance policies and procedures exist, the processes do not constitute an adequate quality improvement program. In addition to the deficiencies discussed below at each facility, the agency and facilities do not conduct studies to determine the efficacy of the offered programs.[91]

- **Indian River:** We were only provided with quality assurance documentation for social work at Indian River, so we were unable to assess the processes for psychology. Clinical supervision

[89] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), p. 24; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 22-23.
[90] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 39-42, 71; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 36-38, 59; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 42, 61-62.
[91] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 39-42.

sessions for social workers focused largely on whether the clinician's notes were organized rather than on the clinician's performance as a treatment provider. Performance Improvement Plans were issued for some social workers; however, documentation was not provided showing follow-up monitoring for improvement.[92]

- **Cuyahoga Hills:** The Psychology Supervisor's reviews of the IDT process identified fairly vague deficiencies in clinical performance, and did not document corrective actions taken. They also largely focused on the youth being reviewed rather than on the clinicians staffing the treatment team. The Psychology Supervisor's observations of therapy groups were very minimal, and clinical supervision sessions focused on the youth who was being reviewed rather than on the clinician's capabilities. Review of psychology documentation did not include sufficient feedback and corrective measures. Clinical supervision sessions for social workers did not clearly document corrective actions or follow-up where improvement in performance was needed.[93]

- **Circleville:** Psychology supervision consisted of notes that a particular issue regarding a youth was discussed. There was no discussion of a clinical formulation of the youth's presentation, and no indication as to whether the clinician was on target. There was no documentation suggesting that advice or guidance of any kind were offered by the supervisor, and no meaningful evaluation of the clinician's performance.[94]

- **Scioto:** Significant improvement was needed in psychology supervision and documentation. The psychology supervisor did not conduct quality assurance reviews of IDT meetings or groups, because of insufficient time to do so. The quality assurance processes involved a review of youth health records; however, it appears that the sample size was far too small and not sufficiently diverse to ensure meaningful monitoring.[95]

Paragraph 144: informed consent

- **All facilities:** There is currently no quality improvement monitoring of the informed consent process for psychotropic medications. It is generally accepted that any medication a prescribing practitioner authorizes must undergo the informed consent process. This must occur even if informed consent had occurred in another DYS facility via another psychiatrist. The current revised policy and procedure is confusing and needs to be edited to reflect generally accepted practices. It is imperative that informed consent for psychotropic medication is provided by the prescribing practitioner, to include risks, benefits, side effects, and alternatives to treatment with a particular medication. Once the policy and procedure is reviewed and revised, quality improvement monitoring regarding procedural fidelity and documentation will be necessary. In

[92] Id.
[93] Id.
[94] Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 36-38.
[95] Scioto, Monitor's comprehensive site visit report (Jan. 2012), p. 42.

addition, as further developments are made in the field of psychopharmacology, medication information sheets provided to the youth and their parent/guardian will need to be updated.[96]

VI. Dental care

Subject matter expert: Don Sauter, DDS, MPA

Paragraphs 158-160, 170-171: Access to urgent dental care / quality assurance for dental care

- **Scioto:** Nine dental companion medical records were reviewed of patients who complained of pain and were housed in the PROGRESS Units. Three out of nine records (33%) were out of compliance with DYS policy. Youth complaining of pain were not transported to the dental clinic in a timely manner when the dentist was present. The treatment of one youth was particularly troubling. This youth had significant dental problems and areas of infection. He requested urgent care repeatedly in writing[97] and to the nurses. His dental record contained documentation of numerous attempts by dental staff to schedule treatment for his complaints over a period of months; and many entries stating that the youth was not transported to the dental clinic.[98] We concluded that the dental care provided to this youth was haphazard and reckless, due largely to the inability and/or unwillingness of custody staff to deliver the youth to the dental clinic when treatment was needed. We reported the same type of neglect for another youth on the PROGRESS Unit in a site visit report six months earlier.[99] Both youth were mental health patients, suggesting larger systemic problems with direct care staff taking the complaints of pain seriously when they present in mentally ill patients.[100]

  The DYS Medical Director, not the contract dentist or shared services dental director, was responsible for addressing the lack of escorts for urgent dental care and did not. No meaningful plan for improvement was created or implemented to address the fundamental failure to provide urgent dental care to the PROGRESS Unit youth. The Medical Director's quality assurance report did not include discussion regarding the timeliness of treatment for urgent dental needs, or the instances of neglect that required immediate action; and there was no documentation regarding the Medical Director's possible interactions with the escort staff and their managers to resolve the problem.[101]

[96] Cuyahoga Hills & Indian River, Monitor's comprehensive site visit report (Sept. 2012), pp. 68-70; Circleville, Monitor's comprehensive site visit report (Feb. 2012), pp. 56-57; Scioto, Monitor's comprehensive site visit report (Jan. 2012), pp. 59-60.
[97] The patient had documented complaints of dental pain on 5/30/12, 6/24/12, 7/26/12, 9/3/12, 9/5/12, 9/26/12, and 10/16/12.
[98] The reason cited for failure to the see the patient was "no transportation" on 7/10/12, 8/9/12, 8/13/12, 8/28/12, and 9/4/12.
[99] Scioto, dental site visit report by Don Sauter (April 2012), p. 12.
[100] Id.; Scioto, dental site visit report by Don Sauter (Oct. 2012), pp. 1-12.
[101] Scioto, dental site visit report by Don Sauter (Oct. 2012), pp. 1-12.

Comprehensive Compliance Chart, December 2012

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
1. Stipulation resolves claims	N/A	--	--	--	--	--
2. Claims; class defined	N/A	--	--	--	--	--
3. Parties agree to fact finding report	N/A	--	--	--	--	--
4. No waiver of sovereign immunity	N/A	--	--	--	--	--
5. Parties agree to Stipulation	N/A	--	--	--	--	--
6. Def.'s best efforts to obtain funding	N/A	--	--	--	--	--
7. Purpose of Stipulation	N/A	--	--	--	--	--
8. Definitions	N/A	--	--	--	--	--
9. Provisions applying to Paint Creek	N/A	--	--	--	--	--
10. Safe environment / LRE	Guiding principle	--	--	--	--	--
11. DYS mission statement	N/A	--	--	--	--	--
12. Decisions must meet letter and spirit of Stipulation	N/A	--	--	--	--	--
13. Continuum of care / regionalized service delivery	Bilchik	SC	--	--	--	--
14. Task force / development of regional facilities	Bilchik	SC	--	--	--	--
15. LRE / limiting population in secure confinement	Bilchik	SC	--	--	--	--
16. Cost-effectiveness	Guiding principle	--	--	--	--	--
17. Disproportionate minority confinement	Bilchik	PC	--	--	--	--
18. Effective and consistent assessments	Guiding principle	--	--	--	--	--
19. Youth-focused care	Guiding principle	--	--	--	--	--

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
20. Quality treatment interventions	Guiding principle	--	--	--	--	--
21. Family engagement	Guiding principle	--	--	--	--	--
22. Qualified workforce properly deployed	Guiding principle	--	--	--	--	--
23. Education system provides opportunities / complies w/ law	Guiding principle	--	--	--	--	--
24. Responsive grievance system	Guiding principle	--	--	--	--	--
25. Access to advocates and attorneys	Nathan	SC	--	--	--	--
26. Strong re-entry programs	Bilchik	PC	--	--	--	--
27. Fair and informed release process	Guiding principle	--	--	--	--	--
28. Accountability and monitoring	Guiding principle	--	--	--	--	--
29. Top priorities: force, isolation, mental health, educ.	N/A	--	--	--	--	--
30. P&P review and revision for priorities in paragraph 29	Martin, Peterson, Crow, Roush, Martinez	SC	--	--	--	--
31. Speedy implementation of new P&P	Martin, Peterson, Crow, Roush, Martinez	PC	--	--	--	--
32. Plan for reforming release standards and procedures	Nathan	[deferred]	--	--	--	--
33. DYS list of changes made within 30 days of Stipulation	N/A	SC	--	--	--	--
34. DYS description of agency and program history	N/A	SC	--	--	--	--
35. Review and revision of P&P in other areas as needed	General principle	--	--	--	--	--
36. P&P review within 9 months / implementation	N/A	SC	--	--	--	--
37. Staff training on P&P	Roush	SC	--	--	--	--
38. Annual in-service	Roush	--	PC	PC	SC	SC
39. Medical and mental health P&P, general and site-specific	Weisman, Glind-meyer, Peterson, Shansky	--	SC	SC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
40. Site-specific P&P consistent with system-wide P&P	Weisman, Glind-meyer, Peterson, Shansky	--	SC	SC	SC	SC
41. Annual review of P&P	Harrell, Schuster	SC	--	--	--	--
42. Subsequent paragraphs contain P&P specifics	N/A	--	--	--	--	--
43. Admissions and intake	Martinez	--	PC	PC	SC	SC
44. Assessments and screenings	Martinez	--	SC	SC	SC	SC
45. Content of orientation	Martinez	--	SC	SC	SC	SC
46. Revision of Introductory Handbook	Martinez	--	SC	SC	SC	SC
47. Security classification appropriate to risks and needs	Martin, Martinez	--	[pending]	[pending]	[pending]	[pending]
48. Role of unit staff in service delivery / family engagement	Roush	--	SC	PC	SC	SC
49. Sufficient unit staffing; social worker caseloads	Roush, Martinez	--	SC	NC	PC	PC
50. Adequate, low-cost phones	Roush	--	SC	SC	SC	SC
51. Unit staff to have access to necessary records	Weisman, Martinez	--	PC	PC	PC	PC
52. All youth entitled to rehabilitation	General Principle	--	--	--	--	--
53. All youth entitled to UCP and resources to implement it	Weisman, Martinez	--	SC	SC	SC	SC
54. All staff have defined role in rehabilitation	Roush, Martinez, Weisman	SC	--	--	--	--
55. Behavior management is consistent, positive, and fair	Roush, Martinez, Weisman.	--	SC	NC	SC	SC
56. Structured programming	Roush, Martinez, Weisman	--	PC	NC	PC	PC
57. Expanding the use of volunteers	Roush	--	SC	SC	SC	SC
58. Care and accommodations for special needs youth	Weisman	--	PC	NC	SC	PC
59. Clear program with P&P for comfort rooms	Weisman	--	[N/A]	PC	PC	[N/A]

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
60. QA for program and intervention implementation	Roush, Martinez, Weisman	--	PC	PC	PC	PC
61. DYS to develop program and staffing plan	Roush, Martinez, Weisman	SC	--	--	--	--
62. Sex offender program / staff training / QA and P&P	Glindmeyer, Weisman	--	PC	PC	PC	PC
63. Release decisions for sex offenders	**Nathan. (lead),** Glindmeyer, Weisman.	**[deferred]**	--	--	--	--
64. Stay should not be extended because of delay in services	Nathan	PC	--	--	--	--
65. Safe living conditions	Roush, Martinez	--	SC	PC	PC	SC
66. Adequate staffing is critical to safety	Roush	--	SC	NC	PC	SC
67. JCOs qualified to work with youth	Roush, Martinez	PC	--	--	--	--
68. JCO youth engagement responsibilities / training	Roush, Martinez	PC	--	--	--	--
69. Staff training topics / lesson plans / evaluations / feedback	Roush	SC	--	--	--	--
70. Use of force generally	Martin	--	PC	PC	PC	SC
71. Guiding principles for use of force policies	Martin	--	PC	PC	PC	SC
72. Fair and appropriate gang intervention strategies	Roush, Martinez	--	PC	NC	PC	SC
73. Adequate video coverage to enhance youth/staff monitoring	Roush	--	SC	PC	SC	SC
74. Safety plans and SMPs tied to treatment / incentives	Roush, Martinez	--	NC	NC	NC	NC
75. SMPs / isolation: designed to meet individual youth needs	Roush, Martinez, Weisman	--	NC	NC	NC	NC
76. Seclusion guiding principles	Martin	--	**[pending]**	**[pending]**	**[pending]**	**[pending]**
77. Restraints P&P / purpose / safeguards / documentation	Martin	--	PC	SC	SC	SC
78. Staff training on restraints	Martin	--	PC	SC	SC	SC
79. P&P re. investigations of use of force and sexual misconduct	Martin	--	SC	SC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
80. Guiding principles for P&P in paragraph 79	Martin	--	SC	SC	SC	SC
81. Eliminating the backlog of investigations	Martin	SC	--	--	--	--
82. Sufficient staffing to conduct investigations	Martin	--	SC	SC	SC	SC
83. Coordinated abuse investigations	Martin	--	SC	SC	SC	SC
84. QA for use of force	Martin	--	SC	SC	SC	SC
85. Opportunity to accomplish the purpose of confinement	General Principle	--	--	--	--	--
86. Mental health care scope / individualized / evidence-based	General Principle	--	--	--	--	--
87. Mental health P&P / disseminated to clinical staff	Glindmeyer, Weisman	PC	--	--	--	--
88. Mental health screening, assessment, and referral	Glindmeyer, Weisman	PC	--	--	--	--
89. Revise protocols for special needs and mental health units	Glindmeyer, Weisman	--	[N/A]	PC	SC	[N/A]
90. Clearly articulated criteria for discharge from MH caseload	Glindmeyer, Weisman	--	PC	PC	PC	PC
91. Adequate trained personnel, space, and time for MH goals	Weisman	--	PC	PC	PC	PC
92. Mental health staff ratios / analysis	Weisman	--	SC	SC	SC	SC
93. Mental health clinical staffing of treatment units	Weisman	--	[N/A]	SC	SC	[N/A]
94. Annual review of MH staffing and allocation	Weisman	PC	--	--	--	--
95. Occupational and general activity therapy	Weisman	--	NC	PC	SC	NC
96. Sufficient clerical support for MH clinical staff	Weisman	--	SC	PC	SC	PC
97. Mental health resources for youth in general population	Glindmeyer, Weisman	--	SC	SC	SC	SC
98. Structured, focused design and planning of treatment	Glindmeyer, Weisman	--	PC	NC	PC	PC
99. Family engagement by mental health staff	Weisman	--	PC	PC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
100. Mental health clinician to meet regularly with girls	Glindmeyer, Weisman	--	[N/A]	PC	[N/A]	[N/A]
101. Disciplinary advocate for youth on MH caseloads	Weisman	--	SC	SC	SC	SC
102. Mental health QA and peer review	Glindmeyer, Weisman	--	PC	PC	PC	PC
103. Mental health staff capacity and performance	Glindmeyer, Weisman	--	PC	PC	PC	PC
104. Mental health leadership	Glindmeyer, Weisman	PC	--	--	--	--
105. Training for clinical and other staff	Glindmeyer, Weisman	PC	--	--	--	--
106. Mental health records and team coordination	Glindmeyer, Weisman	--	PC	PC	PC	PC
107. Guidelines for suicide P&P	Weisman	PC	--	--	--	--
108. Changes to physical plant to prevent self-harm	Weisman	--	SC	PC	SC	[N/A]
109. Youth entitled to medical care	General Principle	--	--	--	--	--
110. Medical services to meet the needs of adolescents	General Principle	--	--	--	--	--
111. Develop and implement chronic care clinics	Shansky	--	SC	PC	SC	SC
112. Expectations of central office medical leadership	Peterson, Shansky	PC	--	--	--	--
113. Define relationship b/w Medical and Nursing Directors	Shansky	SC	--	--	--	--
114. Medical and Nursing Directors drive P&P	Peterson, Shansky	SC	--	--	--	--
115. Resources for and monitoring of Medical Director	Shansky	PC	--	--	--	--
116. New medical P&P subject to review	Peterson, Shansky	PC	--	--	--	--
117. Assessments monitored for quality and accuracy	Peterson, Shansky	--	PC	PC	SC	SC
118. New protocols and revised policies on documentation	Peterson, Shansky	--	PC	PC	PC	PC
119. QI for initial health appraisals	Shansky	--	PC	PC	PC	PC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
120. Screens by LPN / appraisals by RN with Dr. signature	Shansky	--	PC	PC	SC	SC
121. Requirements for initial health and MH assessments	**Shansky (lead)**, Glindmeyer, Weisman	--	PC	PC	PC	PC
122. Medical P&P for transfers; requirements for progress notes	**Shansky (lead)**, Glindmeyer	--	PC	PC	PC	PC
123. Transfer process and medical care / transfer summary	Shansky	--	SC	PC	SC	SC
124. P&P guidelines for injury assessment and referral	Shansky	--	PC	PC	PC	PC
125. Qualitative reviews of documentation	Shansky	--	PC	PC	SC	SC
126. Additional attention to special needs of females	Shansky	--	[N/A]	PC	[N/A]	[N/A]
127. Standards for administration of medicine	**Peterson (lead)**, Glindmeyer	--	PC	PC	PC	PC
128. P&P to ensure assessment of impact of medication errors	**Peterson (lead)**, Glindmeyer	--	PC	PC	PC	PC
129. Prescribing, stocking, and access to "as needed" meds	Peterson	--	SC	SC	SC	SC
130. Routine pharmacy monitoring	Peterson	NC	--	--	--	--
131. Monitoring and reporting of laboratory services	Peterson	--	PC	PC	PC	PC
132. Infection control	Peterson	--	PC	PC	PC	PC
133. Physical plant: medication storage / sanitation	Peterson	--	SC	PC	SC	SC
134. Review and replace medical equipment	Peterson	--	SC	SC	SC	SC
135. Availability / accessibility of medical records	**Peterson (lead)**, Weisman	--	NC	NC	NC	NC
136. Medical record to be chronological and complete	**Peterson (lead)**, Glindmeyer	--	PC	PC	PC	PC
137. Problem lists conspicuous in file / resolved issues identified	Peterson	--	SC	PC	SC	PC
138. Review of medical records / required contents of Dr. notes	Peterson	--	PC	PC	PC	SC
139. Monitoring / review of abnormal vital signs	Shansky	--	PC	PC	PC	PC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
140. Face-to-face appointment for acute illness or hospital visit	Shansky	--	PC	PC	PC	PC
141. QA / QI / peer review / programming to match needs	Shansky	--	PC	PC	PC	PC
142. Protocol for preventive care / health education	Peterson	--	PC	PC	PC	PC
143. Medical staff to inform youth regarding care	Peterson	--	PC	PC	SC	SC
144. Informed consent / education on medication uses	**Peterson (lead)**, Weisman	--	PC	PC	PC	PC
145. Protocol to ensure family engagement in medical care	Peterson	--	PC	PC	PC	PC
146. Assessment of nutrition program	Peterson	--	SC	SC	SC	SC
147. Health care staffing and allocation	Peterson	--	PC	PC	PC	PC
148. Relief factor for 24/7 nursing positions	Peterson	--	PC	PC	PC	PC
149. P&P defined roles of medical staff	Peterson	SC	--	--	--	--
150. Assess medical staff pay and benefits	Peterson	SC	--	--	--	--
151. Health care staff properly credentialed / relevant expertise	Peterson	--	SC	SC	SC	SC
152. Regularly assess staff competency / peer review	Weisman, Glind-meyer, Peterson, Shansky,	--	PC	PC	PC	PC
153. Med staffing sufficient for population needs	Peterson	--	PC	PC	PC	PC
154. All youth have a right to dental care	Makrides, Sauter	--	SC	SC	SC	SC
155. Dental care must meet or exceed national standards	Makrides, Sauter	--	SC	SC	SC	SC
156. General dental care standards to be monitored	Makrides, Sauter	--	SC	SC	SC	SC
157. Dental care P&P reviewed by class counsel and Monitor	Makrides, Sauter	--	SC	SC	SC	SC
158. Access to routine and acute dental care / supplies	Makrides, Sauter	--	SC	NC	SC	SC
159. Urgent dental care within 24 hours	Makrides, Sauter	--	SC	NC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
160. Scheduling of dental treatment / eliminating delays	Makrides, Sauter	--	SC	NC	SC	SC
161. Annual dental exam, cleaning, oral health education	Makrides, Sauter	--	SC	SC	SC	SC
162. Update dental P&P in various areas	Makrides, Sauter	SC	--	--	--	--
163. Dental screening exam / individual treatment plan	Makrides, Sauter	--	SC	SC	SC	SC
164. Preventive care / sealant placement / topical fluoride	Makrides, Sauter	--	SC	SC	SC	SC
165. Develop oral hygiene education program	Makrides, Sauter	--	SC	SC	SC	SC
166. High priority dental caries / stabilization / follow-up	Makrides, Sauter	--	SC	SC	SC	SC
167. Guidelines for partial dentures and crowns	Makrides, Sauter	--	SC	SC	SC	SC
168. Oral surgery / dental radiographs / dental assistant	Makrides, Sauter	--	SC	SC	SC	SC
169. Availability of dental specialists	Makrides, Sauter	--	SC	SC	SC	SC
170. Monitor dental treatment of special needs patients	Makrides, Sauter	--	SC	NC	SC	SC
171. QA and peer review / correction of deficiencies	Makrides, Sauter	--	SC	NC	SC	SC
172. Adequate medical information available to dentist	Makrides, Sauter	--	SC	SC	SC	SC
173. Dental treatment plan for each youth	Makrides, Sauter	--	SC	SC	SC	SC
174. SOAP format for dental record progress notes	Makrides, Sauter	--	SC	SC	SC	SC
175. Appropriate dental space, equipment, and supplies	Makrides, Sauter	--	SC	SC	SC	SC
176. Dental staffing	Makrides, Sauter	--	SC	SC	SC	SC
177. Licensure of dental staff	Makrides, Sauter	--	SC	SC	SC	SC
178. Number and quality of dental staff	Makrides, Sauter	--	SC	SC	SC	SC
179. Infection control / biohazard labeling / sterilization	Makrides, Sauter	--	SC	SC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
180. DYS acknowledges the importance of education	General Principle	--	--	--	--	--
181. Communication between schools and Bureau of Education	Crow	--	PC	SC	SC	SC
182. JCOs in schools / training / classroom management	Crow	--	SC	PC	SC	SC
183. Role of superintendent and facility admin	Crow	--	SC	SC	SC	SC
184. Education staff instruction duties not hampered by security	Crow	--	SC	SC	SC	SC
185. Ensure sufficient education space	Crow	--	SC	SC	SC	SC
186. Safety features in schools: cameras, alert systems	Crow	--	SC	SC	SC	SC
187. Appropriate classroom furniture	Crow	--	SC	SC	SC	SC
188. Repairs / classroom space at CHJCF / HVAC at ORV	Crow	--	[N/A]	[N/A]	[N/A]	SC
189. All youth receive full school day (5.5 hours)	Crow	--	PC	PC	PC	SC
190. Options to meet full school day requirements	Crow	--	SC	SC	SC	SC
191. Recruiting and retaining school staff / diversity recruiting	Crow	--	PC	PC	PC	PC
192. Centralized hiring process / staff allocation / HQT placement	Crow	--	SC	SC	SC	SC
193. Academic credit for certain group programs	Crow	--	PC	PC	SC	SC
194. Analyze vacancies / staffing ratios / staffing plan	Crow	--	SC	PC	PC	SC
195. Budget for substitutes / hire and train permanent subs	Crow	--	SC	PC	PC	SC
196. Full education services in specialty units	Crow	--	[N/A]	PC	SC	[N/A]
197. Facilities to inform Bureau which students in specialty units	Crow	--	[N/A]	SC	SC	[N/A]
198. Special education teacher on specialty units	Crow	--	[N/A]	SC	SC	[N/A]
199. Revise policies to provide professional development	Crow	SC	--	--	--	--

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
200. Pre-service and ongoing training for teachers	Crow	--	SC	SC	SC	SC
201. Staff training on collateral consequences of juv. records	Crow	--	SC	PC	SC	SC
202. Educational aides / yearly contracts for teachers	Crow	--	SC	SC	SC	SC
203. Improve communication between facility and school staff	Crow	--	SC	SC	SC	SC
204. Violence interfering with students' education	Crow	--	PC	PC	SC	SC
205. Identify and help teachers with classroom management	Crow	--	PC	PC	PC	SC
206. Contract with education consultant re. classroom mgmt	Crow	SC	--	--	--	--
207. School discipline / behavior management	Crow	--	SC	PC	SC	SC
208. Improve accuracy of education assessments	Crow	SC	--	--	--	--
209. Clerical support for guidance counselors	Crow	--	SC	PC	SC	SC
210. Transition specialists / links to community / follow-up	Crow	--	SC	PC	SC	SC
211. Explore options for post-secondary education	Crow	--	PC	PC	SC	SC
212. Job training / career tech / vocational education	Crow	--	SC	PC	SC	SC
213. Waivers and funding for career tech programs	Crow	SC	--	--	--	--
214. Satellite career tech / local business and community	Crow	--	SC	PC	PC	PC
215. Career tech certifications	Crow	--	SC	SC	SC	SC
216. AOT classes at reception / additional programs at ORV	Crow	--	[N/A]	SC	[N/A]	[N/A]
217. All classroom space wired for CSLS / staff trained	Crow	--	PC	PC	SC	SC
218. Internet for staff / consider for youth / library technology	Crow	--	PC	PC	PC	PC
219. Speech therapists / literacy / Title I reading teachers	Crow	--	SC	SC	SC	SC

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
220. School for 12- and 13-year-old students	Crow	SC	--	--	--	--
221. Special Education / compliance with IDEA	Crow	--	PC	PC	PC	PC
222. Bureau oversight of Special Education	Crow	--	PC	PC	PC	PC
223. Speedy provision of Special Ed services following intake	Crow	--	SC	SC	SC	SC
224. Special Ed screening / qualified staff to screen	Crow	--	SC	PC	SC	SC
225. Individualized Education Plans	Crow	--	PC	PC	SC	SC
226. Intervention Assistance Teams / "child find" duty	Crow	--	SC	SC	SC	SC
227. Professional development in various Special Ed areas	Crow	--	PC	PC	SC	SC
228. Guidance counselors electronic access to full IEPs	Crow	--	SC	SC	SC	SC
229. Monitoring progress toward IEP goals / teacher evals	Crow	--	PC	PC	PC	PC
230. Transition / comply with IDEA "change of placement"	Crow	--	PC	PC	SC	SC
231. School psychologists available / FBAs / disability evals	Crow	--	SC	SC	SC	SC
232. Grievance system / youth assistance / fairness / trends	Martin	--	[pending]	[pending]	[pending]	[pending]
233. Uninvolved clinician reviews clinical grievances	Martin	--	SC	SC	SC	SC
234. Grievance orientation for youth and parents	Martin	--	SC	SC	SC	SC
235. Youth Advocate position reviewed / redefined	Martin, Schuster	--	PC	PC	SC	SC
236. Discipline system / Youth Advocate pilot program	Martin	--	PC	PC	SC	SC
237. Consequences and time added in line with treatment	**Martin (lead)**, Nathan, Weisman	--	PC	PC	SC	SC
238. Discipline for youth on MH caseload	**Martin (lead)**, Glindmeyer, Weisman	--	PC	PC	PC	PC
239. Documentation / data access P&P / treatment progress	Roush (with input from other experts)	NC	--	--	--	--

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
240. Documentation of MH interventions	Glindmeyer, Weisman	--	PC	PC	PC	PC
241. Youth records useful to treatment teams	**Weisman (lead)**, Peterson	--	PC	PC	PC	PC
242. Appointment of Monitor and subject matter experts	N/A	--	--	--	--	--
243. Def's to pay for monitoring costs	N/A	--	--	--	--	--
244. Monitor to consult counsel regarding experts	N/A	--	--	--	--	--
245. Resolving disputes related to Monitor's budget and staff	N/A	--	--	--	--	--
246. Monitoring team to contract directly with DYS	N/A	--	--	--	--	--
247. Monitor as coach and fact finder / monitoring principles	N/A	--	--	--	--	--
248. Monitoring doc review not a waiver of QA privilege	N/A	--	--	--	--	--
249. Monitor will not disclose confidential, privileged info	N/A	--	--	--	--	--
250. Audit instrument / data request forms for site visits	N/A	--	--	--	--	--
251. Annual compliance report / interim reports	N/A	--	--	--	--	--
252. Monitor's longitudinal study of youth	Harrell, Bilchik	**[deferred]**	--	--	--	--
253. Process for replacing the Monitor	N/A	--	--	--	--	--
254. Monitor not subject to dismissal without good cause	N/A	--	--	--	--	--
255. Monitor shall also serve as Monitor over DOJ findings	N/A	--	--	--	--	--
256. Resolving disputes over substantial compliance	N/A	--	--	--	--	--
257. Youth must still exhaust grievances before legal action	N/A	--	--	--	--	--
258. No motion or legal action without dispute resolution	N/A	--	--	--	--	--
259. No contempt proceedings without prior motion and order	N/A	--	--	--	--	--

Stipulation Paragraph	Expert(s) assigned	General	CJCF	SJCF	IRJCF	CHJCF
260. Presumptive 5-year monitoring of Stipulation	N/A	--	--	--	--	--
261. 5 year monitoring unless compliance achieved early	N/A	--	--	--	--	--
262. Def's may move to terminate if compliant for 2 yrs	N/A	--	--	--	--	--
263. Court to retain jurisdiction / power to enforce Stipulation	N/A	--	--	--	--	--
264. Def's to pay Plaintiffs' attorneys fees and costs	N/A	--	--	--	--	--
265. Parties to work with AG to expedite youth criminal cases	Harrell	SC	--	--	--	--
266. Parties agree that Stipulation is fair / protects class	N/A	--	--	--	--	--
267. Stipulation is binding on Def's, successors, and Plaintiffs	N/A	--	--	--	--	--
268. Def's must meet Stipulation requirements immediately	N/A	--	--	--	--	--
269. P's can move to enforce / class reps can be replaced	N/A	--	--	--	--	--
270. Stipulation does not change PLRA or other laws	N/A	--	--	--	--	--
271. Laws / union agreements not to undermine Stipulation	N/A	--	--	--	--	--
272. Stipulation is the entire agreement	N/A	--	--	--	--	--
273. Stipulation construed as a whole	N/A	--	--	--	--	--
274. Stipulation paragraphs are severable	N/A	--	--	--	--	--