FINAL FACT-FINDING REPORT

S.H. v. STICKRATH

Submitted by:

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S.H. v. Stickrath
FACT-FINDING, FINAL REPORT

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EXECUTIVE SUMMARY
S.H. v. Stickrath
Fact-Finding Final Report
December 13, 2007

United States Magistrate Judge Kemp appointed Fred Cohen as Independent Fact Finder on May 18, 2007. Following an investigative protocol approved by counsel, I assembled a team of 10 experts and we conducted intensive site visits of various Ohio Department of Youth Services (ODYS) facilities, interviewing staff and youth; ODYS officials were interviewed, records and various studies and reports were assembled and studied, policy and procedure were studied and so on.

The Final Report is an amalgam of the entire team's work. The individual expert reports are assembled as Appendix D and properly may be viewed as resource material for this Report. In the event of any real or apparent contradictions, the Final Report is controlling.

S.H. is a broadly drawn, multiple-conditions, class action case that includes all youth who are or will be committed to the ODYS. The issues raised by Plaintiff's Complaint (April 4, 2007), include the application by staff of unnecessary force; arbitrary and excessive use of isolation and seclusion; arbitrary and excessive discipline; inadequate mental health, medical, and dental care; inadequate education services; inadequate structured programming; broadly inadequate training of staff; an unsafe living environment; and a dysfunctional grievance system. The Final Report addresses all these areas and some other areas (e.g., Release Authority, grievances, and training) that are inseparably related to the primary issues raised by Plaintiffs.

The Final Report sustains each area of the complaint, in varying degrees of intensity. Should any of the findings be viewed as conclusionary, as not adequately supported by its accompanying text, the read again is referred to the resource material in Appendix D.

Most ODYS facilities were found to be overcrowded, understaffed, and underserved in such vital areas as safety, education, mental health treatment and rehabilitative programming.

Excessive force and the excessive use of isolation, some of it extraordinarily prolonged, is endemic to the ODYS system.

Juvenile Correctional Officers (JCOs) bitterly complained about the excessive use of mandated overtime, a practice at least partly driven by understaffing, which we estimate to be 188 FTE, JCO positions. JCOs function now more like prison guards (or police officers) than trained partners in a shared rehabilitative effort. Without additional JCOs who are far better trained and psychologically equipped for this difficult job, ODYS likely will continue to vacillate between the rhetoric of treatment and the reality of the adultification of the agency.

With a population as psychologically undeveloped and damaged as the ODYS youth, there must be a well-coordinated mental health system in place. Our experts unanimously found, in effect, there is no mental health system. What goes by the name mental health care actually is a series of well-intentioned responses to crisis.

One unsettling aspect of this constitutionally deficient mental health care is that I co-authored a Report in 1998 and then prepared a more comprehensive Report in 2004 pointing out this same deficiency as to Scioto Juvenile Correctional Facility. I noted also that there was a staff culture of violence there, a theme regrettably repeated in this Report for ODYS as a whole.

There can be no claim of lack of knowledge regarding the paucity of mental health care. Indeed, even as we visited Marion in recent months we found conditions in the so-called Intensive Mental Health Unit appalling. DYS officials seemed caught off guard at this revelation and then worked furiously to find a solution. On December 17, 2007, with just two hours prior notice, team member Barbara Peterson paid yet another visit to Marion and the Intensive Mental Health Unit. Ms. Peterson found encouraging changes: additional office space, new carpet, additional clinical staff, and evidence of important advances in treatment planning and programming. (Brief Report appears as part of Appendix D to this Report.)

For mental health and rehabilitative care to meet minimal constitutional standards there must first be dynamic leadership in Central Office; a reinvigorated and broadly shared sense of mission; the addition of clinical staff, especially psychiatric nurses and child-adolescent psychiatrists; a continuum of care from reception to the home facility;

authentic mental health units; access to hospital level care; quality assurance, peer review, and discharge planning.

The needless and excessive use of force is engrained within ODYS, with Ohio River Valley, Marion and Indian River in the top tier on use of force, restraints, and isolation. We consistently found flawed training, deficient oversight, seriously inadequate reporting and subsequent review of "incidents." Our findings support the conclusion that ODYS youth, with varying degrees of intensity depending on the facility, are not provided with the constitutional minima relating to a safe environment. Their physical and psychological well-being is at risk and often damaged at the present time. This environment, in turn, dramatically impedes whatever efforts are made to provide treatment and programs.

As we note in the Report, we do not underestimate the daunting task faced by ODYS, especially the JCOs, in dealing with this often difficult population. Staff, however, cannot demean, provoke, insult and assault youth and then complain about a violent environment. We found that JCOs' training and early indoctrination emphasizes a "we-they" attitude and a youth's sidelong glance or delay in following an order is then processed as a prelude to a dangerous encounter.

Too often it is because some officers do not know how to, or care to, de-escalate. JCOs have a legal obligation to sustain a safe environment for the youth. In doing so, the JCOs will create a mutually safe environment. Reinvigorated pre-service and in-service training of staff on use of force is essential and a high priority.

Isolation, particularly in conjunction with various special management or behavior plans, is used too often, for too long, and without adequate treatment or educational opportunities. The extended — at times, months on end — use of isolation (i.e., segregation) must be immediately revisited and dramatically changed. Imposing prolonged and highly deprivational isolation whether in the name of treatment, behavior modification, or punishment is not constitutionally permissible.

Our education expert, Ava Crow's full Report on education is must reading. It is attached as part of Appendix D. While Ms. Crow is sanguine about the leadership prospects under new Superintendent Turner, there is little else she found that was affirmative or in compliance with some important legal requirements.

ODYS's top-down management style is found to give too little decision-making to education officials. Ms. Crow's full report provides numerous examples of the difficulties this causes.

There are far too few teachers and substitutes, a lack of schoolroom, office, and administrative space. On a randomly selected, given day, 43% (598 youth) were found to receive less than the legally mandated, full school day.

ODYS is not meeting the mandates of various special education laws; the failure to implement the requisite IEPs is but one dramatic example.

Disciplinary issues abound making education in ODYS facilities an often harrowing task. Increasing disciplinary responses to student misbehavior does not seem to be the answer. If the education mission is to go forward, this area is one of the crucial areas for immediate resolution.

The system lacks academic and career technical counseling making re-entry difficult for some, impossible for others.

In sum, the human and physical resources devoted to educating ODYS youth along with the physical plant are utterly deficient and require basic overhauling.

As for facility overcrowding, only Mohican and Circleville operated under capacity. The other facilities operated at 141% of rated capacity. When overcrowding is combined with a staff culture overly reliant on the reflexive and excessive use of force, this creates a combustible mixture.

With overcrowding, youth privacy is impacted, programs suffer, injuries increase, staff suffers, and, in effect, any commitment to "help" is impaired. The reduction of overcrowding, addition of staff, and richer programming is in the best interests of the youth and often overwhelmed staff.

In considering the estimated JCO staffing shortfall, any resolution of the *S.H.* litigation should consider population restrictions or reductions and/or greater use of Community Correction Facilities, which our compressed examination rated quite favorably. Any agreement concerning staff should occur within the framework of any new direction ODYS may elect to take and such additional study of staffing needs that the parties may elect to undertake as a part of a settlement agreement.

Also, a change in the job description and performance of JCOs seems vital. That is, there should be a movement from “cop” to “counselor.” The parties should consider changes in recruitment and compensation in order to attract and retain highly qualified people for this very difficult job.

Excessive use of force, basically inadequate mental health treatment and rehabilitative programs, and the marginal functioning of the education system are the primary deficits of ODYS. If the system elects to continue to function within its present outline, there must be a major change in training, recruitment, the hiring of additional, qualified staff, quality assurance and peer review that is effective, and more evident leadership at the Deputy Director level.

Director Stickrath has a daunting task with the agency he inherited and he appears committed to leading the agency through the legally required changes and beyond. He must receive the necessary support staff and funds to move forward. He should be congratulated for continuing a policy that generally prohibits “handchecking” (requiring youth to move about in a simulated handcuffed position) and allowing youth to converse during meals, something not allowed by his predecessor.

As for medical and dental care, the Report makes it clear that the Medical Director spends too much time providing direct care and this, in turn, impairs his ability to provide needed leadership. There are problems with initial health appraisals, failure to document basic clinical information, chronic care is seriously compromised, medication administration is below accepted practice standards, infection control is compromised, quality assurance is lacking, medical education for youth needs to be enhanced, and professional staffing levels are inadequate. [See Final Report, page 152 for details.]

The overall ODYS dental care program was determined to be inadequate. There are, however, sufficient numbers of dentists if they are supplemented with now non-existent dental hygienists.

> “Changes need to be made in the areas of: staffing (dental assistant), diagnostic radiography (pre-extraction radiographs), infection control (labeling of biohazards, sterilization of instruments, spore testing, gowns and patient eye protection) urgent care tracking (complaints of pain assessed, and consistently stabilized and documented by nursing or dental

staff within 24 hours), primary prevention (fluoride treatments and sealants, annual prophylaxis and adequate oral health education, access to dental floss), categorizing treatment priorities-secondary prevention (caries stabilization-secondary prevention, annual follow up exams, fabrication of partial dentures without caries stabilization), dental record documentation (treatment plans, SOAP format), and access to care (written and verbal instruction on the specifics of requesting emergency, urgent and routine dental care)." [Final Report, page 167.]

The impact of the Release Authority (RA) reverberates throughout the entire ODYS system. It is at the center of an arcane, legislatively created maze touching judicial and administrative decision-making. For ODYS youth, the time added by the RA to the presumptive release date was a recurrent source of agitation and confusion.

Where youth were delayed in program completion and the delay was not attributable to the youth, frustration with deferred release was at its highest.

A recent Report on the RA by the University of Cincinnati (Professor Ed Latessa, et al.), found that from July 1, 2003 to November 30, 2006, ODYS youth spent 2,092 *years* beyond what the so-called matrix (i.e., presumptive release date) prescribed. See Edward Latessa, et al., An Analysis of the Ohio Department of Youth Services Release Authority's Decision Marking Process, pp. 16-19 (November 2007)(received by us on November 21, 2007, after the RA section for the Final Report was completed.)

The Final Report describes the Ohio law on point as confused and regressive. Protection of the public is rhetorically mixed with concern for the development of children; accountability competes with rehabilitation. The allocation of dispositional, release, and community supervision discretion between the judiciary, ODYS, and the Release Authority is almost impossible to decipher, let alone detect some coherence.

Ohio, like a number of states, is constitutionally free to use a discretionary release authority such as the RA. The Report points out, however, that the functioning of the RA contributes to the uncertainty and confusion of the youth in the system and it urges that the RA itself be closely re-evaluated.

The "Latessa Report" did not have crucial data on treatment services and completion of services; it never mentions the impact of extended terms on the youth, and

simply accepts the matrix as a given rather than addressing the inherent value to juvenile justice of presumptive sentences. Any future evaluation must assess the continued viability, certainly in its present structure, staffing, and operation of the RA.

While there is no constitutional obligation to have a grievance system, the system now in use does not appear to function as a viable problem-solving mechanism. Too many JCOs simply brush off simple requests by youth by saying, “File a grievance, I’m too busy.”

A good many ODYS youth have great difficulty in writing a coherent grievance, orally presenting their “case,” and in pursuing an appeal. There is, however, no mandated assistance for such youth. Grievance coordinators have varying backgrounds and an ambiguous role. Grievances too often go unanswered or are answered late. We did note some progress in enhancing timeliness. ORV remains particularly vulnerable in its handling of grievances.

There is a Youth Advocate position within ODYS that consists of one person, a car and a cubicle. Obviously, the incumbent cannot travel the state by himself and with no support staff he inherently is unable to serve as a viable Ombudsman.

Looking at the grievance system and the Youth Advocate position as attempts to defuse conflict; resolve individual complaints; and identify, then resolve systemic problems, it is our finding that those objectives are not being achieved.

In conclusion, the allegations in the Plaintiffs’ complaint are essentially supported by this Report. It is now up to the parties to construct a remedy consonant with these findings. A remedy may track, and improve on, the existing architecture of ODYS or it may seek a broader reform by, for example, moving increasingly to a community-level of care with smaller, local, richly staffed facilities.

An earlier draft of this Report was submitted for review by the Defendants to this action. This led to a face-to-face discussion of various points by Fred Cohen and Barbara Peterson along with Director Stickrath and his staff and his counsel, Joseph Mancini. Some adjustments have been made to the earlier draft and in the areas of treatment and education I elected to include in whole or in part submissions from DYS.

In this Report we want to recognize the number of people we encountered within the system — from JCOs to clinicians to Central Office — who do heroic jobs. For a

JCO to stand-up for a youth, for example, in the face of derision from colleagues is a heroic act. For a psychiatrist to go to work every day, and work incredibly long hours, in a system he or she knows is dysfunctional is truly heroic. For teachers to show up in classrooms with students often less than enthusiastic about learning also is heroic.

As ODYS moves forward, it must build on these heroes and heroics. They must become the models for change and their exemplary efforts the norm. We also believe that Chris Money, the relatively new Superintendent at Scioto, has gained traction and she, along with Deputy Nan Hoff, represent the hope for the future at their respective levels.

Finally, the Paint Creek facility, with its low recidivism rates, intensive programming, and rich staff may be viewed as an important model for Ohio's juvenile facilities. Our brief site visit and investigation led to some very positive findings but I concede that further evaluation would be necessary before any wholesale adoption of the model.

Fred Cohen, Esq.
January ___, 2008

FACT-FINDING, FINAL REPORT
S.H. v. Stickrath
December 13, 2007

I. FRAMEWORK: LEGAL & OPERATIONAL

I am privileged to present to the Court and the respective parties in the above captioned matter, the Final Fact-Finding Report (Report) required in accordance with the Case Management Plan filed with the Court on May 18, 2007. *S.H. v. Stickrath*, in brief, is a class action encompassing all persons who are or will be committed to the legal custody of the Ohio Department of Youth Services and housed in the various facilities it operates or contracts with.

The Court certified the class on July 9, 2007 pursuant to a Motion for an Agreed Upon Classification Order.

The Second Amended Complaint in this mater was filed with the Court on April 4, 2007 and is attached hereto as Appendix A. [That complaint mistakenly describes the lead Plaintiff as "S.W." I will refer to the case as S.H. throughout.] The Complaint accurately may be characterized as a broad-based conditions lawsuit.

Class counsel allege that the youth are subject to unnecessary force; arbitrary and excessive use of isolation and seclusion; arbitrary and excessive discipline; inadequate mental health, medical, and dental care; inadequate education services; inadequate structured programming; broadly inadequate training of staff; an unsafe living environment; and a dysfunctional grievance system.

Appointed as Independent Fact Finder by United States Magistrate Judge Kemp on May 18, 2007, I prepared an investigative protocol that has been approved by counsel for the parties. In brief, that protocol calls for site visits to the various DYS facilities whereby youth and staff are interviewed; relevant files, protocols, and policy and procedure studied; facilities inspected; and relevant activities observed.

Given the scope of the issues raised by the Complaint, with the approval of counsel, the following experts were retained to serve as members of the investigative team:

- Kathryn A. Burns, M.D., M.P.H.
- Fred Cohen, LL.B., LL.M.*
- Ava Crow, J.D.
- Edward J. Loughran, M.A.*
- Steve J. Martin J.D.*
- Barbara Peterson, R.N.*
- Robert A. Prentky, Ph.D.
- David W. Roush, Ph.D.*
- Donald Sauter, D.D.S., M.P.A.
- Ronald Shansky, M.D.
- Leta D. Smith, Ph.D.*

(* Indicates member of the "core team." Medical, dental, sex offender programs, and education specialists were given site visit schedules different from the core team.)

The "core team" visited Scioto, Marion, Freedom Center, Circleville, Ohio River Valley, Mohican, and Indian River.

Ava Crow, our education specialist, visited Scioto, Marion, Freedom Center, Circleville, Ohio River Valley, Mohican, Indian River, and Cuyahoga Hills.

Ron Shansky, M.D. and Don Sauter, D.D. S, accompanied by Barbara Peterson, R.N. of the core team, visited Scioto, Marion, Ohio River Valley, Indian River, and Cuyahoga Hills. It was my judgment that the medical and dental allegations could be fully understood without visiting all the DYS facilities. I was prepared to have the "medical/dental team" expand their site visits if it appeared to be necessary. In our collective opinion, we learned enough from what was done to feel comfortable with our fact finding and conclusions.

Barbara Peterson visited Paint Creek, a privately operated facility, on October 2, 2007.

Finally, Robert Prentky, Ph.D. was retained as our expert on sex offender classification and treatment. He is a world-renowned expert in the field and he constitutes an expert "team" of one. I asked Dr. Prentky to visit Scioto and Circleville and study relevant policy and procedure as well as the all important assessment tools.

These facilities are most involved with sex offender treatment, especially Circleville, and while other facilities may have offenders who receive sex offender treatment, it was my judgment that study of the facilities described above would be adequate for our fact finding and conclusions.

On November 2 and 3, 2007, the core team, absent Ned Loughran, along with Ava Crow, met with Fred Cohen in Tucson, Arizona. This was a highly productive, cross-fertilization meeting.

The table below reflects all site visits completed by all teams:

DYS Facility	"Core" Team	Medical/Dental Team	Education Specialist	Sex Offender Treatment
Circleville	September 11-12		August 6-7	September 22-23
Cuyahoga Hills		August 8-9	July 30- Aug 1	
Freedom Center	August 1		July 26-27	
Indian River	August 30-31	August 6-7	August 22-24	
Marion	August 2-3	September 19-20	August 15-17	
Mohican	August 28-29		August 20-21	
Ohio River Valley	September 13-14	July 30-31	August 8-10	
Paint Creek		October 2		
Scioto	June 13-15 & July 31-Aug. 1	September 17-18	July 24-26	September 21

Additionally, Kathy Burns visited Scioto on August 27-28 and Marion on August 29-30

There have been a number of other investigative activities that we have engaged in that also form a basis for this Report: interviews at Central Office with the Director and his ranking staff, field interviews with staff, discussions with other persons and academics familiar with DYS, legal and policy research, and more.

While this is likely to sound like the empty, typical, "thank you to all," it is not. Director Stickrath could not have been more helpful and supportive of our efforts and for that we all offer our heartfelt thanks. The Director assigned Ms. Shelly Fitzhugh to serve as the agency's point person with the team. She gathered data, worked on travel and interview schedules, answered questions, and made our difficult job much easier. Ms. Fitzhugh attended the above noted meeting in Tucson at the invitation of Fred Cohen and was present at all of our deliberation. She also has our heartfelt thanks.

Counsel for the plaintiffs and the Attorney General's office have been a pleasure to work with. These are all professional and honorable members of the bar who pursued our non-adversary, collaborative approach in a highly principled fashion while never appearing to lose sight of the interests of their clients and the youth who constitute the class.

Finally, a special thanks to Linda Mitchell, my Staff Director and all-around assistant, for word processing, organizing, and producing this Report.

Respectfully submitted by:

Fred Cohen, LL.B., LL.M.; Independent Fact-Finder

Who is grateful for the expert assistance of:

Kathryn A. Burns, M.D., M.P.H.
Ava Crow, J.D.
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Leta D. Smith, Ph.D.

II. CONCEPTUAL FRAMEWORK & OVERVIEW

A Damaged Population

The allegations made in the Complaint with varying degrees of intensity are essentially supported by our findings. Perhaps our gravest concern relates to staff use of force, isolation and restraint. The paucity of mental health care we uncovered lacks the drama, the shock value, of youths being taken to the floor by staff and placed in dangerous chokeholds, youths suffering a variety of broken bones and dislocations due to needless and dangerous physical restraints; plainly disturbed youth locked into segregation cells for 23 hours a day, 7-days a week for months on end with no semblance of needed treatment — and more, as will be developed, *infra*.

I might add here that the Mohican and Circleville facilities were found to be much more moderate in the use of force and various types of restraint. It is no accident that these DYS facilities also are the most treatment oriented. This will be more fully developed also, *infra*.

The youth confined within the ODYS system are, of course, not strangers to abuse and violence; to feelings of worthlessness and for some, an almost reflexive reaction to violence with violence. It is our premise that the persistent and deeply rooted culture of DYS staff violence either breeds, and most certainly reinforces, youth-on-staff and youth-on-youth violence.

Whenever this writer conducted group sessions with youth, the question would be asked, "How many of you experienced sexual or other physical abuse while growing up?" I cannot recall having fewer than half the youth answer, "yes" and with the girls confined at Scioto, the "yes" fell into the 80%-plus range. I understand this is not a scientific study and the term "abuse" may have a different meaning to different youth — typically as to the degree of the battery and consequent injury — but the answers of these young people give color and tone to some of the bland statistics residing in the scientific journals.

Institutions housing juvenile delinquents are not alone in the mistreatment of youth. Testimony before the House of Representatives, Committee on Education and Labor described thousands of allegations of abuse of troubled youth housed in residential

programs across this nation. These facilities did not include public programs or systems such as DYS.[1]

The GAO conducted the study leading to the testimony and, inter alia, found that in 2005 alone 33 states reported 1,619 staff members involved in the abuse of youth housed in residential programs; and in 10 selected, closed cases involving the death of a youth, significant evidence of mismanagement was found including the hiring of untrained staff.

There are no federal laws that regulate and define residential treatment programs for youth.

A recent series in the New York Times discloses shocking abuses in New York City's well-intentioned child foster care program.[2] Children are found malnourished, burned, abused, and dead. Oversight is virtually non-existent and media-cultivated child advocates are uncovered as fraudulent, profiteering schemers.

The air is filled with rhetoric of abiding concern for our children. And then there is the sobering practice of providing the least for those most in need. The troubles we identify at DYS are not isolated. They reflect the failure of social welfare and social control policies. States do not frame child welfare policies — certainly not for juvenile justice — in terms of child welfare preferring instead an emphasis on crime control.

Poverty is the single biggest risk factor for youth and poverty disproportionately affects minority children.[3] The population of minority youth in the custody of DYS reflects this imbalance.[4]

In 1988, Congress amended the Juvenile Justice and Delinquency Prevention (JJDP) Act to require states receiving federal funds to ensure equitable treatment on the

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[1] Residential Treatment programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth (October 10, 2007) available at GAO-08-146T.
[2] Leslie Kaufman, Foster Children at Risk, and an Opportunity Lost, (NY Times, Nov. 5, 2007), available at www.nytimes.com
[3] See Barry C. Feld, Bad Kids: Race and the Transformation of the Juvenile Court, pp. 331-345 (1999). Professor Feld calls for the abolition of the juvenile court as a device to uncouple social welfare and social control policies. He notes the significance of "gun crimes" by juveniles and the impact this has had on disposition practices. In Ohio, "gun spec" offenses have led to increased minimum sentences and influenced the control tactics of the Release Authority.
[4] In fiscal year 2006, 59% of the youth admitted to the DYS were Black, Bi-racial, or Hispanic. Whites constituted 40.7% of admissions. Males constituted 92.2% of the admissions.
At the same time 85% of the Ohio population was white, and the above minority groups totaled only 15.5%. Adult and juvenile breakdowns for the overall population was not located.

basis, inter alia, of race and to assess the sources of minority overrepresentation in juvenile detention facilities and institutions (42 U.S.C. Sec. 5633(a) (16) [Supp. 1993]. In response, a number of states examined and found racial disparities in their juvenile justice systems. A review of these evaluation studies reported that, after controlling for offense variables, minority youths were overrepresented in secure detention facilities in 41 of 42 states and in all 13 of 13 states that analyzed other phases of juvenile justice decision making and institutionalization.[5]

In the context of this lawsuit we cannot alter the socio-economic policies that even directly influence the pool of eligibles for DYS jurisdiction. We would be remiss, however, if we did not point to the larger context and clarify our belief that DYS is not some isolated state agency that somehow malfunctions.

We do not underestimate the daunting tasks faced by ODYS in managing what is often a difficult population. On the other hand, we did not look for extraordinary performances producing miraculous outcomes. Staff, however, cannot demean, insult, and otherwise provoke youth in their custody and then complain about a violent environment. Staff cannot impulsively react to a youth's self-destructive behavior with needless physical force at times creating life threatening situations for the youth. The three use of force examples contained on the attached DVD will illustrate needless, excessive, and dangerous force more likely the product of a lack of training and effective oversight than venality.

Staff may not be required to create dreams but they need not shatter them either. Adolescents who speak of going home must not be told, "you ain't got no home" or "you're a sex offender, who would want you released!?"

As novice JCOs launch their employment they are warned about the dangers they will face; of the need to be vigilant, wary, and on guard. A youth's sidelong glance or seemingly mocking tone is elevated to a threat to survival. A youth's refusal to follow an order becomes a threat to one's manhood and the forewarned dangerous environment suddenly is real and the need to aggressively respond is at hand.

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[5] See, for example, Carl Pope, Racial disparities in Juvenile Justice System, ch. 5 Overcrowded Times, 1(1994).

DYS facilities, however, are not the street and not the officer's home; these are involuntary, custodial situations where the law governs use of force and not the street or autonomy of the home rule. DYS facilities cannot be proving grounds for staff power. That power exists, of course, but must first be used to de-escalate, to teach alternatives to violence, and to use only that force that is minimally necessary to preserve order and to protect life and limb.

As this lawsuit moves forward, a dramatic reduction in staff violence should be the first order of business. It is difficult to imagine constructive mental health care, rehabilitative programming, and effective education occurring where youth fear staff and other youth, and staff fear youth.

Constitutional Standard on Safe Environment

This is a damaged population, some far more than others and, at a minimum, DYS should echo the physician's mantra: "First, do no harm." The constitutional standard in some of our areas of concern may be open to reasonable debate; e.g., the precise contours of the right to, and constitutional basis for, mental health treatment. But the right to a reasonably safe environment echoes repeatedly through the reported cases and the combination of excessive force, restraint and isolation in ODYS is closely tied to the right to be safe, the right not to be in constant fear and to not deteriorate. See *Doe v. Strauss*, No. 84C2315, 1986 WL 4108, at *4 (N.D. Ill. Mar. 28, 1986) (unreported) "[Concluding] that what we have here is a long elevated Fifth, Eighth and Fourteenth Amendment right decisionally recognized in this state and many others. It protects juveniles when they are placed by state action in special custody, management and control because of their homeless, their delinquent conduct, and their unmonitored living. It is a right to care, management and therapy reasonably designed and calculated to effect rehabilitation, moral restoration and proper development."

In *K.H. v. Moran*, 914 F.2d 846, 851 (7th Cir. 1990), the court held that *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982), made it clear that the Constitution requires responsible state officials to take the necessary steps to prevent, inter alia, youth in state institutions from deteriorating physically or psychologically. See also *Mary and Crystal v Ramsden*, 635 F.2d 590 (7th Cir. 1980), finding that youth have a constitutional right to be protected from harm inflicted by others. Coincidentally, *Mary and Crystal*

also determined that it could be a constitutional violation for a contract psychologist to refuse to visit Mary while she was in prolonged isolation. To also suspend her from their regular program of treatment while so confined added another dimension to the cruel and unusual punishment she suffered. 635 F.3d at 598

Incidence of Mental Disorder

In considering the prevalence of mental disorder among the population of incarcerated youth, there is virtual unanimity that it far exceeds the estimate of between 9% and 13% in the general population. Joseph Cocozza & Kathleen Skowyna, Youth with Mental Health Disorders: Issues and Emerging Responses, 7 Juv. Justice 3, 4 (2001). For juveniles in confinement, the low estimate is 20%. Gail Wasserman, et al found that 67.2% of youth in secure placements in Illinois and New Jersey met the criteria for the existence of a psychiatric disorder in the preceding month: Gail Wasserman, et al, Assessing the Mental Health Status of Youth in Juvenile Justice Settings, Off. Juv. Just. & Delinq. Prev. 3 (June 2004).

The highly regarded Linda A. Teplin, studying youth in detention, found 66.3% of the males and 73.8% of the females met criteria for a mental disorder or substance abuse. Linda A. Teplin, Psychiatric Disorders in Youth in Juvenile Detention, 59 Archives of Gen. Psychiatry 1133, 1136 (2002).

There are other studies where the estimates run as high as 76%. In our own work in Ohio we found that for the 90 girls confined at Scioto as of June 2007, 80 were on the mental health caseload (89%) and 66 were taking psychotropic medication (73.33%). The males held in reception had much lower numbers, reflecting what I believe is a desire to defer diagnosis and treatment to the ultimate home facility. Girls do, however, tend to present with a much higher percentage of mental illness in juvenile and adult facilities.

Curiously, in 2007 conduct disorders, drug dependence, PTSD, and mood disorders were the most common Scioto diagnostic categories while in 2004, almost all the girls on the caseload were determined to be bi-polar. See, Fred Cohen, Interim Report: Scioto Juvenile Correctional Facility: Girls Units, August 16, 2004 (hereafter Interim Report). This reflects an issue that is endemic nationally to this area: lack of clarity and agreement on what constitutes a mental illness along with diagnostic discordance.

Competing Models

These two factors lead to another salient observation the response to which will have significant implications for this Report and any remedial agreements that may follow. If the right to mental health treatment ultimately agreed upon here is limited to the medical (or disease) model and kept within the limited boundaries of the Eighth Amendment right for adults, the first limiting factor will be serious mental illness and the other constitutional limiting factor would be the deliberate indifference, culpability standard. See Fred Cohen, The Mentally Disordered Inmate and the Law, ch. 2 (CRI, Inc., 1998 & 2003 Supp., Second Edition in 2 volumes, now "in press").

Some argue that this limited legal and policy model is inappropriate; that an expansive right to treatment for juveniles flows from the Due Process Clause and as an incident to being civilly adjudicated as delinquent with the right to rehabilitation, then, linked to the civil status of an adjudicated delinquent. See Fred Cohen, Ibid Section 20.3 [1] (2003 Supp.)[6]

Rehabilitation, as used above, becomes the larger category encompassing the medical model of treatment while also including a right to individualized care for the entire set of behavioral problems linked to the youth's delinquent behavior. Neither serious mental illness nor deliberate indifference would be applicable. Each youth would be entitled to an individual treatment or rehabilitation plan not dependent on shifting diagnostic categories.

Education: Holistic Approach

Education usually is dealt with independent of a treatment or rehabilitative concern. While there certainly are different legal mandates and objectives — e.g., achieving literacy — not usually packaged with treatment or rehabilitation, education issues should be seen as part of the effort of DYS to enhance the opportunities of youth in its custody to succeed, to avoid recidivating. As Professor Douglas E. Abrams writes, in describing the much discussed "Missouri Plan:"

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[6] In a CRIPA letter to Governor Musgrove of Mississippi regarding the horrendous conditions in that states' juvenile facilities, the DOJ stated that the Constitution requires that youth confined at Oakley and Columbia receive adequate rehabilitative treatment citing: *Morgan v. Sproat*, 432 F.Supp. 130, 1135-36 (S.D. Miss. 1977); *Pena v. New York State Division for Youth*, 419 F.Supp. 203, 207 (S.D.N.Y. 1976).

> [Because studies] have shown that confined youths who participate in educational and vocational training programs have lower risks of recidivism, educational programming belongs at the forefront of delinquency treatment and rehabilitation. Sound programming requires qualified instructors, adequate books and other supplies, a student-faculty ratio that permits individual attention, and clean classroom space conducive to the educational enterprise. The task may be daunting because so many delinquents enter state custody far behind in their studies and prone to "act out." As in Missouri, educational programming should exceed the bare constitutional and statutory minima by implementing individual assessments completed when the youth is admitted to the facility. (Douglas E. Abrams, Reforming Juvenile Delinquency Treatment to Enhance Rehabilitation, Personal Accountability, and Public Safety, 84 Oregon L. Rev. 1001, 1081-82 (2005)).

In the Report (p. 35) prepared by Ava Crow, assisted by Anne Flynn, she notes that 62% of all the DYS teachers express dissatisfaction with school safety. Her overall assessment is equally grim. Federal requirements for special education students are basically and systemically violated, security is found to trump education in most matters, organization and administration does not now further DYS's own goals, staff and space are festering problems, youth placed in extended isolation are de facto denied education, full school days generally are not provided, and virtually nothing is done to help youth who are released successfully re-enter society.

Education obviously must be at the same table with mental health and rehabilitation. Joint planning, implementation, and oversight are required and this, in turn, requires more staff, more space, and more time to collaborate.

Our findings support the general observation that one is unlikely to find a facility with a commendable mental health program but a singularly poor education and vocational program. Indeed, where both components are substandard, there is likely to be a corresponding over reliance on the use of force. Where both components are viable then use of force correspondingly is diminished. As our educational expert, Ava Crow, points out, those teachers rated most favorably as to their instructional process invariably

filed the fewest disciplinary infractions reports. When this Report moves into more detailed discussion of these areas, it will become even clearer that these areas of concern are interdependent.

The urgency of the excessive use of force problems dictates that it should be among the first areas addressed for change but it does not also follow that excessive use of force — like educational defaults — is somehow divorced from treatment, rehabilitation, and education.

If I may then take this somewhat holistic approach one step further, I would add, what the U.S. Department of Justice in its CRIPA letters and reports, describes as anti-therapeutic conditions. See e.g., DOJ, Letter to Mississippi's then Governor Musgrove (June 19, 2003)(available at http://www.usdoj.gov/crt/split/findsettle.htm#CRIPAletters). The CRIPA letter notes that conditions at Columbia, one of Mississippi's flawed juvenile facilities, cause depression and mental deterioration. There is a lack of activity, social interactions, counseling, undue restraint, and fear.

Similarly, and with broad variations in Ohio's DYS facilities, there is a harshness in the social climate that is created by verbally abusive and militaristic JCOs, the imposition of group punishments (even though forbidden by rule), excessive amounts of penal isolation — and more. In a recent, albeit undated, letter (p. 2) signed "The Staff at Marion JCF," the youth at Marion are described as "lost to society and will not, and cannot be reformed no matter what new program is attempted." Later, DYS youth are described as a generation of violent predators treading water until release and the opportunity to reoffend. This is not a promising basis for altering the current climate within DYS.

The individual experts' reports are replete with calls to expand the JCO role from purely custodial to the inclusion of caseworker-like functions. This, in turn, would enhance the professionalism of the position as well as the basis for compensation. This call for "role enhancement" may be chimerical if the Marion staff letter expresses widely held staff beliefs. Those attitudes, if unrestrained, can lead only to reform along a heightened security-punishment model.

Team member Ned Loughran, in his "Summary Report" of November 12, 2007, reached similar conclusions and also contrasted Ohio with jurisdictions attempting to pursue a different path:

> The Juvenile Correctional Officers (JCO), the direct care staff in every DYS institution I visited, constantly interact with the youths throughout the day but so little of their interaction fosters rehabilitation. The correctional officer's relationship with the youths is basically a custodial one. Youths appear to be uncomfortable with staff and staff are uncomfortable with youths. As long as uniformed correctional officers perceive their role in the institutions to be correctional rather than rehabilitative, the Ohio institutions will never become treatment programs. Other states, such as California, Illinois and New Jersey that use uniformed correctional officers who are trained primarily in carrying out custodial duties, experience similar problems — high rates of use of restraints and isolation and high rates of injuries to youths and staff - as Ohio DYS. Staff and youth's fear for their safety runs high in these jurisdictions as well.
>
> Many other states interpret the role of direct care staff philosophically different from Ohio. These staff are called rehabilitation counselors in Washington State, youth counselors in Pennsylvania, youth care workers in Massachusetts, and youth correctional counselors in Oregon to name a few jurisdictions. The various titles of direct care staff imply that their role is rehabilitative not custodial. Staff do not wear correctional officer uniforms but rather their own clothing. Pennsylvania outfits its youth counselors with a golf shirt with a logo that identifies them as youth development center staff.

Beginning in May 2007, ODYS began to replace the current prison-like JCO uniforms with a civilian-type outfit consisting of a blue shirt and khaki pants. Director Stickrath (by Memo to Staff, May 17, 2007) explained that this is part of a more comprehensive effort to create a youth-oriented environment.

In my interviews with JCOs held in every facility that the core team visited, there were three consistent views expressed: (1) Mandation (i.e., required overtime) must be totally overhauled. (2) JCOs require training in use of force and the signs and symptoms of mental illness, effects of medication, and non-compliance. (3) Staff numbers must be increased.

I heard concerns about personal safety, gang problems, and difficulties in managing some of the youth, but never to the extent of the defeatist, alarmist views expressed in the Marion staff letter referred to earlier.

Thus, we can begin to embrace the interrelatedness of the seemingly disparate allegations made in the Complaint and substantiated by our investigation. An environment of fear; an environment where youths undergoing sex offender treatment are told by some staff, "Why do you worry about going home? Nobody there wants you anyway;" an environment where youth are physically subdued with life and health threatening techniques is not an environment conducive to effective care and treatment.

It will be for the parties to ultimately reach agreement on the model for "treatment v. rehabilitation" and the interrelationship of that model with education and use of force. The staffing, training, programming and disciplinary implications of the choice of models are profound. To the extent that the Marion staff letter reflects systemwide beliefs of JCOs, there will be no "fix" without resolving the "mandation" issues; the underlying attitude of "nothing works" and the belief that it is staff who are more at risk than the youth.

Medical Issues

Juveniles have health problems that are different than adults simply because they are still developing; brains are incomplete and bodies often not yet fully formed. Given the demographics of an incarcerated juvenile population, the usual developmental issues are exaggerated and the medical and dental needs of the population are much greater than what might be expected.

The American Public Health Association encapsulates these needs in their recently issued Standards.

> ***Public Health Rationale***: Children and adolescents are still developing physically and mentally. They may have health problems that are

different from those of adults and that require the care of physicians and other health professionals with training and experience in adolescent care. In addition, incarceration itself may have a more serious emotional impact on youth than adults.

Youth in the justice system have substantial health needs. Dental, mental health, and substance abuse problems, including the abuse of tobacco, are widespread. Many of the most common medical problems (i.e., traumatic injuries, sexually transmitted diseases, and pregnancy) are directly related to impulsive, high-risk behaviors associated with immaturity.

Dental caries (soft, decayed area in a tooth) and fractured front teeth are the most common physical health problems among incarcerated youth. Moreover, adolescence is the age of greatest incidence of caries in the permanent molar teeth. Filling existing caries and application of pit and fissure sealants to intact molars are highly effective interventions to stop further deterioration and preserve the permanent teeth into adult life.

Asthma is the most common chronic medial condition among young people, but there are a wide variety of other chronic diseases and disabling conditions originating in childhood. For example, many of the chronic illnesses commonly associated with middle age first appear in adolescence. Early diagnosis, patient education, and effective management of diabetes, hypertension, hyperlipidemia, and smoking beginning in adolescence will prevent or reduce serious end-organ damage later in life.

Children have limited experience with and knowledge of health care issues. Emotionally immature and impulsive youth react very poorly to demands or ultimatums from institutional authorities. Health care staff needs to take a developmental approach to youth by answering questions truthfully, patiently explaining the reasons for necessary procedures or medications, and offering alternatives. It is not uncommon for a youth to adamantly refuse care at one moment and then request services a short while later. (American Public Health Association, Standards for Health Services in Correctional Institutions, Standard VII.B (2003).

As will be discussed, *infra*, our findings indicate there are substantial problems in the provision of medical care in the DYS system. In particular, a chronic care system does not exist and significant problems exist as to the prescription, distribution, and storage of medication.

We found no evidence of a sustained effort to provide these youth with a health or dental education program. We did not detect a strong leadership role on those issues, or the requisite oversight, emanating from Central Office.

Ohio Law: Confused and Regressive

The statutory law of Ohio certainly does not help to resolve any of the dilemmas associated with following a coherent, consistent rehabilitation or treatment goal. Ohio Revised Code Annotated (ORCA) § 2152-01(A) provides, in part:

> (A) The overriding purposes for dispositions under this chapter are to provide for the care, protection, and mental and physical development of children subject to this chapter, protect the public interest and safety, hold the offender accountable for the offender's actions, restore the victim, and rehabilitate the offender. These purposes shall be achieved by a system of graduated sanctions and services.

Here, at least some homage paid to the care, protection, and development of youth brought into the juvenile justice system. This mixed commitment to the youth, the victim, and public safety threads its way through the labyrinth of the Juvenile Code with concern for the youth gradually giving way to a victim-oriented, public safety, penal code model. At ORCA, Section 5139.50 et seq., dealing with the Release Authority, the criminal law model is rather clearly established. At Section 5139.51(A), for example, discussing the release or discharge of a youth, there is provision for notice of consideration of release or discharge to the committing court, prosecuting attorney, and the victim. I find no mention of such notice to the youth's parent, guardian, attorney, or other mature person upon whom the youth may rely. (The latter term is used in the ABA, Juvenile Justice Standards Project to describe a mature friend not legally connected to the youth.)

In re C.S., 874 N.E.2d 1177 (Ohio 2007) grappled with some complex issues related to a juvenile's constitutional right to counsel in a delinquency proceeding. While

affirming the importance of the right, the Supreme Court of Ohio held the right could be knowingly and voluntarily waived and while a parent cannot "represent" their child they may play an important role in the waiver decision.

The supreme court also made clear that while the juvenile code may have taken on some characteristics of a penal code, it remains "an administrative police regulation of a corrective character." The majority opinion reflects an oft-stated judicial view of juvenile justice: While rehabilitation may not be the only goal, it remains the primary (or important) goal.

The allocation of dispositional, release and community supervision discretion between the judiciary, the agency, and the Release Authority is almost impossible to decipher, let alone detect some coherence. One point does emerge, however, and that is the "rehabilitative ideal," slowly gives way, as noted, to a criminal law-like Code. I would assert that the punitive aspects of the DYS culture, the very architecture of such facilities as Marion and Ohio River Valley, the security staff wearing of prison guard uniforms, the emphasis on punishment, responsibility and security cannot be detached from a Juvenile Code that is more criminal than juvenile.

ORCA Section 2152.11 "Range of dispositions of child adjudicated delinquent" is illustrative both of the criminal law flavor of the Juvenile Code and its Byzentine complexion.[7] This Section is offense- and age-based in its allocation of judicial dispositional discretion. It must then be configured with other provisions of law relating to the power of the Release Authority and DYS with its time enhancing authority exercised incident to disciplinary proceedings.

If we add the bewildering issues related to detention credit to this maze, the spirit-sapping complexity of the Ohio system becomes even more apparent. Team member, Ned Loughran, in his Scioto Site Visit Report (Aug. 26, 2007) writes:

ISSUE OF DETENTION CREDIT

- For example: A youth is committed to DYS by the court for 9 months. The youth earns 60 days of detention credit (DC), which brings his commitment down to 7 months. The DYS Release

[7] The entire Section is reproduced as Appendix B.

Authority (RA) must conduct a release review for parole at the minimum sentence – in this case 41/2 months. In this scenario, a youth could be up for release review while still in the reception center.

- Extreme example (actual case): Youth entered reception center on 6/27/07 with 148 days of DC on a six month commitment, having already passed the mid-point in his sentence. His minimum sentence is August 5. He needs a release authority review before he can be placed on parole. The RA can give him additional days by utilizing the "matrix" looking at the presenting offense, the victim, age of victim, whether or not there was injury to the victim and whether or not a weapon was used to commit the crime. The RA can defer the parole decision based on treatment needs and a youth's behavior.
- Example of a county giving detention credit: A youth in a county detention center is committed and placed on probation, i.e., supervised in the community by the court. The youth's probation is violated and he ends up back in the detention center. He is ultimately committed to DYS. The DC clock begins at the first instance of placement in detention. And some counties give DC for placement time whether it's in the community or a detention center. The incentive for the county to give DC credit for any placement is because the county pays for the bed up to the six-month or one-year sentence the judge imposes on the youth. After that DYS pays for the bed.

GIVING DETENTION CREDIT HAS BECOME A COMPLEX PROBLEM

The court sends data to the reception center via the Journal Entry. DYS has created a form called the Detention Credit Addendum to close the gap

between information received on the journal entry and the actual credit that the court intended to record on the journal entry.

- The formula: detention credit begins to accrue from the day the youth is taken into custody and the day the youth is committed to DYS. Add to the time in detention prior to commitment the time between commitment to DYS and admission to the reception center.

PROBLEMS ENCOUNTERED BY THE COURT LIAISON AT SJCF:

- The journal entry from the court doesn't always have DC days
- Often times the reception center receives conflicting information from the courts between what is in the journal entry and what the Detention Addendum states.
- The way the county (Probation Officer and others) records DC information sometimes is not consistent with the information on the journal entry and Detention Credit Addendum
- Youths can appeal their DC by filling out a request to speak with legal counsel
- The Detention Credit Addendum does not have the date the youth entered detention and the date he left for the reception center.
- The Catch 22: The Detention Credit Addendum was developed to close the gap and get additional information for the purpose of awarding the correct DC. Now the counties are not recording the information in the journal entry and waiting to include it on the Detention Credit Addendum. Not getting the information needed to assess DC wastes time and impacts the time that DYS has to treat youths. (Loughran, Scioto Report at pp. 9-10)

The youth in this system are utterly bewildered by this dispositional scheme. They repeatedly expressed to us their confusion; their feeling that the release and retain system is arbitrary and not particularly concerned with helping them. Not knowing if and when you are "going home" and not grasping how and why that decision is made and

then remade, in our view, creates yet another, and significant, barrier to the rehabilitation of these youth.

We understand that not all these structural-legislative issues are directly a part of the litigation at hand, yet we would be remiss if we did not call attention to these matters since they create a framework within which this litigation is played out.

Guarino-Ghezzi and Loughran, describing the Ohio Juvenile System in 1994, found 1800 youth in institutional settings (the approximate same number as of September 2007). Ohio is described as moving toward improvement in institutional programming and community alternatives. The authors wrote hopefully about unit management; specialized treatment; two new facilities designed to accomplish downsizing, more programming, and better medical and mental health treatment. Susan Guarino-Ghezzi & Edward J. Loughran, Balancing Juvenile Justice 43-44 (1996).

Ohio River Valley (ORV) and Marion Juvenile Correctional Facility (Marion) were opened in 1996 and 1999 respectively. Whatever the ceremonial rhetoric, one glance at their architectural plans would disclose that each facility is designed as a very secure prison. Sad to say, our site visits disclosed that these new facilities are among the leaders in gratuitous staff-on-youth violence and are almost devoid of meaningful treatment.

These facilities are the architectural embodiment of what S.H. team member, Dave Roush, terms the adultification of Ohio's juvenile justice system. Scholars, like Professor Barry Feld, argue that "juvenile courts punish delinquents in the name of treatment but deny to them the protections available to criminals." Barry C. Feld, Bad Kids: Race and the Transformation of the Juvenile Court 288 (1999).[8] Feld despairs of legislators who are unwilling to provide for the welfare of all children providing for children who are delinquents.

This writer spoke at length with a 15-year resident who had been confined in ORV's Special Management Unit for about four months. This meant confinement in a small, barely furnished segregation cell for 23 hours a day, 7 days a week. A level system does allow youth to regain some freedom and amenities in two-week, discipline-

[8] See e.g., Aaron Kupchi, The Decision to Incarcerate in Juvenile and Criminal Courts, 31 Crim. Justice Rev. 309 (2006), finding no differences among factors predicting sentencing across these two supposedly distinct legal forums.

free increments. The level system itself lacks any meaningful, procedural fairness, treatment team input, or oversight.

ODYS's current practice of isolating youth in these special units by whatever name the practice is given, is unconstitutional on its face. Extended room isolation or in cells resembling those in use at Ohio's Supermax (OSP) is a practice that should immediately cease.

Adequate treatment and educational opportunities in the isolation unit simply were not present. What was called a treatment team met weekly without the youth or a psychiatrist and functioned essentially as a unilateral classification-program committee.

Marion's Intensive Treatment Unit was similarly secure and similarly without adequate treatment. We observed a tape of a slight, 15-year-old youth who had "cut" being subjected to a needless, life-threatening effort by five staff members to apply leather restraints. Only when the youth instructed the staff, including a Unit Manager, on how to apply this particular restraint did the horrifying, 35-minute incident conclude.

This same mentally ill youth later, and coincidentally, was observed during a disciplinary hearing charged with creating an "institutional hazard;" that is, cutting on his arm. The youth had no one to assist him; he was not informed of the potential consequence of a plea, which he quickly entered; and he was not competent to challenge self-injury by a mentally ill youth as inapposite for a possible, sentence-lengthening disposition.

The youth slowly withdrew as the hearing droned on; gradually settling into putting his head down into the arms he had enfolded at his desk. This, in my view, was not an act of official venality. It was more likely a rigid adherence to a one-size fits all disciplinary proceeding; it was the conversion of a therapeutic opportunity into a psychologically hazardous event. It lacked elemental fairness and even a semblance of rationality. It became all too emblematic of this facility.

The likelihood of settlement negotiations in *S.H.* was the stimulus for my modest effort to gain some understanding of Ohio's Community Corrections Facilities (CCFs). To that end, I asked team member, David Roush to briefly visit the Northern Ohio Juvenile Community Corrections Facility in Sundusky and the facility in Canton.

His Report of October 19, 2007 is attached as Appendix C. He noted that both facilities operate very good treatment programs; that the small units are well staffed; youth were polite, well mannered, and felt "safe;" and that the education program at Northern Ohio could serve as a model.

There is more and it is all positive. Should settlement discussions include downsizing and a greater reliance on a community-based model, it would appear that Ohio's CCFs should be very seriously considered as models.

In the succeeding sections of this Report, we will use an area, or topical, approach as opposed to a facility-by-facility approach. We will provide sufficient examples to support a particular finding but readers should be aware that the individual Reports, attached as Appendix D, and the notes of the experts will contain even more examples of case studies and observations.

The direction of this Report has been discussed by most of the Team during a two-day meeting (Nov. 2-3, 2007) held in Tucson, Arizona. This de Facto is the Report of the Team, although the Principal Investigator, Fred Cohen did the bulk of the writing and it is submitted in his name. Readers will detect a certain unevenness in length in the various Sections that follow. The fact that one section has far more space devoted to it than another is not by itself indicative of relative importance. I did not impose any rigid limits on team members' reports and, frankly, some just wrote more than others and I wielded a lighter editor's touch than I might have.

As such, the writer accepts responsibility for any errors or editorial lapses that may be found. At the same time I wish to thank the members of the *S.H.* investigative team for the high level of professional work reflected in their deadlines I felt constrained to impose.

III. A SAFE ENVIRONMENT: FORCE, ISOLATION, AND RESTRAINT

Safe Environment

A safe environment is a necessary albeit not sufficient requirement for achieving any positive results with the youth entrusted to the custody of the Ohio DYS. Our initial site visits were to Scioto and they sparked some hope that DYS might have turned the corner in this area.

A new Superintendent, Chris Money, the eighth in seven years, is widely admired for her work with adult prisoners and then in the Central Office of DYS. Her Deputy for Direct Services, Nan Hoff, appears wholly committed, not merely to the safety of the Scioto girls but to helping them. The majority of the Scioto girls that I interviewed individually and in groups answered yes to the question: Do you feel safe here?

In August 1998, acting as consultants to the then Director of DYS, Dr. Jane Haddad and I wrote:

> [L]ine staff follow a "control model" rather than a "treatment model" and especially during hours when administrative and clinical staff are not present. Indeed, we may go further and suggest that staff reliance on force exceeds many adult prison systems. It seems so pervasive that the overall normative culture regimen becomes a rather hollow shell; a contradiction quickly absorbed by the youth. Fred Cohen & Jane Haddad, Ohio Department of Youth Services Consultative Report, (Aug. 3, 1998)[9]

Some six years later in the Interim Report, I wrote, "We found the unwarranted use of physical force and seclusion to be endemic to Scioto We [including Steve Martin] found countless examples of situations where no force at all should have been used and others where the force used was excessive."

Thus, while we found essentially no change in this vitally important area over a six-year period, ending in 2004, there is a glimmering of change accompanied by hope, for example, at Scioto in 2007. While this is hardly cause for celebration, Scioto has at least applied the brakes and begun to inch forward. For DYS as a whole however, the

[9] The Report was prepared in response to the initiation of a CRIPA investigation by the U.S. Dept. of Justice. The term "normative culture" refers to the DYS's then in vogue treatment philosophy. It was difficult to find any staff member who even knew what this treatment approach entailed.

unwarranted and excessive use of force along with questionable isolation/seclusion practices remains of serious concern.

Director Stickrath has repeatedly communicated a DYS policy of zero-tolerance of staff abuse toward the youth. New approaches to investigations of staff abuse are being adopted; training in verbal techniques to manage disputes will soon be complete for all staff; volunteers are beginning to saturate the various facilities bringing with them the potential for reducing staff violence; supervision on the units is being streamlined; and a new classification system may contribute to a reduction in violence.

This Report, of course, is constrained by what team members observed at a particular point in time. While I credit the good faith commitment of Director Stickrath to reverse the embedded "culture of violence," I believe he would agree that there remains "many miles to go."

The November, 2004 Report also noted that we could find no integrated, overall mental health plan; only a well rehearsed, verbal adherence to so-called "normative culture," the buzzword for a now abandoned treatment philosophy. While Scioto clearly has made some progress in the area of a safe environment, neither DYS nor Scioto has yet to develop and implement a cohesive, integrated, broadly understood overall approach to treatment and rehabilitation. Scioto however, has at least begun to lay the groundwork for a safe environment and, thereafter, possibly a more viable treatment-rehabilitation system.

A juvenile custodial system might well be safe yet have an ineffective treatment-rehabilitation program. However, it is inconceivable to even imagine an effective program of treatment-rehabilitation where the youth are afraid; afraid of staff or afraid of each other. At ORV we determined also that staff fear the youth.

Fear at ORV is an all-consuming fire, fueled by the three-dimensional aspects of fear: youth fear other youth, youth fear staff, and staff fear youth. The team expert in use of force, Steve Martin, writes in his individual report:

> There are serious deficiencies in the administration of staff use of force at ORVJCF. The deficiencies are so pervasive that youth protection from harm by staff use of force is seriously compromised. Having reviewed almost over 350 incident reports, numerous videos and investigations, in

addition to two days of on-site work, I believe there is evidence to support a finding of a pattern and practice of unnecessary and excessive staff use of force that can be placed in one of three categories of risks of harm to youths.

a.) unsafe practices that are a product of untrained or ill-trained personnel simply doing their best to manage troublesome youths, e.g., inappropriate application of tactical holds causing injury.

b.) reckless practices in disregard of obvious risks of harm to youths, e.g., chokeholds

c.) malicious infliction of force on youths, e.g., use of hard impact fist strikes. (Martin, ORV Report, p. 3)

This expert's conclusions will come as no surprise to the DYS administration or the staff at ORV. During the opening session of our September 13, 2007 site visit, Superintendent Fred Nelson candidly told the Team of his concern with the level of violence and property destruction.

He noted that general population youth have serious concerns for their personal safety. Staff are on "stress leave." Mr. Nelson indicated that he has even contacted the State Patrol for help.

In my at times heated group interview with ORV's JCO union representatives, they all passionately agreed that they do not receive sufficient training on use of force. With some minor variations, that complaint was raised in every group discussion I had with union representatives from each facility we visited.

The variations included a complaint about a lack of clarity in the "rules of engagement" themselves; that is, exactly when is it proper to use force and exactly what physical restraint techniques are permitted under what circumstances. I will return to this theme, *infra*.

Most union representatives adhere to the "just a few bad apples" explanation when confronted with the observation that there is a pervasive culture of violence in DYS. During my ORV, JCO session, I told the group that I believed they would not be completely honest with me concerning use of force issues.

One officer plainly was offended by that remark and suggested I was being somewhat arrogant. (That may not be the exact term used). I then slid my legal pad in the officer's direction and asked that the officer write the names of the "few bad apples" at ORV.

Silence.

My invitation obviously went unaccepted. The "few bad apples" then, are protected by a code of silence.

We talked more easily of group activities having been dropped as too dangerous and the dangers of housing 13-year-olds with some 20-year-olds as "crazy."

Expert Steve Martin went on to point out that of the six facilities investigated ORV has the most dysfunctional system in place for controlling staff misuse of force.

Quoting again from Steve Martin's ORV Report:

> The use of force incident packets often don't reflect whether incidents have been reviewed, other packets have review forms that are totally blank, and some packets contain two separate review forms, neither of which was complete. The administrative review doesn't include a viewing of available video unless the incident is referred for investigation. Neither the DSDS or the OA[10] could articulate a reliable set of criteria used to conduct their reviews, nor was it clear when they refer an investigation to the CIO.
>
> In addition to a flawed administrative review system, the facility has failed to utilize or employ a tracking system to monitor the status of the use of force incidents they refer to local investigators. Recently, an administrator temporarily assigned from another facility to assist in identifying management deficiencies at the facility, found 88 incidents that had been assigned to local investigators and had just "piled up" and had not been completed. These investigations were forwarded to the CIO[11] where they were reviewed to determine which incidents should be investigated locally or by the CIO. The majority of those incidents have been returned for

[10] DSDS is Deputy Superintendent of Direct Services; OA is Operations Administrator.
[11] CIO is Chief Inspectors Office, a Central Office staff position.

local investigation. It is important to note that the number of use of force investigations at ORVJCF is disproportionately high compared (both local and CIO investigations) to the other DYS facilities. The investigations that are completed at the local level are of a very questionable quality, often resulting in facially unreliable findings. Finally, employee sanctions are often inconsistent with the seriousness of the use of force violation(s). (Martin, ORV Report at pp. 3-4)

With ORV, along with Marion and Indian River, in the top tier on the use of force, restraints, and isolation, we find that of all the facilities that would benefit from a sound system to control misuse of force, ORV may well be the least equipped to do so.

We are well aware of the administrative oversight implications inherent in this analysis. We are also aware of a variety of efforts by Director Stickrath to resolve the ORV dilemma. Our investigative task, however, is to describe and analyze what we find at a given moment in time and for ORV we find a culture hostile to helping these youth and unable or unwilling to properly investigate use of force.

Readers are referred to the Steve Martin, ORV Report of September 28, 2007, pp. 5-7 for his incident/investigation summaries. You will discover delayed investigations, compromised investigations, and in Local Investigation 2007-136 March 23, 2007, where a JCO was found to have hit a youth four to six times with a closed fist and the facility Superintendent recommended removal from service. The State Collective Bargaining Board held that the findings did not support removal.[12]

[12] In *Ronald C. Wilson v. ODYS*, Case No. 06-REM-04-0214 (Dec. 5, 2007), the Administrative Law Judge upheld the decision of ODYS to remove appellant from his position as Operations Manager at Scioto. Wilson was found to have escalated a volatile situation leading to the needless restraint of a youth. In another incident, Wilson used a finger-flex hold on a youth, which resulted in this youth's wrist being broken.

Restraints & Isolation[13]

The use of mechanical restraints and room isolation may fairly be dealt with in the same general area as a "Safe Environment." Physical force and mechanical restraints never may be used for punishment while some forms of limited isolation are legally acceptable as punishment in both the adult and juvenile systems.[14]

In general we found that isolation is systematically used too frequently and for much too long. Mechanical restraints, however, are rarely used except for two-point restraints used to transport youth. At Scioto, for example, we could find no record or evidence of the use of four-point restraints except a single instance where a girl asked to be so restrained.

Based on their categorical vulnerability, juveniles have prevailed in court on isolation and restraint claims where adults would not have. See *Lollis v. N.Y. State Dept. of Social Services*, 322 F.Supp.473, 482, 484 (S.D.N.Y. 1970)(voiding the two-week confinement of a 14-year old girl in a bare room with no recreation or reading material and finding the use of shackles on a male juvenile in isolation for periods of time ranging from 40 minutes to two hours impermissible). See also *Nelson v. Heyne*, 355 F.Supp. 451 (D. Ind. 1972)(discussing the right to treatment in conjunction with use of solitary confinement).

While I have elected to treat isolation and restraints as a question of safety, other categorize this area as a constitutional deprivation of liberty. Relying on an assessment

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[13] Restraints refer to a device designed to interfere with the free movement of one's arms and legs or which totally immobilizes the person (for example, the four-point restraint) and which device must be modified or discontinued by a third person.
Analytically, one may approach the use of mechanical restraints in three different circumstances: (1) point-to-point movement within a facility; (2) movement outside the perimeter of a facility, typically to another destination (such as to the hospital, court, prison); and (3) immobilization within the facility.
Various forms of mechanical restraints — cuffs and leg irons are the most common — are used when transporting certain inmates, during visits, or when simply moving about the facility.
The primary concern in this Report is with category (3), immobilization within the facility. See *Cameron v. Tomes*, 990 F.2d 14 (1st Cir. 1993)(interestingly discussing the transport issue).
Isolation or seclusion in the DYS system does not he a precise meaning. In essence, seclusion involves placing a youth alone in his or her own room or a so-called safe room for varying amounts of time. Youths also may be placed in a highly restricted cell for as much as 23 hours a day, 7 days a week as part of a Special Management Plan that appears to have no durational limit. This more nearly resembles the penal isolation found in adult supermax prisons or segregations units.

[14] See Fred Cohen, Isolation in Penal Setting: The Isolation-Restraint Paradigm, 22 Wash. U.J. of Law & Policy 295, 306 et seq. (2006)(Based on testimony before the Commission on Safety & Abuse in Prisons).

conducted by the San Francisco-based, Youth Law Center, a recent OJJDP-ABA Report concluded:

> **Restraints/Isolation.** Mechanical restraints and excessive isolation in juvenile detention facilities stripped away the juveniles' liberty in violation of constitutional due process requirements. The report commented that "our experience in past litigation is that courts are not persuaded by the excuse [that restraints and isolation become necessary because] the mental health agency has not provided adequate services for, or removed from the facility, emotionally disturbed youth." Furthermore, "an extensive body of case law sets limits on the deprivations to which inmates may be subjected in isolation" and provides due process rights for disciplinary hearings on institutional rule infractions. (Patricia Puritz & Mary Ann Scali, Beyond the Walls: Improving Conditions of Confinement For Youth in Custody 43 (ABA, 1998))

Whether approached as an issue of safety or in the more legalistic terms of deprivation of liberty the use of mechanical restraints and physical isolation raise serious questions. In addition to the universally-endorsed "never for punishment" injunction several other principles should be articulated:

1. The factor of youth itself is a significant limitation on the use of isolation and mechanical restraints. Thus, whatever the legal limitations in this area for adults, juveniles have a right to even greater protection.
2. The frequency, duration, and rationale for the use of isolation and mechanical restraints are reliable indicators of the extent to which a system, or individual facility is more or less punitive more or less devoted to treatment or rehabilitation. Expert Steve Martin, reporting on Scioto writes:

   The use of isolation and seclusion is governed by at least three separate SOP's: Seclusion, 301.05.03; Special Management Plans, 305.01.01; Youth Disciplinary Sanctions, 303.01.02. The Seclusion SOP identifies four separate categories of seclusion: Extended Seclusion (more than 24hrs), Seclusion (less than 24hrs), Room Seclusion (less than 1hr), and Safe-Room (no time limitations). The SOP for Youth Disciplinary

Sanctions provides for a period of seclusion up to 5 days. The SMP SOP provides for seclusion without time limitations.

SJCF very frequently uses seclusion pursuant to all three SOP's. The "Seclusion Summary Report," ("SS Report") May 1 through June 30, 2007, reflects 267 seclusion intervention events totaling 3,485 hours. The basic seclusion policy, 301.05.03, at Section IV.A.15., provides that seclusion is not to be used "beyond 24 hours from the time seclusion was implemented unless the youth behavior is a threat to the safety and security of the institution and/or others." However, pursuant to SMP's, the facility is imposing a pre-determined number of hours in seclusion for acting out behaviors, see Incidents, ID 5502070733 & 5502070703, in which one youth "was placed in seclusion for 12 hours per SMP and another in which cursing behavior "warrants an 8 hour seclusion period." In discussing this issue with the DSDS it became apparent that the term "seclusion" may be applied too broadly at the facility, or rather too imprecisely, and may inflate the total number of hours reported. If for instance, a youth is committed to a term of isolation pursuant to a disciplinary hearing, should this event be reported/recorded as "seclusion?" Further, if a youth is placed in "seclusion" for a predetermined number of hours pursuant to a SMP, how should it be reported/recorded? [Note: this is aside from the issue of whether such predetermined lengths of stay are appropriate.] It may be that SJCF officials rely too heavily on seclusion as a management practice; however, until administrators, et al., determine exactly what constitutes "seclusion," and the proper basis for a placement decision, a truly qualitative analysis is difficult to complete. On a final note regarding seclusion, a review of the SSR reflects a small number of the same youths produce a large number of seclusion interventions. This same pattern was also evident in my review of use of force incident reports. (Martin, Scioto Report at pp.12-13)(The incidents referenced in the text will be found in the full Report attached to the Final Report)

Perhaps the most pernicious form of isolation relates to the Special Management Plans (SMP).

With reference to Scioto mental health expert, Dr. Leta Smith examined the mental health implications of SMP's, noting:

> [A]ccording to the 2006 SOP 301.05.03 concerning Seclusion, youth placed in seclusion shall be checked visually by staff at least every 15 minutes and shall be visited at least once each day by personnel from administrative, clinical, social work, religious, *or* medical unit. There is no separate seclusion Mental Health policy, and youth are too frequently placed on the POD as part of special management plans and for suicide watch. The Adjustment Pod is teaching youth little to nothing, especially when time and again Special Management Plans do not provide meaningful opportunities to work toward defined goals related to behaviors and/or to increase recovery. Plans are generally punitive and very similar in structure for different circumstances and behaviors.
>
> A review of SMPs for youth recently on the POD provided additional clear confirmation that the plans are problematic. These youth are on the mental health caseload and taking psychiatric medications. For all these youth a visit by psychology was the very rare exception. Case #1 provided for a 2-1/2 month plan rather than a plan extending time as necessary, and with no provision for shortening the time. Although the plan called for daily contact from one member of the treatment team professional staff to minimize isolation and monitor mental health this was not the case. The SMP for youth #2 and youth #3 also included 'regular' meetings with clinical staff but these too were infrequent, and certainly far from daily. Youth #2 and youth #3's plan called for 8 additional hours of seclusion for 'refusing direction.' There are exceptions as youth #4's plan is time limited and provides graduated sanction, but again positive incentives are virtually non-existent.
>
> Staff need continued training and oversight on using these Special Management Plans for behavioral improvement rather than punishment.

> They should not routinely include the use of seclusion and need to be time limited, individualized, with graduated punishments, incentives, and carefully monitored and supported by clinical staff. (Dr. Leta Smith, Scioto & Marion Site Visits July 31-Aug. 3, 2007, p. 6-7)(Again, the youth plans that are referenced are discussed in some detail in the full Report, which is attached.)

At ORV, as noted in Section II, I interviewed a 15-year-old youth confined to the Intensive Program Unit (IPU). He had spent four months in this antiseptic, lock-down unit that resembled the units and cells at the Ohio State Penitentiary, Ohio's supermax. The only difference is the cells at OSP had more furniture (a desk) and every cell has a television.

Level 1 (Red) involves a minimum two-week, 23-hours a day, 7-dyas a week lockdown. Youth can, and often do, stay at this level well beyond the two weeks. Meals are taken in the cell and out-of-cell movement seems limited to showers.

At Level 2, youth are out for one hour of daily recreation, meals are available on the unit outside the cell.

Level 3 involves an hour at the gym, classroom attendance, and a bit more freedom.

There is only one social worker on the unit with 20 youth in confinement. There is in practical effect, no treatment whatever. What goes by the name treatment team (a JCO, unit manager, teacher, and social worker) is more like a unilaterally, functioning classification team.

The youth is not present on the Monday's when they meet nor is there any psychiatrist. The Team makes the all-important level decisions and does not review treatment plans or progress.

The youth I interviewed conceded that there are fights on the unit, especially at Level 2 and mainly around showers or phone calls. He was surprisingly calm about his situation; his desire to leave DYS and succeed. He was most disappointed at not getting help with his problems and not being pushed with his education. He wanted to be challenged intellectually and not just vegetate in a secure cell on a secure unit.

This youth believed he had an I.Q. of 160. Something I was unable to verify. He had some hope in his eyes; he was articulate and, no doubt, hard to manage. The youth had read all the Harry Potter books and wondered if I could get him some similar books to read. I could only wonder how long that hope would survive, when would he simply give up on a decent future and succumb.

The unit itself made an indelible impression with me as bringing to bear the worst that adult corrections has — the supermax/secure segregation unit — to juveniles who have been sent to DYS for treatment and rehabilitation.

This use of prolonged isolation under stark conditions, whether in the name of treatment, management, or punishment must be dealt with in the resolution of this litigation. The current practices simply cannot be sustained.

Incident Reports

With regard to Marion, expert Steve Martin reached the same conclusions as to use of force as he found at ORV, finding a similar pattern and practice of unnecessary and excessive staff use of force. Mr. Martin then examined use of force reporting and after reviewing hundreds of recent Marion incident reports he concludes that staff frequently submit reports that are incomplete and/or false.

Quoting Mr. Martin:

> Moreover, there are incidents of force that are not reported at all. Reports are often conclusory and lack sufficient detail to even determine the nature of force used. Moreover, staff often use terms such as "fight break-up" without fully describing what they actually did. The following representative incidents provide examples of a badly flawed reporting system at Marion Juvenile Correctional Facility.
>
> Incident ID–4102070485, June 25, 2007**:** This is an incident in which a JCO kicked a restrained youth in the head multiple times in plain view of six staff members (based on my review of the video that captured the entire incident). None of the JCO witnesses reported the kicks. A nurse in attendance reported that the JCO's "boot made contact with the left side of the helmet the youth was wearing to prevent him banging his head." The

single staff member who accurately reported the incident was the Operations Manager ("OM"). The investigation of this incident did not address any reporting issues. [Note: at the time of my site inspection, the investigation had been completed sustaining the allegations against the JCO who kicked the youth; however, she remained in a contact position supervising youths at the facility. The Deputy Superintendent confirmed that the facility is lacking a policy directive as to when staff are prohibited from working in a contact position during the pendency of an investigation of allegations of improper force.]

Incident ID–4102070455, June 16, 2007: This was an incident in which a youth sustained "a possible separated shoulder" when "fight break-up" tactics were used. Neither of the officer participant reports was sufficiently detailed to allow any assessment of the cause of the injury to the youth.

Incident ID–4102070449, June 14, 2007: This was an incident in which one officer reported that a Unit Administrator ("UA") used a "fight break-up" tactic on a youth. The UA reported that he used "Emergency Defense & Basic Block" on the youth. The UOF policy defines Emergency Defense as the "highest level of staff response that carries a substantial risk that it shall proximately result in the serious physical harm or the death of any person." There is evidence to suggest that the UA simply pushed the youth back into his cell; however, the incorrect use of terms in the absence of detailed reporting simply creates serious ambiguity as to what actually occurred.

Incident ID–4102070292, May 9, 2007: This was an incident in which a youth sustained a dislocated shoulder. The two participant/witness officers simply reported a "fight break-up" tactic that provided no plausible explanation for the dislocated shoulder. A youth witness reported a chokehold was used.

Incident ID–4102070487, June 25, 2007: This was an incident in which a youth reported that he was choked by an officer. A medical exam noted

that his “tonsils [were] enlarged.” The video established that the officer did indeed “wrap his left arm around the neck area” of the youth. The officer had failed to submit any report of this incident. (Martin, Marion Report at pp. 5-6)

Some of the more egregious use of force situations at Marion involved supervisors directly and improperly participating in the application of force. This practice is objectionable even where the force might be needed and properly applied. The two disturbing incidents that follow are somewhat more aggravated than others reviewed but are nonetheless instructive:

Incident ID–6020342, April 11, 2006: This was an incident in which officers intervened in a fight between two youths in a classroom. As the two youths were escorted through the hallway around other non-involved youths, one of the non-involved youths exchanged words with an OAM (one of the supervisors should have secured the hallway prior to the escort of the two youths from the area). As the youth was walking away with his back to the OAM, rather than continue to supervise the dispersal of other youths in this potentially volatile situation, the OAM suddenly attacked the youth with a chokehold and took him to the ground. Notwithstanding this gratuitous assault on the youth, compounded by his failure to report the incident and his false statements during the course of the investigation, the disciplinary sanction imposed was a 3-day suspension. [Note: one of the youths involved in the fight had earlier been taken down in the hallway with a chokehold in which a very large officer remained on top of the youth until the youth experienced a loss of consciousness. When the OAM arrived upon this scene, he immediately became directly involved in the restraint of the now motionless youth. The medical report indicated the youth had sustained multiple head injuries, was “sluggish to reaction” and was “profusely diaphoretic.”]

Incident ID–4102070363, May 26, 2007: This incident involved a youth with an extensive history of mental health problems who was observed threatening to engage in self-harm with a piece of plastic from a scrub

brush. After complying with orders to relinquish the piece of plastic, the youth was cuffed and an UA arrived on the scene to direct his movement to a safe room. The UA was accompanied by multiple staff, including no less than four officers. A decision was made to strip the youth[15] and place him in a suicide smock. Rather than supervise staff, the UA took the diminutive youth to the floor and straddled him with her considerable body weight. Thus began an excruciatingly long application of force in which the UA continued her direct involvement and failed to prevent other staff from repeatedly engaging in tactics that created extreme risks of harm to the youth. In reviewing the video of this incident, I observed multiple instances in which the youth was placed in positions commonly associated with in-custody deaths from positional asphyxia. In a remarkable display of reckless force tactics, one officer attempted to place the suicide smock on the youth's head as a make shift spit-mask (see Incident ID-4102070448, in which a shirt was used on a cuffed youth as a make shift spit-mask). In another instance, an officer can be seen with his full body weight on the youth's back with his knee across the youth's neck. The decision was then made to place the youth in 2-point restraints. Notwithstanding that the youth was cooperating with staff and even trying to assist them in securing the restraints, they were unable to secure the restraints in a proper and timely fashion. [Note: In my considerable experience reviewing use of force videos, I have rarely viewed an incident that more graphically exemplifies the reckless risk of harm that may be visited on a subject by ill-trained personnel. It is not idle conjecture to suggest this youth could have been fatally injured. Finally, while I have not conducted a full analysis of this event, I believe it is questionable as to whether the initial use of force that precipitated the protracted application of force was even necessary.] (Martin, Marion Report at pp. 7-8)

[15] Several youths in the group this writer interviewed reported that JCO's "rip off our clothes and throw us in our rooms." How common this might be and under what circumstances is not known.

Having viewed the same video I will state in even stronger terms, there was no need for the application of any force. The frail youth was standing alone in a safe cell, subdued, and no immediate danger to himself or anyone else. Staff had only to remain at the open door, observe the youth, and he would eventually have disclosed the implement he used to scratch/cut his arms.

Beyond this critique on use of force is the total absence of a clinical presence or response to this incident involving a seriously mentally ill youth. DYS staff view the "cutting" as open to a disciplinary charge of "creating an institutional hazard." (The youth's blood, I am told, might create an infectious disease potential.)

Surely this is an event (cutting) in which to intervene and to provide needed medical care for these superficial wounds. Just as surely this is a mental health event calling for a clinical presence and involvement in de-escalation tactics and then supportive therapy. We, in turn, are constrained to report the event in its crudest, most primitive terms: unnecessary and life-threatening, use of force plus the involvement of a UA.

The administrative reporting and review process here also is flawed beginning with often deficient reports and an absence of identified criteria by which to conduct reviews. There is no routine examination of video evidence.

The use of seclusion and isolation at Marion illustrates some important system-wide issues. Marion makes frequent use of seclusion. However, the Seclusion Summary Reports do not include isolation imposed pursuant to the youth disciplinary system; youths placed on the IPU (this includes the "23/7" room or cell confinement for the first two weeks); and the "lockdown" of youth who are disruptive at school.

The Marion Seclusion Summary Report for May 1 – June 30, 2007 identifies 268 seclusion events, with 25% of these involving just three youth. All three also are over-represented in use of force incidents and have histories of mental health problems.[16]

Our findings on use of force at Indian River regrettably mirror those for ORV and Marion. To quote directly from expert Steve Martin:

> There are serious deficiencies in the administration of staff use of force at IRJCF. The deficiencies are so pervasive that youth protection from harm

[16] We uncovered no significant problems in the use of mechanical restraints at Marion.

> by staff use of force is seriously compromised. Having reviewed almost 500 incident reports, numerous videos and investigations, in addition to two days of on-site work, I believe there is evidence to support a finding of a pattern and practice of unnecessary and excessive staff use of force. . . The patterns and practices seen at IRJCF are not unlike those seen at virtually all the facilities subject to our inspection. While there are certainly differences and variances in the magnitude of particular deficiencies at IRJCF vis-a-vis other facilities, the cumulative deficiencies across all issues subject to my review result in the same findings of pervasive risks of harm to the youths confined at IRJCF.
> Use of force reports are often lacking in detail, contain conclusory statements, and in some cases, are not even filed by all participants or witnesses. Supervisors are too often applying force rather than managing/overseeing an incident. Administrative reviews are not systematically conducted to include video reviews nor is identifiable criteria consistently applied in making investigative referrals.
> Investigations are generally of a poor quality and are not conducted with the degree of impartiality necessary to yield reliable findings. Finally, employee disciplinary sanctions are often too lenient, reduced in their severity without a sound evidentiary basis, or not imposed at all. (Martin, Indian River Report at pp. 3-4)

Readers are advised to consult the representative five summaries of incidents and investigations contained in the aforementioned Martin Report. You will discover false and misleading statements by staff; dubious, if not simply unbelievable investigations and reports, avoidable physical injuries inflicted on youth; and staff actions and reactions that either initiated or accelerated a confrontational situation.

For the May-July period, there were 818 intervention events at Indian River totaling 26, 204 hours as compared to Mohican that totaled 2,874 hours for the same time period. Indian River had 143 youths who each spent 72 or more hours in seclusion totaling 17,271 hours as compared to Mohican who placed four youths in seclusion for more than 72 hours each totaling 383 hours. A large number of the seclusion hours for

this time period can be attributed to a program initiated by the superintendent in May 2007 intended to reduce/manage high levels of violence and disruption occurring at the facility.

Youths who were engaging in disruptive conduct were isolated on one particular unit and single celled for program participation similar to the questionable Intensive Programming Units at the Marion and Ohio River Valley facilities. While the program reduced the violence in the general population, it increased significantly on the unit to which the disruptive youths were housed. The superintendent abandoned the program in August due to her concerns over the number of youths being held in virtual "lock-up" on the unit.

Even discounting the seclusion hours attributed to Operation Fresh Start, Indian River seclusion hours remain high. Steve Martin's review of incident reports for the period showed that seclusion is often used for punishment without utilizing the formal youth disciplinary sanction process.

When a youth is given seclusion time pursuant to the disciplinary process, he may appeal the sanction which cannot be served until the appeal is resolved by central office. It can often be weeks until the appeal is processed; thus, the youth serves the time far removed from the violation itself. Facility officials understandably believe that the punitive value of seclusion is undermined for two reasons. First, such punishment is most effective if it is imposed close in time to the violation. Second, if the youth has made positive adjustment since the violation, to place him in punitive seclusion weeks after the event can undermine his now positive adjustment.

In Steve Martin's discussions with the OA on the Seclusion Summary Report it became apparent that it needs to be audited both by facility and central office officials. For instance, some facilities include disciplinary seclusion on the Seclusion Summary Report but Indian River doesn't. Indian River's report was replete with entries in which "Room Seclusion" exceeded the one-hour time limit imposed by the seclusion policy yet no official had questioned these apparent violations of policy. The Seclusion Summary Report provides extremely valuable information to both facility and central office officials in terms of oversight; however, it simply is not being utilized at either level to monitor this issue throughout the system.

Finally, it should be noted that the vast majority of youths placed in seclusion at Indian River are placed in their assigned room. When a youth is placed in seclusion in a double cell situation, during the waking hours the bedding for both youths is removed which penalizes the non-involved youth. Each housing hallway has a wet cell that is used when a youth is given seclusion pursuant to a disciplinary hearing.

With regard to the Circleville and Mohican facilities we found that while there were isolated instances of questionable use of force there is no pattern or practice of harm inflicted on youth confined there.

At Circleville, for July-August 2007, there were 30 interventions with any kind of physical force, the lowest total for all six facilities visited. By way of contrast, Marion's totals for a recent two-month period were 272.

Mohican was determined to be the facility where the review process most often resulted in predictable and systematic referrals for investigation. Mohican also strictly follows the review process required by the SOP on point whereas Marion and Indian River do not appear to use the appropriate form.

This, of course, suggests a flaw in the Central Office oversight/auditing of the administrative review process.

Interestingly, where the review of use of force is faithfully and systematically done, we also find no serious pattern or practice of either unnecessary or excessive use of force.

Circleville uses seclusion less frequently and for briefer periods than the other five facilities visited. Over 91% of the seclusion events are for less than eight hours in duration with 70% less than four hours.

Over a recent, three-month period, only five events resulted in seclusion for over 36 hours and the incident reports show that serious misbehavior precipitated the event.

Mohican, on the other hand, makes more frequent use of isolation, although 76% are for zero-four hours in duration. By way of contrast, Indian River averaged 32 hours, Scioto 13 hours, and Marion eight hours. Even so, the Superintendent at Mohican developed a survey instrument to determine whether youth seek seclusion to be alone and to determine if a designated area versus a locked room might be a more appropriate approach.

Four-point restraints at Mohican and Circleville appear to be rarely applied. Mohican rarely uses any kind of restraints and when applied, they are used in conjunction with a Special Management Plan.

As a general proposition, where isolation and seclusion raise significant questions and present challenges for reform, the DYS system does not appear to make excessive, inappropriate or harmful use of mechanical restraints.

It is important, however, that training continue in this area emphasizing when and how to use two- and four-point restrains and the special procedural and monitoring issues related to immobilizing youth with mental illness.

Select Use Of Force Incidents

Enclosed with this Report is a DVD that contains several select" use of force" incidents that were witnessed by team member Steve Martin. What follows is a narrative to accompany and enhance your understanding of the events portrayed on the DVD.

We request that the court keep the DVD under seal and that counsel not disclose the DVD in order to protect the privacy of the youth.

1). Scioto Incident, March 9, 2007: This incident involved a female youth who had recently engaged in self-injurious behavior (inflicting wounds with paper clips/writing instruments). She pushed past staff to get out of her room on the Buckeye Unit. A JCO employed a chokehold as a takedown technique. Immediately after the takedown two staff members can be seen recklessly yanking and pulling on the youth's legs. The JCO continued to place his body weight on the youth while continuing the chokehold. In the presence of an OM, the JCO was allowed to continue this dangerous position for an extended period of time, actually hindering the application of restraints, and causing the youth to repeatedly scream and hysterically plea to be released from the chokehold. None of the incident reports referenced the chokehold. Various reports described her as "very combative" after the takedown when in fact she was likely struggling as a result of air hunger or suffocation panic. This incident was not referred for any follow-up inquiry or investigation. There is no evidence that the video was ever reviewed in concert with the incident packet.

2. Marion Incident, May 26, 2007: This incident involved a youth with an extensive history of mental health problems who was observed threatening to engage in self-harm with a piece of plastic from a scrub brush. After complying with orders to relinquish the piece of plastic, the youth was cuffed and an UA arrived on the scene to direct his movement to a safe room. The UA was accompanied by multiple staff, including no less than four officers. A decision was made to strip the youth and place him in a suicide smock. Rather than supervise staff, the UA took the diminutive youth to the floor and straddled him with her considerable body weight. Thus began an excruciatingly long application of force in which the UA continued her direct involvement and failed to prevent other staff from repeatedly engaging in tactics that created extreme risks of harm to the youth.

In viewing this video it should be noted that there were multiple instances in which the youth was placed in positions commonly associated with in-custody deaths from positional asphyxia. He remained in a face-down prone position much too long. In a remarkable display of reckless force tactics, one officer attempted to place the suicide smock on the youth's head as a make shift spit-mask which clearly impaired his air passage ways. An officer can be seen with his full body weight on the youth's back with his knee across the youth's neck with the suicide smock over his airways. The youth actually screams that he can't breathe.

The decision was then made to place the youth in 2-point restraints. Notwithstanding that the youth was cooperating with staff and even trying to assist them in securing the restraints, they were unable to secure the restraints in a proper and timely fashion. It should be noted that 2-point wrist-to-wrist restraints (ambulatory restraints) are designed for the wrists to be cuffed to the side-front of the body. In the video, it is clear that officers are attempting to cuff in the side-back with his arms turned backwards greatly increasing the risk of fractures to his arms/shoulders. After abandoning the first set of restraints, the officers persist in cuffing the youth in the same dangerous fashion. It should also be noted that the extraordinary length of time to make either set of restraints available greatly increased the risks of harm to both the youth and staff.

3. Marion Incident, June 25, 2007: This is an incident in which a JCO can be seen kicking the fully restrained youth in the head multiple times in plain view of six staff

members. After the JCO had been physically pulled away from assaulting the youth, all staff then exited the room leaving the youth alone with the offending JCO. The JCO remained in the room alone with the youth for at least ten minutes.

None of the JCO witnesses later reported the kicks. A nurse in attendance reported that the JCO's "boot made contact with the left side of the helmet the youth was wearing to prevent him banging his head." The single staff member who accurately reported the incident was the Operations Manager ("OM"). The investigation of this incident did not address any reporting issues. [Note: at the time of my site inspection, the investigation had been completed sustaining the allegations against the JCO who kicked the youth; however, she remained in a contact position supervising youths at the facility. The Deputy Superintendent confirmed that the facility is lacking a policy directive as to when staff are prohibited from working in a contact position during the pendency of an investigation of allegations of improper force.]

IV. MENTAL HEALTH CARE: TREATMENT, REHABILITATION & PROGRAMMING

Dr. Leta Smith in beginning her Summary Report of Initial Site Visits 1 (October 7, 2007) states, "Overall the provision of mental health care and treatment throughout ODYS is fundamentally deficient and structurally inadequate in design and function." Apart from the often heroic efforts of isolated mental health care providers — certainly including Dr. Julie Neidermeyer — we could find no strength upon which to comment or build. There has been a flurry of corrective plans and some action in this area, at least at Scioto and Marion, but it came after our field investigation and too late to materially influence our general observations.

In our Interim Report of 2004 at pp. 27-31 we found that there were virtually no proactive mental health services; individualized treatment plans were lacking, along with proper documentation and a continuum of care. There was no mental health unit, except in name.

Scioto, at best, provided crisis care and yet the then Clinical Services Director, believed that mental health care was good. The then Director of DYS asked me to prepare a "Mental Health Program" for reforming mental health care, which I did. (See Appendix E). That program was never even commented upon by any DYS official. There are a number of initiatives in place, described in an Addendum to this Section but we were unable to detect a measurable impact during the course of this investigation.

Kathy Burns, M.D., a highly regarded forensic psychiatrist, was asked to visit only Scioto and Marion. Dr. Burns found that the very basics of fundamental mental health are lacking. This echoes Dr. Smith's finding, it echoes the findings in the Interim Report, and it echoes my individual conclusions based on our current investigation. The DYS officials in charge of mental health and rehabilitation cannot claim ignorance. I have been sounding the alarm now for about 10 years.

Please note that this investigation and Report does not confront mental health and rehabilitative care at the level of a debate e.g., on treatment modalities, efficacy studies, bed utilization studies, the formulary, and so on. Those are matters to be dealt with in the context of even a dimly outlined system of care, a system we find lacking.

The overall mental health caseload is roughly 25% to 35% of all DYS youth and that is low compared with other states and the available incidence data

In constructing a Model for dealing with the identification and treatment of youth involved with the juvenile justice system, Skowyra and Cocozza conducted the most comprehensive study to date: 1,437 youth in three different states in three different types of juvenile justice settings detention, corrections, and community-based programs.

The results of the study, which were incorporated into the Model, confirmed that, regardless of level of care or geographic region of the country, the majority of youth in the juvenile justice system meet criteria for at least one mental health diagnosis. Overall, 70.4% of youth were diagnosed with at least one mental health disorder, with girls experiencing a higher rate of disorders (81%) when compared to males (66.8%). For many of the youth in the study, their mental health status was complicated by the presence of more than one disorder. Of those youth who were diagnosed with a mental health disorder, 79.1% met the criteria for at least one other mental health diagnosis. The majority of youth who met criteria for a mental health diagnosis were also diagnosed with a co-occurring substance use disorder. Among those youth with at least one mental health diagnosis, approximately 60% also met criteria for a substance use disorder.[17]

There is a stunning difference between this latest study and the Ohio caseload even allowing for the contingency that caseload figures may not completely reflect diagnostic and off-caseload care. It is not hyperbole to state that the Ohio DYS, like all similar state agencies, is a proxy mental health agency. That being said, the need for fundamental change is — and has been — painfully obvious.

To the extent that one accepts significant system-wide underdiagnosis and treatment, the consequences are broad and severe. Delayed treatment means needless suffering and preventable deterioration, the essence of Cruel and Unusual Punishment; self-harm and harm to others; inappropriate and harmful punishment for acting out behavior driven by mental illness; needless isolation and its multiple, harmful consequences; and, too often, the enhancement of self-loathing linked to self-destructive behavior.

[17] Kathleen R. Skowyra & Joseph J. Cocozza, Blueprint for Change: A comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System, p.IX (National Center for Mental Health & Juvenile Justice, 2007).

Whether a class member's right to treatment and rehabilitation is framed in terms of Due Process or Cruel and Unusual Punishment, our findings on the inadequacy of the system and the consequent harm will meet either a denial of a Due Process liberty interest or deliberate indifference to a serious mental disorder.

Alexander S. v. Boyd, 876 F.Supp. 773, 796 (D.S.C. 1995), is perhaps the most recent significant affirmative federal decision on behalf of juveniles' rights to various forms of care. The court specifically looked to the purpose of the juvenile court and found that *Youngberg v. Romeo*, 457 U.S. 307 (1983), required that children receive training that provides them with a reasonable opportunity to accomplish the purpose of their confinement, to protect the safety of the juveniles and the staff, and to ensure the safety of the community once the juveniles are ultimately released.

Alexander S. determined that minimally adequate programs and services are constitutionally required and are to be designed to teach juveniles the basic principles that are essential to correcting their conduct. These generally recognized principles include: (1) taking responsibility for the consequences of their actions; (2) learning appropriate ways of responding to others (coping skills); (3) learning to manage their anger; and (4) developing a positive sense of accomplishment. ODYS officials indicate an existing commitment to these principles.

This ruling is interesting for two other reasons. First, unlike the court in *Youngberg*, the *Alexander S.* court envisioned training or treatment in relation to the outside world, not solely in relation to life inside the institution. Second, in no right to treatment case with which I am familiar before *Alexander S.* did a judge articulate the purpose of treatment. While there is frequent talk about the need for treatment or rehabilitation, and many authorities set forth the techniques by which it should be done, none grapple with the elusive, qualitative goals of treatment and none clearly defines rehabilitation or attempts to distinguish treatment from rehabilitation.

Alexander S., then confirmed a right to treatment on behalf of the juveniles in the custody of the South Carolina Department of Juvenile Justice and perhaps unwittingly did so in a fashion that enlarged the disease-oriented concept of treatment to include the broader concept of rehabilitation.

Judge Alexander did link South Carolina's statutory commitment to rehabilitation — much like Ohio's — to the constitutional duties he articulated. See *Alexander S.*, 875 F.Supp. at 795-800 for a discussion of applicable constitutional standards, settling on the Due Process Clause.

Miller v. Natalucci-Persichetti, 1992 WL 1258522 (S.D. Ohio) concluded that a juvenile who is committed to a correctional, as opposed to a mental health institution, has a right to treatment under the Fourteenth Amendment. Judge Rice focused on Ohio law and the absence of procedural safeguards which parallel those in a criminal proceeding. The court appeared to accept the fact that the juvenile involved in this case, and who committed suicide in a juvenile facility, had severe emotional problems. Thus, this is not a decision finding a broad-based right to treatment; only the relatively easy finding that involuntary custody in a government facility requires treatment of serious illnesses.

It is my view of the law on point that all juveniles who are involuntarily confined have *at least* the same right to mental health treatment as pretrial detainees and prison inmates. Indeed, I feel certain that is the current state of the law. What is it that the hedge-term "at least" may encompass?

Simply , being young — an adolescent — should be a powerful factor in determining the precise application of due process to a juvenile's claim to adequate mental health care for serious mental health needs. Deliberate indifference, if that is to be the test, should be informed by the knowledge we now have concerning adolescent cognitive, intellectual, emotional, social, and moral development.

The general acceptance of a need for early detection and intervention and of a very high incidence of emotional and mental disorders among youth in official custody should become benchmarks for the duty of care evaluated as a part of deliberate indifference analysis. Early detection means one thing for an adult; for a young person it includes early in life as well as early in onset.

What follows is a slightly redacted version of the Report prepared by Dr. Kathy Burns after her site visits to Scioto and Marion.[18] DYS's problems begin at the front door during reception at Scioto and then pervade the entire system; understaffed, lacking

[18] Dr. Burns' September 27, 2007 Report is so comprehensive and yet succinct that I see no point in paraphrasing from it. This Report, then, will not also appear in the Appendix since the redaction relates only to procedural-type matters.

coherence and direction, lacking leadership, lacking the rudiments of legally mandated mental health care and basic rehabilitation efforts.

Scioto & Marion Report: Kathryn A. Burns, MD, MPH, 9/27/2007

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Scioto Juvenile Correctional Facility

Scioto Juvenile Correctional Facility serves as the reception center for both males and females entering ODYS. Boys stay at the facility for the reception and classification process and are transferred out to their assigned institutions within 30 days. There are approximately 200 boys at Scioto at any given time. Scioto is the only ODYS facility for girls. It serves as both reception center and parent institution for girls. There are approximately 90 girls at Scioto. The mental health program consists of reception screening and assessment for both boys and girls and outpatient, including crisis intervention, and residential treatment for girls. The residential treatment unit for girls at Scioto is analogous to the Intensive Mental Health Unit at Marion for boys.

Mental Health Services for Boys at Scioto: Reception Screening & Assessment

When boys arrive at Scioto, they are seen within the first hour of arrival by medical nurses who screen for physical health issues, immediate mental health needs and psychotropic medication history. Two medical nurses are assigned to the reception process for boys. They are located in a small office/examination room inside the building that is used for reception. Medical nurses refer to the psychiatrist(s) based upon a youth's current or past psychotropic medication history. Currently prescribed medications are discussed with the psychiatrist on site and ordered by the medical nurses to prevent any lapses in medication. Non-emergency referrals are scheduled to be seen by the psychiatrist within a few days of arrival. Emergency referrals for mental health are seen by the psychology staff assigned to reception. (Depending on the nature of the crisis, if a

psychiatrist is on site at the facility, he or she will see the emergency referrals in the reception area or can be contacted via telephone to provide consultation and medication orders as necessary.)

Psychology staff assigned to reception score the arriving youths' MAYSI-2, review the documentation accompanying the boys and conduct individual standardized interviews with each boy within the first two weeks of arrival. No further psychological or psychometric testing is routinely conducted; some intelligence testing is completed in rare instances. The purpose of the psychological assessment appears to be to arrive at an appropriate housing disposition and institutional classification and not for mental health treatment. Psychology staff in this area rarely make recommendations for treatment beyond placement on a watch or expedited transfer to an "intensive" or "non-intensive" mental health unit believing that their role is simply to compile information for eventual treatment providers further downstream as the boys are shipped out to their permanent/parent institution within 30 days. In fact, one Ph.D. level psychology assistant who has been working in reception for several months (and was at the institution previously as well) said she did not even know how to make a referral to psychiatry, assuming that if it was needed, the medical nurses would already have done so. Mental health staffing levels do not allow for the provision of treatment during the reception phase except for psychotropic medication, psychiatric assessment/follow-up and crisis intervention as needed.

Mental Health Staffing

At the time of the August site visit, mental health staffing levels consisted of one licensed psychologist and three psychological assistants for boys' reception in addition to some adult psychiatry contract hours. As previously noted, this level of staffing provided for boys' reception permits nothing in the way of treatment beyond on-going prescription of psychotropic medication and expedited transfer to another facility if additional care is needed.

Mental health services for girls (reception, general outpatient, crisis intervention and residential treatment) are provided by one full time psychologist and one 25 hours per week psychologist, two psychology assistants, 2 licensed (but not independently licensed) social workers, one psychiatric nurse and some psychiatric hours provided by adult psychiatrists on contract from Ohio State University (OSU.) As in the case with services for boys at Scioto, girls' mental health services are profoundly understaffed given the prevalence and severity of mental disorders present in the population as well as the diversity of missions at the facility (reception, classification, multiple security levels in the same institution, education, outpatient mental health care, crisis intervention, residential mental health care, medical operations, etc.) in addition to there being no access to an inpatient level of psychiatric care for girls so that even the most acute conditions are managed on-site! The lone psychiatric nurse serves as a liaison from all areas of the institution to the contract psychiatrists and assures that boys and girls are scheduled to be seen by the psychiatrists in a timely manner, that they receive prescribed psychotropic medications as ordered and without lapses and that all psychiatric orders are implemented. There is little to no time whatsoever available to do any sort of medication education or other psychiatric nursing intervention. Further, the psychiatric nurse serves many clerical functions in that there are no clerical positions for the mental health program at Scioto.

There are approximately 34 hours per week of psychiatric time at Scioto split among boys' reception (approximately 20 hours), girls' outpatient and residential mental health treatment unit. Three psychiatrists provide these hours – none of them are Child and Adolescent Psychiatrists (CAP). When queried about whether or not this was believed to be a problem, the "chief" or "main" OSU/ODYS psychiatrist said that most of the kids were older adolescents/young adults rather than children and so didn't consider the lack of CAP training to be a problem. While

chronologically, I cannot argue with her rationale, I strongly believe that these kids are psychologically and emotionally quite immature and that at least some psychiatric time or consultation by a CAP is extremely and urgently important.

Psychological and social services staffing levels for girls do not permit regular, individual (or group) on-going focused therapy because of the frequency and urgency of crisis interventions and multiple daily mental health watch risk assessments. At least one girl at Scioto had been on a 1:1 watch every day, 24-hours per day, continuously for more than two months at the time of the August site visit. Others had been on and off watches for shorter, but still extraordinarily long periods of time.

Girls' Residential Mental Health Unit (Special Needs Unit)

The girls' Special Needs Unit at Scioto is a 14 bed residential housing unit for severely mentally ill girls. It also contains an additional approximately 5 rooms behind a walled off area of the unit where mental health watches can be conducted in an area that is near, yet apart from and quieter than the rest of the unit. As with the boys' Intensive Mental Health Unit, the admission, discharge and continued stay criteria for the girls' Special Needs Unit are unclear in existing DYS policy and procedures. None of these decisions appear to be functions of the psychiatrists, although their input is considered. Similarly, programming and treatment expectations are non-specific. However, most of the girls housed on the unit appeared at the time of the site visit did appear to suffer from significant mental health problems which included a high prevalence of self-injurious and suicidal behavior.

Staffing levels to manage a unit of this size and acuity were woefully inadequate. There was essentially no mental health group programming. Social workers conducted some groups although these have not historically been considered mental health interventions; they are not documented in the mental health file nor necessarily part of the mental health treatment plan which is developed by psychology staff independent

of other disciplines. Individual mental health interventions are primarily crisis interventions. There is little or no time for routine, regular, on-going focused psychotherapy. Mental health care is essentially "on demand" through verbalizing intent to harm oneself or actually engaging in self-injurious behavior. Although there was some training for staff on the use of Dialectical Behavioral Therapy (DBT) several years ago, it is not utilized for reasons that are not clear given the population at Scioto and DBT's demonstrated efficacy in the treatment of borderline personality characteristics including self-injury.

Girls in the mental health unit and in the watch area can be placed on some level of individual observation for periods of days, weeks or even months, without a clear behavioral or other plan to intensify or otherwise modify treatment interventions to get them off watch and back into routine activities. This continues to reinforce the notion that the way to get attention is to threaten or actually harm oneself because staff have no time to see anyone else. It further diverts already scarce staff resources away from on-going, regular and perhaps prophylactic treatment of others.

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Mental Health Treatment

At the time of the site visit, 47 girls (approximately 50% of the female population) and 26 boys (13%) were prescribed psychotropic medications. These prevalence rates are substantially lower than we expected and as reported in some other prevalence studies conducted in juvenile correctional populations. The screening and referral processes both at the time of reception and thereafter raise enough questions to call for closer scrutiny during the remediation phase of *S.H.*

Boys in reception receive little mental health treatment beyond psychotropic medication and individual psychiatric follow-up appointments. Psychological staff conduct a type of reception assessment but it appears to be aimed at arriving at an appropriate classification and

placement decision rather than designed for assessing (and then addressing) mental health treatment needs.

As was the case for boys on the mental health caseload at Marion, the girls on the mental health caseload receive parallel rather than integrated care by the various staff involved. Mental health treatment plans, if present, are developed unilaterally by psychology staff without ever having treatment team meetings. There are three other types of meetings at Scioto during which mental health information is discussed, but none of them are actual mental health treatment team/treatment planning meetings. There are "Psychiatry Team Meetings" conducted weekly in which one psychiatrist and psychology staff meet to discuss girls prescribed psychotropic medications. These meetings are not documented and the patient does not attend. There are "Clinical Team Meetings" during which psychology staff, the unit manager and social worker meet to discuss the mental health caseload. These are not documented and neither the psychiatrist nor the patient attends. There are "Interdisciplinary Team Meetings" that are meetings of psychology staff, unit staff, social workers, juvenile correctional officers, educational and recreational staff during which individual girls are discussed and also invited to participate. The psychiatrist is not included. These meetings are documented – but not in the mental health file. Subsequently, it is not a surprise that mental health interventions are parallel rather than integrated and this is reflected in the documentation plan: psychiatric assessments, follow-up notes and medication information are contained in the youth's medical file while psychology notes are contained in the "Psychological File." Psychological files are maintained in the psychology staff offices and are not provided to the psychiatrist when he or she is seeing cases. Each youth also has a social services file which could contain additional mental health information. Additionally, psychology notes and social service notes are in the process of being entered into Microsoft Access Databases. At the present time therefore, there are three

paper files and two electronic files containing mental health information for each youth. Due to the ODYS interpretation of confidentiality rules and protected health information, not all disciplines have access to all of these multiple files at the present time.

As previously mentioned, psychological interventions are frequently limited to crisis interventions due to the paucity of staff available to provide any on-going type of treatment as well as the acuity level of the girls on the Special Needs Unit. Essentially no psychological testing for diagnostic clarification, assessment or any other use of standardized, objective instruments to monitor response to treatment are utilized. Mental health staff at Scioto are looking forward to the adoption of a trauma-informed care treatment model department-wide as planned by Central Office Mental Health administrative staff. Presently, essentially all mental health treatment provided is via individual sessions with the psychiatrist or a psychologist; there is no group treatment and there is no unifying model of psychotherapeutic intervention at the institution.

The psychotropic medication formulary is unrestricted and all classes of medications are available. The frequency of psychiatric follow-up is approximately monthly, more frequently in reception given the short stays there. The psychiatrists work with the lone psychiatric nurse and are able to schedule youths more frequently than monthly based upon clinical need. Laboratory studies and monitoring for potential physical health complications from the use of psychotropic medications are appropriate and timely. The psychiatrists generally obtain verbal informed consent from a parent or guardian via telephone discussion when a child is under age 18. This is documented in the medical paper file. Informed consent documents are also mailed to parents for signature and return. As was the case at Marion, prescription of stimulant medications for treatment of ADHD was extremely conservative, substituting use of Clonidine, atypical antipsychotics and mood stabilizing medications.

Access to psychiatric inpatient care is not available unless a youth is 18 years old and can be hospitalized in an adult state psychiatric hospital. This is a grave and unacceptably dangerous situation.

<u>Marion Juvenile Correctional Facility</u>

Marion Juvenile Correctional Facility is one of two "close security" facilities operated by ODYS and houses only adolescent boys. Close security is the highest security level in the ODYS system. The average daily population at Marion is approximately 275. Most residents at the facility are transferred from the reception process at Scioto Juvenile Correctional Facility although some transfer in from other lower security facilities as a consequence of behaviors leading to an increase is security classification.

The mental health program at Marion consists of outpatient services, including crisis intervention services and an "Intensive" Mental Health Unit. The intensive mental health unit is a 12 bed residential unit to house boys who have been diagnosed as severely mentally ill. The intensive mental health unit at Marion is the only such residential unit operated by ODYS and is intended to serve all boys, regardless of actual security classification, in need of this level of mental health care. ODYS operates three "Non-intensive" Mental Health Units at other facilities for boys who have "a moderately severe diagnosis and whose adjustment in the general population would be compromised." (Mental Health Classification Standard Operating Procedure)

In addition to general housing units and the intensive mental health unit, Marion also contains "Critical Program Unit" housing which is analogous to an adult institution maximum security segregation unit.

Mental Health Staffing

At the time of the August site visit, mental health staffing consisted of one full-time psychology supervisor, one full-time psychologist, one full-time psychology assistant, one full-time clerical support person and 20

hours per week of an adult psychiatrist contractor. Notably, there were no psychiatric nursing staff, no independently licensed mental health social workers and no access to a child and adolescent psychiatrist (CAP). In addition, I was informed that the psychology supervisor had submitted her resignation and would be leaving in mid-September. ODYS Central Office staff were unable to articulate an emergency/temporary coverage plan for the psychology supervisor vacancy. We have since learned that a contract has been entered into and that position has been filled.

Mental health staff assignments were aligned as follows: psychology supervisor position to provide administrative function, clinical supervision, crisis intervention and coverage for other psychology staff; psychologist assigned to cover the Critical Program Unit and all other outpatient care; psychology assistant recently reassigned to Intensive Mental Health Unit full time (previously 50% outpatient and 50% mental health unit) although he hadn't yet started assignment full time on the unit because of the need to terminate/transfer previous outpatients; 20 hours per week psychiatric time to cover general outpatient, Critical Program Unit boys on psychotropic medications and Intensive Mental Health Unit. In addition to the mental health staff, one institutional social worker was recently reassigned to the Intensive Mental Health Unit full time. (She had previously provided part-time coverage there.) Notably, this social worker is not Master's prepared, independently licensed or a mental health social worker per se. She also had not yet been on the unit full time at the time of the site visit due to personal illness and participation in departmental/institutional in-service training requirements (unrelated to mental health training.)

Marion's psychology supervisor was not aware of any plans to increase mental health staffing nor was she consulted with respect to staffing needs. Dr. Scott-Johnson from Central Office reported that an additional 2.5 psychology positions, one psychiatric nurse position and 0.5 FTE occupational therapist had been approved and another social worker

position had been requested for Marion. She was not able to project when the approved positions would be posted or ultimately filled.

Intensive Mental Health Unit (IMHU)

As previously noted, the Intensive Mental Health Unit is a 12-bed mental health residential treatment unit designed to house youth diagnosed as severely mentally ill according to ODYS policy and operating procedures. Existing policy and procedures are not clear with respect to admission criteria, continued stay criteria, discharge criteria, programming/treatment expectations on the unit and they do not provide a clear distinction between the Intensive and so-called "Non-intensive" Mental Health Units. Dr. Scott-Johnson explained that referral into either the Intensive or Non-intensive mental health units is made via discussion between sending and receiving institutional psychology staff with ultimate approval authority for transfer into or discharge from the units being a function of Central Office. Notably, the psychiatrist is not involved in admission or discharge decision-making process. Similarly, neither the psychology supervisor nor the psychology assistant on site at Marion felt empowered to make admission or discharge recommendations: they had attempted discharge recommendations in the past without success and so were resigned to working with whoever was sent to them for however long they were there. The Marion mental health staff believed that at least half of the boys residing on the Intensive Mental Health Unit were not seriously mentally ill but rather displayed highly problematic behaviors as a result of Conduct Disorder and/or antisocial tendencies.

At the present time, there are no mental health programming or mental health related group activities on the Intensive Mental Health Unit. The sole treatment modalities are monthly psychiatric follow-up for psychotropic medication checks and infrequent individual sessions with the psychology assistant. These are the same interventions and frequencies of interventions as received by boys on the mental health caseload residing in general population and receiving so-called outpatient

treatment. Approximately half of the boys on the Intensive Mental Health Unit attend classes at the high school on site for six hours daily which begs the question of why they wouldn't be more appropriately housed on either a Non-intensive Mental Health Unit or simply in general population since they aren't receiving anything resembling "intensive" mental health treatment and are clearly functioning fairly well. I observed the boys who could not attend regular school and so were attending a shortened school day in a classroom on the housing unit. They displayed clear signs of highly impulsive behaviors, hyperactivity and impaired attention span suggesting un-treated, under-treated or treatment-resistant Attention Deficit Hyperactivity Disorder (ADHD.)

Mental Health Treatment

At the time of the site visit, 51 boys were prescribed psychotropic medications which represents approximately 18% of the population at Marion. The complete mental health caseload consists of these 51 boys and an additional 11 boys being seen regularly by psychology staff (totaling 22.5% of the population.) By all existing prevalence studies in juvenile correctional populations, this is a remarkably low prevalence and indicates deficient screening, assessment and referral procedures and practices – both during the reception process (addressed in the Scioto section of this report) and subsequently.

Mental health treatment plans, if present, are developed unilaterally by psychology staff without ever actually having treatment team meetings. (There are other types of meetings at which individual boys mental health needs and conditions are discussed but these do not include all disciplines or the youth, and are not always documented in any fashion.) Subsequently, it is not a surprise that mental health interventions are parallel rather than integrated and this is reflected in the documentation: psychiatric assessments, follow-up notes and medication information are contained in the youth's medical file while psychology notes are contained in the "Psychological File." The psychological files I

reviewed contained copies of some psychiatric notes, but no record of psychotropic medications. Psychological files are maintained in the psychology staff offices and are provided to the psychiatrist on request when she is seeing cases. Each youth also has a social services file that could contain additional mental health information. Additionally, psychology notes and social service notes are in the process of being entered into Microsoft Access Databases. At the present time therefore, there are three paper files and two electronic files containing mental health information for each youth. Due to the ODYS interpretation of confidentiality rules and protected health information, not all disciplines have access to all of these multiple files even though all may be providing treatment to the youth.

Psychological interventions are frequently limited to crisis interventions due to the paucity of staff available to provide any on-going type of treatment. There is no departmental expectation regarding the format for documentation of mental health sessions. (The psychiatrist uses a Subjective, Objective, Assessment, Plan or SOAP format routinely as her own personal preference.) Similarly, there is no department-wide direction or prescription for type of psychological therapeutic interventions provided although Central Office has recently initiated some preliminary training and steps to adopt a model for providing trauma-informed care throughout the department. Presently, essentially all mental health treatment provided is via individual sessions with the psychiatrist or a psychologist; there is no group treatment. No psychological testing for diagnostic clarification, assessment or any other use of standardized, objective instruments to monitor response to treatment are conducted at Marion. The rationale for this omission in a system in which psychology staff are the very backbone of the mental health system was inexplicable by any of the on-site psychological staff. They said they had repeatedly requested psychometric tools and that their requests were repeatedly denied because of the expense involved. Central office staff

acknowledged that they had not been involved in securing these types of materials for the institutions, but were "getting ready to see what everyone needed." The Deputy Superintendent of Programs said she was not aware that psychological staff needed psychological testing materials but that if they put together a list of what they needed, she would purchase the materials.

On a brighter note, the psychotropic medication formulary is unrestricted and all classes of medications are available. The frequency of psychiatric follow-up is approximately monthly. The psychiatrist does her own follow-up scheduling so is able to see youth more frequently as she believes necessary. Laboratory studies and monitoring for potential physical health complications from the use of psychotropic medications are appropriate and timely. The psychiatrist herself generally obtains verbal informed consent from a parent or guardian when a child is under age 18. This is documented in the medical paper file. Informed consent documents are also mailed to parents for signature and return.

Surprisingly, only 2 of the 51 boys receiving psychotropic medications were prescribed stimulants in spite of the high prevalence of ADHD in this population and stimulants being treatment of choice for the condition. When queried, the psychiatrist explained that some boys had previously failed trials of treatment with stimulants; and some parents refused to consent to stimulants. Subsequently, she prescribed Clonidine and/or atypical antipsychotic medications and/or mood stabilizing medication for diagnoses of ADHD and affective disorders. (I suspect the exceptionally low use of stimulants is also due in part to the fairly conservative prescribing practice of the adult psychiatrist herself since treatment failures on previous trials was certainly not documented anywhere. Other contract psychiatrists use stimulants more frequently.)

[On further reflection, the author of this Report wishes to make it clear that there is room for legitimate disagreement here as to the prevalence and use of medication for the ADHD population.]

Youth in the custody of ODYS have no access to inpatient psychiatric care until they are 18 years old and can be hospitalized in a state psychiatric hospital. Dr. Scott-Johnson and Dr. Marrow both said that they have tried to secure a contract with an inpatient psychiatric care provider to no avail because all providers that have been approached have refused to serve this population.

Conclusion

The very basics of fundamental mental health care are seriously lacking at both Marion and Scioto Juvenile Correctional Facilities. Existing policies and procedures lack sufficient detail and clarity. Mental health treatment is essentially limited to either crisis intervention and/or psychotropic medication. This is partly based upon inadequate staffing levels but also based upon a culture that appears not to recognize that they are missing substantial numbers of youth who need treatment. Caseload prevalence data alone is indicative of deficient screening, assessment and referral procedures both at the time of reception and subsequently. Additional clinicians, including independently licensed, master's prepared social workers, psychiatric nurses and clerical staff are needed immediately.

Mental health treatment records are fragmented at best. There are at least five files containing mental health information, three paper files (medical, psychological and social services) and two electronic files (psychological and social services). Although this is part of a transition to an eventual fully electronic file, it is not acceptable at the moment because not all parties providing mental health interventions are permitted access to all parts of the information! The fragmented nature of the documentation is a reflection of the fragmented care provided.

The psychotropic medication formulary is open and unrestricted. However, there appears to be a profound underutilization of stimulant medications for the treatment of ADHD, particularly among the males at Marion who were observed to be exhibiting highly problematic symptoms

and behaviors of the disorder, but also among the girls. I believe this is partly a cultural issue in which the use of stimulants was not supported by the ODYS medical director in the past, as well as the fairly conservative prescribing practices of the psychiatrist, Dr. Neidermeyer, *[see author's comment at p. 60, supra]* in addition to the issues she raised with respect to lack of guardian consent in some instances. However, I also believe that the lack of access to a Child and Adolescent trained psychiatrist, either to provide services directly or to serve as a consultant, is a serious problem for ODYS and impacts upon the ability to secure guardian consent as well as a myriad of other areas, not the least of which is recognition of the profound psychological and emotional developmental delays experienced by these youths.

The two residential mental health care units I visited were little more than housing units. There was essentially no mental health program above that available to any other youth in any other housing unit at either facility: some social service groups (not considered mental health), individual monthly psychiatric appointments, psychotropic medications and occasionally, some individual psychological intervention (mainly crisis intervention.) I will not dwell on the Scioto use of "restraints upon request" again except to reiterate that this practice falls well outside the accepted standard of care. Lastly, the inability to access an inpatient level of psychiatric care is a grave and clinically dangerous situation that should be addressed immediately.

* * * *

[End Burns Report]

What has been said of Scioto and Marion can be said of the other DYS facilities with variations based on size and mission. Dr. Leta Smith visited and reported on all six facilities visited by the "core team" and prepared a comprehensive summary of those visits.

As with Dr. Burns' Report, Dr Smith's excellent "Summary" should be allowed essentially to speak for itself. It is presented in an edited version and represents this writer's individual findings as well. There is some overlap with areas previously covered, but in my view the overlap tends to strengthen the points and does not appear to be inconsistent.

Summary Report Of Initial Site Visits: Leta D. Smith, Ph.D., 10/7/ 2007

A. PROVISION OF MENTAL HEALTH CARE

Introduction

Overall, the provision of mental health care and treatment throughout ODYS is fundamentally deficient and structurally inadequate in design and function. Although reported percentages vary from facility to facility, the identified mental health caseload of roughly 25-35% is notably low (e.g., Marion 23%; ORV ~1/3) compared with other states and as cited in the prevalence literature, suggestive of inadequate mental health screening, assessment, and referral processes. This is a serious deficiency as it leaves unidentified youth potentially at risk of unmet and untreated mental health needs, symptoms which may deteriorate or exacerbate, and the behavioral manifestations of their illnesses to potentially jeopardize their own safety and that of other youth and/or staff. Given the extremely limited clinical staffing throughout the system of mental health care, a youth who may be quietly suffering could easily be overlooked and needed mental health services neglected. According to psychiatry at Indian River Juvenile Correctional Facility (JCF), depression and anxiety disorders are under-diagnosed because youth do report their symptoms for fear of looking weak. Meeting with non-mental health caseload youth can contribute to early detection and possibly prevention of mental/ emotional disturbance, crises situations, and deterioration to more serious conditions.

The vast majority of youth on the mental health caseload statewide were identified at Scioto Reception (see Intake below) and/or receiving psychiatric medication, with the remainder referred by social work or other staff generally for acting out or 'weird' behavior [Ohio River Valley JCF (ORV)]. For example, at Scioto, because of staffing constraints and other impediments to adequate treatment (discussed below), Psychology infrequently meets with girls on the mental health caseload for individualized non-crisis oriented treatment, and rarely meets with the non-mental health caseload youth. Depression is one of the most frequent diagnoses, especially for mentally health caseload females in the juvenile justice population, with psychotherapy as the treatment of choice, according to the American Academy of Child and Adolescent Psychiatry, along with careful administration and monitoring of SSRI medications if prescribed.

The result of a lack of appropriate recognition and response to serious mental health disabilities can result in self-harm, harm to others, and/or inappropriate punishment for acting out behaviors.

B. ADEQUACY OF POLICIES AND PROCEDURES

In a most major areas of mental health governance and service delivery ODYS lacks adequate policies and protocols. These policies and procedures must clearly articulate expectations and consequences for non-compliance.

Aside from the inadequacies in content, there does not seem to be the requisite clarity and working knowledge of existing policies and procedures by clinical administration or staff. There seems to be confusion over what are existing, newly adopted, and/ or unofficial draft policies and procedures. This may, in part, be the result of recent changes, some of which were driven by our team's findings, in administration, staff, and policies, procedure and practice. Written policies and procedures need to meet good practice standards, but more importantly must be explicitly

articulated, internally consistent, and communicated/disseminated so that administration and staff are clear about expectations.

Policies and procedures are the minimal guidelines for service delivery and help to define what services should be provided to which youth. To illustrate this point, per SOP 403.30.02 Psychology Services, youth on the mental health caseload who are identified as appropriate *may be* (emphasis added) provided with individual treatment sessions.

Another blatant example is the lack of clarity as to mission and official policies/protocols concerns definitions and operations of the Special Needs as well as Intensive and Non-intensive Mental Health Units. This has resulted in grossly inadequate mental health services for those youth with the most serious levels of mental health need. There continues to be an absence of mental health programming or groups; inadequate staffing, training, etc. The needs of youth with serious mental health disabilities are neither understood nor adequately addressed, despite almost 10 years of recommendations to correct these gross inadequacies. This situation continues to pose serious risks, and is a serious waste of the appropriated limited clinical resources.

Decisions to develop or define facility mental health programs (policies, procedures, protocols, staffing, space, etc.) must include review and signoff by the clinical mental health hierarchy through Central Office in order to promote informed decision-making and present consistent staff expectations and accountability. A unit's clinical supervisor and/or clinician should be an integral stakeholder in this endeavor.

Other Procedure:

Consequence Log - Of serious concern is the use of a Consequence Log at Indian River's NIMHU which JCOs can use to cite certain behaviors without review of the UBIR process; however, this counts against the youth. This is a "slippery slope" and needs close attention.

C. QUALITY ASSURANCE AND PEER REVIEW PROCEDURES

Quality assurance and peer review procedures are grossly insufficient. Although there are some worthy data collection efforts (e.g., Performance-based Standards Project; Circleville recidivism data), as the mental health program and staff expectations are clarified, quality assurance and peer review procedures must be developed.

Staffing competencies, performance indicators/outcome measures and formal systems of care coordination (integrated treatment plans and meetings, records, logs, communications) are largely undeveloped aspects of a quality service system. Monitoring of staff performance is needed, based on clearly specified staff expectations.

The Mental Health Administration has been working to establish a mental health database, which they feel will provide some means of monitoring clinical performance (e.g., individual contacts, family contact, etc.). Although the new database offers some information concerning the nature and amount of staff contact with youth, it does not rectify the problems with ODYS individual treatment planning and perpetuates the lack of integration between the disciplines (see Adequacy of Mental Health Records below). Without necessary quality improvement systems, there is no adequate clarity of clinical vision or purpose, ability to monitor performance, nor necessary systematic capacity to identify and improve problems.

In the context of a comprehensive mental health system, it is essential that ODYS develop competencies in specifying and assessing individual improvement toward mental health goals, along with clinical performance, in order to move toward individual youth and staff progress and positive outcomes.

D. MENTAL HEALTH STAFFING

Mental health staffing does not yet support or promote adequate treatment in accordance with good practice standards of care for juvenile justice mental health. The lack of mental health staffing significantly

compromises the safety and well being of youth by failing to support opportunities for adequate assessment, treatment or follow-up mental health services, especially given the large proportion of youth with extensive mental health needs.

Clinical staffing must be increased, preferably as part of a coordinated plan to reduce the facility census.

Leadership:

The absence of effective mental health leadership continues to be of great concern. We find a failure to adequately recognize and respond to the serious and complex needs of the mentally ill youth in the ODYS system; a demonstrated lack of knowledge of pertinent issues; and little evidence of leadership and commitment to advocate for critical mental health system needs and required change.

Facility Clinical Leadership Positions:

Facility clinical leadership positions cannot continue to remain unfilled. Vacancies in some facilities in the positions of Program Deputy, Psychology Supervisor, and/or Social Work Supervisor create a void in clinical leadership, supervision, advocacy and support for the mental health program (see below).

Psychiatry:

Psychiatric services are extremely limited and for the most part, do not include much more than brief medication monitoring every 30 days. At ORV for example, one psychiatrist provides 2-3 hours of services per week with 121 youth on psychiatric medications. With so few hours the psychiatrist cannot participate in team meetings including the clinical team, nor meet with psychology. Extended periods of time between medication reviews, along with limited opportunity for monitoring and follow-up at each visit, increases the risk of untoward medical, emotional, and behavioral outcomes.

Social Work:

Social workers are largely case managers who provide behavioral groups. In order to begin to establish mental health staffing ratios, ODYS must clarify whether Social Workers as presently trained and credentialed should be included as clinical staff. If social workers are to continue in their stated role as clinicians, then their credentials and job expectations must be commensurate with professional standards. Under present circumstances, there is a major problem including social workers who are not appropriately trained and credentialed as clinical staff.

Most of the social workers encountered at the various facility site visits hold bachelor's level degrees if they have a license. It is important that any additional mental health unit social work staff are master's level licensed social workers (MSW, LICSW, etc.) Given the Union constraints, and that ODYS social workers almost exclusively do case management and behavioral groups, ODYS might consider clinical titles other than social worker (e.g., psychologist, mental health nurse), when enhancing current levels of clinical staffing, until and unless master's level social workers become the standard. Perhaps the current social work title would more appropriately serve as the 'therapeutic' Unit Manager to support system needs.

Psychology:

Psychology is greatly understaffed, resulting in a crisis- oriented approach, and largely precluding the ability to provide needed individual preventive, on-going, and follow-up treatment. Since psychiatric hours are few, and many social work staff have questionable clinical credentials, this leaves Psychology with the responsibility for treatment, provision of clinical groups, as well as providing assessments, clinical input for unit staff, contact with families, etc. As a result, mental health needs largely go untreated and related risks increase due to the understaffing.

Psychiatric Nurse:

Aside from Scioto, I am not aware of other mental health nurses in the system. A Psychiatric nurse is an important interface in conveying clinical information to and from the psychiatrist, monitoring side effects, and behavioral and emotional adjustment, and providing individual and group medication education.

As proposed at Marion, for example, a minimum of 0.5 FTE Psychiatric Nurse could provide support for the Intensive Mental Health Unit and also serve an additional .25 for the general population and .25 for the CPI/ disciplinary unit.

Occupational Therapist (OT) and Recreational Therapist (RT) Services:

OT and RT provide valuable support for mental health populations, especially those on units with more intensive mental health needs because they can provide fine and gross motor activities as well as tasks which focus attention and have a high probability of success for individuals suffering from serious mental illness. These activities promote self-esteem and self-confidence for mentally ill youth who are frequently unable to participate in the more challenging schedule of general population. As part of an individual treatment plan, these activities also help youth divert excess physical energies into positive/ constructive activities, rather than negative emotional disturbance and/or behavioral acting out.

Clerical support:

Most facilities do not have clerical support that is essential to timely clinical communication, documentation, record-keeping, and monitoring. Without clerical support, clinical information frequently cannot be processed and shared with Team members as needed to provide appropriate program placement decisions and treatment response. Moreover, valuable clinical time necessary for provision of assessment and other mental health services for youth is otherwise 'wasted' on clerical tasks, unnecessarily increasing the risk of harm due to unmet clinical concerns. (This is not unlike the dentist situation where dentists

do “prep” and other work typically done by unavailable dental assistants/hygienists.)

STAFFING RATIOS[19]

As previously stated, in order to begin to determine clinical staff-to-youth ratios, the qualifications of social worker must first be clarified. Facility size, physical plant, and level of care as part of a defined continuum of mental health services are all relevant to these decisions. Adequate case finding is necessary to determine the extent of mental health need throughout ODYS in order to plan for and define a system of care. Notwithstanding these issues, it is clear that clinical staffing is inadequate.

Once the extent of mental health need is assessed, it is likely that ODYS will find that most youth have mental health needs that can be served in the general population given adequate resources and program support for the provision of clinic services. Adequate mental health clinical staffing is necessary in general facility populations where the majority of the youth with mental health needs reside. They require: ongoing monitoring, brief intervention, and/or continuing mental health services. This model also contributes to prevention by early identification and intervention before mental health deterioration and decompensation.

For the purpose of this draft, clinicians are defined as psychologists, licensed master’s level social workers, and psychiatric nurses.

GENERAL POPULATION CLINICAL STAFFING

Although there are no formally accepted national standards for clinical staffing ratios for the juvenile justice setting of which we are aware, staffing ratios will be offered here as general guidelines and a basis for settlement talks based on the professional experience and expertise of the team. Generally accepted clinical staffing for children and youth is

[19] The staffing ratios provided in this and the following sections are offered in the context of litigation leading, hopefully, to a settlement. They should be viewed as springboards to discussion and not fixed ratios to be “defended” by the Team.

double that of adults. Given the particularly serious, complex, and deep-rooted mental health issues evidenced in the female juvenile justice population, even richer ratios are justified. The literature demonstrates that the mental health needs for females are far more complex and extensive than their male counterparts, whose needs are also significant.

Staffing ratios should meet the need to provide an individualized treatment plan and needs for each youth, with prescribed interventions toward specified goals and youth outcomes and group sessions to address pervasive youth clinical needs (e.g., co-occurring substance abuse and mental health diagnoses). Overall facility population clinical caseloads are proposed at a ratio of 1 clinician to approximately 15 identified mentally ill girls (i.e., 1:15). This level of staffing would allow youth individual therapy up to twice a week, and still provide the opportunity to attend to the other clinical functions (e.g., suicide watch, discharge planning, etc), as well as time consuming ancillary functions. Clinical staffing levels for males in general population might be considered at 1 clinician to 20 (i.e., 1:20).

Adequate psychiatric resources are also necessary to provide medication monitoring and adjustment as dictated by ODYS policy and good practice, along with other traditional psychiatric services. Recognizing that Child and Adolescent psychiatrists are a scarce national resource and traditionally few and far between in juvenile justice settings, every effort should be made to attract and cultivate partnerships (e.g., through Child Psychiatry and Forensic fellowship programs) with individuals who have training and expertise in child and adolescent psychiatry. Dr. Burns, of course, echoes this call.

Psychiatric support is proposed at 1:60-80.

(INTENSIVE) MENTAL HEALTH UNIT STAFFING

The Mental Health Units must provide a level of staffing to ensure a safe and therapeutic environment. Clinical staffing patterns for each IMHU include a minimum of two (2) and preferably three (3) full time

equivalent (FTE) mental health clinicians and a Treatment Team Leader. The goal is to establish a multi-disciplinary treatment team, with a Treatment Team Leader and the remaining FTE's selected from the titles of Psychologist, Licensed Master's level Social Worker and Psychiatric Nurse. A minimum of 0.2 FTE (preferably 0.5 FTE) Psychiatrist is necessary for the IMHU (plus an additional minimum of 0.3 FTE, preferably 0.5 FTE Psychiatrist for identified mentally ill youth in the facility general population.

NON-INTENSIVE MENTAL HEALTH UNIT STAFFING

In order to determine appropriate levels of staffing and number of non-intensive mental health units needed, programs must be defined as components of a continuum of mental health care.[20] Other relevant factors are discussed at the beginning of this section. If ODYS determines that a number of NIMHUs are necessary then perhaps additional classification considerations (e.g. age) could be added. Depending on program definition (see Section K), the population for a step-down or intermediate care program should not exceed 20 and should be staffed similarly to the IMHU given that the number of beds would be nearly double. If located proximate to the NIMHU, the Treatment Team Leader as well as the specialized support staff (e.g., OT, RT) could be shared. Additional psychiatric services (~ 0.2 FTE) would be necessary.

E. SUFFICIENCY OF ANCILLARY STAFF

Without a safe environment, effective treatment, programming, and/or learning cannot take place. Treatment and security go hand in hand, each required for the effectiveness of the other. All personnel must operate with the expectation and understanding that they are, in effect, part of a Treatment Team, in which they function to support the treatment/ rehabilitative goals.

[20] The term "Intermediate Care Units" as preferable to Non-Intensive Mental Health Units. Non-Intensive is inaccurate since seriously ill youth could be on this unit, requiring more enhanced care than available in the general population.

Currently JCOs function almost exclusively as custodial staff. The addition of mid-level managers (i.e., Unit Managers) has provided some ameliorating this security predilection; however, administration must support the UM's important functions by minimizing their needs to be pulled from their units for a variety of purposes.

Juvenile Correctional Officers (JCOs) ultimately should be integrated into the treatment team. Behavioral issues should be addressed by JCOs within the structure of an effective behavioral management system, with an individual plan as indicated. The Ohio JCO job description, now ignored, specifically includes implementing treatment services for mental health, sex offender, and chemical dependency programs.

F. TRAINING, SUPERVISION AND DISCIPLINE OF CLINICIANS

SUPERVISION

Filling all Program Deputy and Psychology positions is essential in order for there to be appropriate facility clinical leadership presence, clinical support and supervision. A number of these positions have been vacant which drains scarce clinical resources to cover supervisory functions and more importantly further dis-empowers the clinical program, particularly when combined with an absence of mental health leadership and supervision in Central Office (e.g., Circleville CJF)

TRAINING

Mental health in-service for clinicians as well as for all levels of staff is inadequate, thereby compromising their ability to respond as effectively to the serious mental health needs that the ODYS population present.

In-service opportunities must provide consistent messages, tied to clear expectations, including but not limited to newly articulated policies and protocols. For training to be effective, credible, and productive, it must be clearly coordinated, planned, and delivered.

Clinical staff need system-wide consistent clinical enhancement training (e.g., DBT, treatment planning, etc.). Currently clinical staff are able to pursue additional clinical training of their own initiative and choosing, and to then be reimbursed by ODYS. While this opportunity can provide a positive supplement, the mental health administration must develop its own core clinical curriculum in order for all clinical staff to have requisite training and skills that are expected and supported by the agency.

G. ADEQUACY OF MENTAL HEALTH RECORDS

Staff need to develop specific individual treatment plans and goals, and assess progress toward these goals. Plans need to include interventions that are strength-based, work toward specific individualized goals, and include families whenever possible in treatment planning and delivery. Current ODYS treatment planning is generally inadequate. Progress notes are not in standardized (SOAP) format. *Without an integrated treatment plan, a coordinated and purposeful treatment response does not exist. The separate systems of clinical record-keeping are an obstacle to integrated and effective planning and treatment. In general administration and staff do not seem to be clear on what a treatment plan is and particularly a coordinated treatment plan.*

There is no single unified mental health clinical treatment plan where the youth participates in setting goals with steps to get there, and where progress is measured and documented. There needs to be one team that sets a normative culture and speaks a common language that addresses the treatment of all aspects of the youth's behavioral and emotional health and well-being. There needs to be a 'holistic' approach, so that there are consistent goals for the individual youth and so that staff of the various disciplines function as a team and provide informed and consistent direction and support for successful youth treatment outcomes. Treatment and security are being compromised by the current inadequacies.

Also noted consistently in all reports since 2004, ODYS has not established *an integrated* clinical hierarchy, treatment plan, or documentation system. Psychology is not a component of a multidisciplinary treatment team in the commonly accepted sense. The record keeping is a nightmare, even with the new database. It is not in a standard medical record format. There are at least four separate records [i.e., psychology, social work (Unified Case Record/general file), school, and medical record]. There is no single mental health clinical treatment plan. There is a psychological file and a psychology database, not a mental health file. The Special Management Plan is not part of the database. The Clinical Team Meeting notes are not kept in the file. It is extremely difficult to find necessary clinical information with the beginning of a database and paper files in multiple locations. The paper files are not ordered consistently, and the records could benefit from tabs. The Circleville clinical program is further limited by the absence of a centralized file system, and psychology's inability to access each other's files without a cumbersome time-consuming process. This fragmented means of documentation and communication impedes integrated treatment planning and necessary sharing of information for continuity of care.

There are a number of meetings where youth on the mental health caseload are discussed, but they are neither consistently held nor documented throughout the facilities. Psychiatry Team Meetings are intended to include psychiatry and psychology; Clinical Team Meetings to include psychology, social work and unit manager; and Interdisciplinary Team (IDT) meeting which is scheduled once per week and includes social work, psychology, UM, JCO, with until recently, the occasionally participating education, recreation, and/or health personnel. The IDT seems to be the best documented meeting; however, suffers from lack of psychiatric participation, limited opportunity/ time to discuss each youth, what staff expressed as a major focus on behavioral/ custodial concerns, and limited capacity for psychology's direct participation given multiple

simultaneous meetings and one/few psychology staff. This limits integrated treatment planning with the risks and liabilities of failing to communicate and address treatment needs.

Effective treatment of youth does not and cannot occur until there is integrated treatment planning, communication and documentation.

H. CRISIS MANAGEMENT AND SUICIDE WATCH POLICIES AND PROCEDURES

As discussed in the 2004 report regarding Scioto, youth were using the threat of suicide as a means of gaining attention or the opportunity to speak with psychologists. The relatively few psychologists spent most of their time responding to crises. Obviously suicide threats and the need to perform risk assessments further limits psychology time and ability to provide other treatment aside from crisis intervention, and reinforces such attention-seeking behavior.

While it can be difficult in many cases immediately to distinguish definitively between a suicide gesture and attempt, youth remain on suicide watch for questionably long periods of time, at Scioto, up to 30 days or more. Extended suicide watch beyond several days is rarely, if ever, clinically warranted. Extended use of watch is generally indicative of the need for youth to be receiving 1) more adequate assessment, 2) therapy and/or 3) hospital level care.

There are youth who seek suicide status as a means of gaining safety from perceived or actual threats in population. Clinicians at ORV (Psychologists and Social Workers) note the increase in manipulated use of suicide watch to escape potentially threatening situations during the past seven to eight months. The number of suicide watch and behavior status also hit an all time high over the first seven months of 2007 increasing from 11 to 29 on suicide watch, 4 to 6 on observations, and 11 to 27 on behavior status.

Psychology indicates that they have seen a dramatic increase in youth who report being scared of peer violence, who are not on the mental

health caseload, but who are manipulating suicide watch, once again, in pursuit of a safe haven. Now precautionary status is not just for the psychiatrically vulnerable but is a result of a highly stressful environment for youth, and certainly for staff as well.

CRISIS MANAGEMENT

Safety Plan – According to the revised 2006 SOP concerning Youth Disciplinary Procedures, a Safety Plan is a special management plan written to specifically manage assaultive and/ or threatening behavior(s).

Special Management Plan (SMP) is a procedure designed to decrease severe and/or chronic problem youth behavior(s).

The 2002 Special Management Plans Standard Operating Procedures (SOP) 305.01.01 requires that SMPs are to be signed 'by the Psychology Supervisor (at institutions where there is one), Deputy Superintendent of Programs and Superintendent or designee.' If an SMP is developed for a youth on the mental health caseload or being followed by psychology, the plan must be signed by a psychologist. SMPs requiring the use of seclusion…will be reviewed on at least a weekly basis. As the Psychology Supervisor position was vacant at Scioto, for example, non-clinical staff provided signoff.

Mohican and Indian River JCF were more effective in having psychology sign-off on an SMP for a youth on the mental health caseload or followed by Psychology. Both the Psychologist and the facility Program Deputy Mohican agreed that the Psychologist can refuse to sign a youth's SMP and this will be supported by the Program Deputy. In discussions with these staff, they recalled specific cases.

The Psychologist notes that the goal is to keep youth out of seclusion and the SMPs are intended to help youth learn how to do so. The Psychologist *and* Social Work Supervisor are first to review the plans at Indian River and this way can reject them if they are clinically unsound.

However, even with their good intentions, with all the youth on their caseloads, and so many SMPs, some plans may ‘fall between the cracks.”

As discussed further below in Section M., these plans for the most part are not individualized, strength-based, tied to treatment goals, nor providing adequate incentives. Plans routinely include what we believe is constitutionally excessive use of seclusion and frequently do not involve clinical signoff in non-mental health units.

I. USE OF MECHANICAL RESTRAINTS ON MENTALLY ILL WARDS

The Standard Operating Procedure (SOP) for Mechanical Restraints 301.05.02 requires that ‘Mental Health staff shall conduct an initial assessment of the youth upon notification of mental health or psychiatric concerns or when youth are restrained beyond 4 hours. JCOs must report any health or mental health concerns immediately to nursing staff and/or mental health staff and the Unit Administrator/Operations Manager.

In the event that restraints may be necessary to prevent self-injury, a more restrictive separate SOP 301.05.04, Mechanical Restraints Used for Psychiatric Purposes applies. Both of SOPs are relatively new and issued in 2006. The SOP for psychiatric purposes to prevent *self-harm* requires that mechanical restraints ‘shall only be applied with the approval of the Superintendent and institutional Psychologist, Psychiatrist or Physician.’ The use of mechanical restraints for these purposes is fairly well defined to include procedural requirements for a suicide risk assessment, less restrictive interventions (but other forms of restraint nonetheless), along with a plan which limits their use to an hour, with constant visual monitoring including interaction, etc. JCOs who monitor the youth are required to report any health or mental health concerns immediately to nursing, and/or mental health staff and the Unit Administrator/ Operations Manager.

J. ADEQUACY OF MENTAL HEALTH CARE FACILITIES/ PHYSICAL PLANT

MENTAL HEALTH UNITS

The Circleville NIMHU is the only ODYS mental health unit with two tiers, having 12 rooms upstairs, and 12 down. The tiers are open, and also have vertical rail bars. Youth who are doing best have beds upstairs. This physical plant design poses an unacceptably high suicide risk, especially for youth with more serious mental health disabilities who are already at higher risk of self harm and suicide as evidenced by their placement and retention on the NIMHU. The physical plant is ripe for diving into the floor below, surely resulting in serious injury and/or death, and/or hanging from the rungs on the rails, which provide no meaningful protection from jumping, diving, or hanging. There are relatively easy physical changes that should be made as suicide prevention measures.[21]

RUBBER ROOMS

The condition of the two rubber rooms at Indian River is disgraceful, and again seriously limits the ability to provide necessary protection for youth who require this room to prevent self-harm as a result of their mental illness. The rubber rooms actually are not seclusion rooms but safety rooms.

Other youth outside the NIMHU are brought onto the NIMHU, mostly at night, when they cannot be managed elsewhere in the facility for their behaviors. For these facility youth, Psychology does not decide on entry and release from these rubber rooms. According to staff and youth reports, these youth disrupt the Unit with their loud noise, preventing them from sleeping, and intensifying their emotional distress.

Non-NIMHU youth have trashed the rubber rooms. There is graffiti carved into the walls, floors, and ceiling, including with pen. One rubber room has at least a 10-inch circle where the rubber is ripped out of

[21] For example, encase the railings so there are no spaces and no ability to leap over the second floor railing and remove/repair loose and broken floor tiles, which can pose a potential risk for being used for cutting self or used as a weapon.

the door, exposing wood and leaving the loose door rubber exposed, posing hazards for health and safety by ingestion and head banging. The second Indian River rubber room is also covered in graffiti and ripped up by youth in cuffs severely misbehaving from the E Unit. The damage to the door of the second rubber room is even greater than the first. Neither of these rooms may now be used for mental health purposes as intended. One youth on the NIMHU caseload routinely bangs his head on the wall, but the rubber rooms cannot be used to protect him.

No youth from outside the NIMHU should be brought onto the Unit. While there is a need for certainly of protective, simple room housing there must be a more appropriate place designed to house victim-prone and victims of violence.

The rubber room at Marion Intensive Mental Health Unit also continues to be unavailable because a youth bit a hole in the wall. That room is unavailable for use by the youth who have 'intensive' mental health needs and are at the highest risk of harming themselves or others.

The very term "rubber room," with its disgraceful, mental hospital implications, and then the room itself and questionable usage calls for an urgent change in policy and procedure for youth who require brief periods of time in a safe place to sleep.

SUICIDE WATCH ROOMS

At ORV (McGuffey), what distinguishes Suicide Watch rooms from other unit cells is that there are no shelves and that they have two as opposed to one window for observation. The metal beds provide unacceptably high risk factors for suicide and/ or harm to self or others.

Although Intake is not in a mental health unit, youth at intake are among those at highest risk of suicide. The wet room at Indian River's Intake Unit is also used for suicide watch. Everything is in view except the shower, which has handicap bars and can be observed only through a small window slot in the outer hallway. This is a high risk area. [Another

major risk in using this room for suicide watch is the metal bed with legs, which should be replaced with a safety bed.]

LACK OF DEDICATED CLINICAL SPACE

The impact of the systemic lack of dedicated physical space for clinical services is most blatantly exemplified at Indian River. In order to provide necessary *access* to Psychiatric treatment, Psychiatry needs a dedicated clinically appropriate space to meet with youth on their caseload. The time psychiatrists and social workers spend looking for a clinically appropriate space, locating and transporting youth, and finding ancillary clinical information obviously diminishes the limited psychiatric time available for providing necessary and timely treatment and monitoring of youth.

Mental health care, at all facilities, requires a dedicated clinically appropriate space, assigned JCO transport of youth to and from their appointments, and necessary integration (including space proximate to clinical staff) between the disciplines for sharing of critical clinical information. All of these improvements would enhance fiscal efficiency and professional time needed for provision of treatment.

MENTAL HEALTH UNIT FURNISHINGS

Beds

There are five of double bunk beds on the NIMHU at ORV. Although they are kept vacant, bunk beds provide an opportunity for youth to dive into the floor from the top bunk. The upper bed, even if unoccupied provides an unacceptable suicide risk for this population. They also provide the capacity for double-bunking which contributes to the level of aggression where they exist. Clinical staff on the NIMHU noted that some of the emotional and behavioral improvement of youth on their unit can be attributed simply to the single bunking.

Safety furniture

Safety furniture is a commonly accepted standard for mental health populations. Metal bunk beds are unacceptable on a mental health unit

(e.g., Circleville NIMHU) as they pose safety risks for their potential for affixing a ligature and their sharp edges. Units should also have sand chairs or some form of heavier chairs (such as Moduform) rather than the standard lighter chairs (e.g., Circleville NIMHU) so they cannot be thrown.

NIMHU Ceiling Grate

The Circleville bathroom ceiling has open grates which can provide unnecessary suicide risk as a ligature can be suspended or affixed to the grates.

Door Stop, Door Handles, Sink Fixtures

Even the rather simply remedied physical plant recommendations from the Team's first site were not addressed at the update visit to the Marion Intensive Mental Health Unit. The door stop behind the conference room door was not removed as recommended, presenting a continuing suicide risk for a population with intensive mental health disabilities.

The other recommended repairs also remained unaddressed. This includes the door handles and sinks that need to be replaced with more suitable fixtures for this population. The door handles pose suicide risks and do not meet the commonly accepted standard for this population. The sink fixtures are easily disassembled and can be used as devices to cut self or others. The IMHU has already experienced this problem a number of times but rather than replace the sinks has continued to simply repair the same sink fixtures.

[Information received after these issues were raised strongly suggest that ODYS is being responsive to the physical plant problems identified at Marion.]

Lack of Adequate Cameras

Throughout the system greater video camera coverage is needed. Staff and youth claim peer and staff abuse in areas where there is inadequate camera coverage (e.g., ORV sallyports). Indian River NIMHU

is developing a comfort room that is being planned near the end of a lengthy hallway of cells. Cameras should be installed to enhance necessary monitoring and to avoid the risks of self-harm and other potential abuse in the use of this fairly isolated room. Additionally, there needs to be a clearly articulated program with policies and procedures for utilizing the comfort room.

K. ADEQUACY OF MENTAL HEALTH PROGRAMS (INCLUDING NUMBER OF PROGRAMMING BEDS)

PSYCHIATRIC INPATIENT CAPACITY

A capacity for psychiatric inpatient hospitalization is a critical component of a mental health continuum of care that currently is lacking in ODYS. A mental health unit does not and cannot provide hospital level care. It is totally unacceptable, legally and as a matter of policy, that there is no identifiable means to access psychiatric inpatient care for youth under age 18.

OTHER MENTAL HEALTH PROGRAM COMPONENTS

This section will more specifically discuss the lack of an ODYS continuum of mental health care. Access to and the extent to which program beds need to be developed has been discussed. The adequacy of program beds is a moot point when the units have no clear purpose or definition. There are no formal admission, retention and/or discharge criteria or policies and procedures for these program components/ units.

The mental health programming on the mental health units is largely indistinguishable from that on the other units. The unit staff have little-to-no additional mental health training, and additional treatment protocols have not been clearly defined. As has been noted, an integrated treatment team needs to be developed, with the JCOs included as integral members of the team in order to provide a coordinated and consistent treatment response.

[End Smith Report]

Certainly, any reader who has come this far will conclude that there simply is no mental health program worthy of the name now functioning within ODYS. There are certainly a series of ad hoc arrangements for care; there certainly are some dedicated providers of care who struggle daily to help, but minimal constitutional obligations are not being met and, sadly, this was the theme of the November 2004 Report.

We constantly hear a series of “we can’t,” “we tried,” “we didn’t know,” and “we’ll do better.” This reminds me of a term I heard used by Federal District Court Judge Thelton Henderson in describing the dysfunctional California Department of Corrections as staffed by persons with “trained incapacity.”

At this point, however, an absence of funds or the difficulty of recruitment may serve as explanations but not as valid excuses for not having an acceptable mental health program.

The remainder of Dr. Smith’s full Report discusses continuum of care issues in the form of units designed for intensive care and intermediate care and the need for programs and services in the various restricted housing units. Those areas of discussion and her concluding sections may be consulted but are not offered as findings by this writer.

It is of the highest priority that ODYS cease and desist from the extended terms of de facto punitive isolation practices while adopting measures to assure the safety of youth and staff. This will require staff enrichment, design modifications, new policy & procedures, and close oversight. Beyond this troublesome area, DYS officials should avoid the ad hoc responses to mental health care crisis — crisis that emerged because they were observed, not sudden events — and develop, staff, and implement an overall, comprehensive plan for a continuum of care.

ADDENDUM [22]

Section IV, Mental Health Care

Initiatives in place to address Treatment:

NATIONAL GRANT FOR MENTAL HEALTH

- Ohio has been selected as one of four states to participate in the MacArthur Foundation Models for Change Mental Health / Juvenile Justice Action Network Grant. This initiative focuses on system reform in mental health and substance abuse services for youth involved in the juvenile justice system, including DYS. It will assist Ohio's juvenile justice system in developing and implementing improved policies and practices based on the best available research and techniques for mental health and substance abuse services.

TRAUMA INFORMED CARE

- Because of the amount of trauma that ODYS youth have experienced, ODYS is working to equip staff with more effective ways of working with a highly traumatized population. There is a Childhood Trauma Task group assembled to develop staff training on the prevalence and impact of trauma and provide strategies for assisting these youth to cope and point out how "traditional" correctional practices have the potential to be re-traumatizing.

- Training on Trauma Informed Care has begun and ODYS senior staff, psychology staff, social work supervisors and mental health unit staff will be included in the training as well as unit staff. As of December 2007, Dr. Marrow has trained well over 100 staff assigned to mental health units using the 6-hour trauma informed care curriculum.

- Trauma related programming has begun for the female population utilizing nationally recognized clinician Stephanie Covington's work, with additional programming being developed for the females and males to assist them in managing their own trauma.

- ODYS, in collaboration with the Ohio Department of Mental Health, is funding the implementation of the curriculum *Trauma Affect Regulation: Guide to Education and Treatment (TARGET)* through a contract with Advanced Trauma Solutions. The curriculum was selected by the Trauma Steering Committee and is a promising practice developed by nationally known expert, Dr. Julian Ford. Intensive training for mental health units began in September 2007 and will continue in January 2008.

[22] Submitted by ODYS to Fred Cohen on December 21, 2007. Fred Cohen excised some of this submission and slightly edited other parts.

MENTAL HEALTH SERVICES

- Capital funds in the amunt of $2.85 million were secured for the FY07-08 biennium with the anticipation of building or restructuring the mental health units.

- The programming, environment, and staffing are being modified on the male and female mental health units. The new curriculum addresses the specific mental health needs of the population by focusing on stabilization, emotion regulation and the development of coping skills. This program integrates different phases with a richly staffed unit, sensory programs and therapeutic atmosphere. The last phase will focus on preparing the youth to return to a lower level of care or for release.

- ODYS is working with A.R. Phoenix Resources Inc., Dr. Alton to select a group of flexible curriculum to use with our youth in order to better meet their individual needs. The curriculum will be administered on a dosage basis which means that we can create program tracks that would benefit youth of all risk levels, lengths of stay and need. We anticipate training on the new curriculum to begin in 2008.

- An intensive adolescent recovery substance abuse program has begun for female youth at Scioto Juvenile Correctional Facility.

- In 2005 the OSU contract for psychiatry was expanded to include all of ODYS' central Ohio facilities.

- Contract negotiations with OSU to formalize the process for inpatient psychiatric services has led to a contract, which is anticipated to go into effect January 15, 2008. Our team did not review this contract.

- A psychology position has been added to Scioto, specifically to assist with the mental health unit.

- All psychology assistants are masters trained clinicians.

POLICIES AND PROCEDURE

- Beginning in October 2005, following extensive discussion with the union, requirements for clinical positions have been enhanced. Since 2005, the number of licensed social workers has nearly doubled from 26 to 50.

- Policy has been developed to address restraint use on the mentally ill population and staff are now being trained on restraint techniques from the National Technical Assistant Center (NTAC). All training officers have been trained on the new techniques by a nurse administrator.

- A mental health database is being created to monitor and share information.

AESTHETICS IN THE UNITS

- Comfort rooms are being designed for use by youth on mental health units. These rooms, or designated areas, will provide some degree of privacy and quiet where youth can explore the use of many sensory items to assist them in managing stress and developing coping strategies. The rooms are to be painted in serene tones and stocked with items that engage the senses such as video rockers, weighted blankets, stress balls, bean bags, and music which can be used by the youth while in the room.

- General population units are also to be changed and to become less punitive and more normalized by including couches, rugs, richer colors and plant life.

- Approximately 150 leisure reading books (i.e. Harry Potter and Chicken Soup for Kids) are now available in nearly every housing unit in each DYS institution.

EFFORTS IN RECRUITMENT

- Given the difficulty of all state agencies to recruit psychologist and even greater difficulty in finding adolescent and child trained psychologists ODYS is enhancing its effort in the hiring and recruitment of mental health professionals to include the following:

    - ODYS participated in the Child and Adolescent Psychiatry Services Task force to review and determine creative ways of dealing with the issue of a significant deficit locally and nationally of child and adolescent psychiatrists
    - Partnered with the Ohio Psychological Association to assist in recruiting psychologists
    - Expansion of the psychiatry contract for OSU.
    - Development and continuation of a social work internship program with The Ohio State University School of Social Work
    - Development of an Internship/Postdoctoral program with Marshall University at ORVJCF
    - Another postdoctoral program is planned with Wright State University School of Professional Psychology for the Central Ohio Facilities
    - A new bureau chief with background in residential mental health was hired in December 2007.
    - A psychiatrist has been identified for ORVJCF and will begin providing 20 to 40 hours per week in January 2008
    - ODYS has created one SW 3 position for each IMHU that requires a master's level social worker with a license (LISW) or Professional Clinical Counselor (PCC)

V. PROGRAMMING FOR JUVENILE SEX OFFENDERS

The vast majority of juvenile sex offenders (97%) that are processed through reception at Scioto have been adjudicated on a sexual offense. These youth represent about one-fifth (21%) of all the youth in the custody of DYS.

At the time of expert Dr. Robert Prentky's visits to Ohio (Sept. 21, 22, and 23) that amounted to some 384 youth designated as sex offenders in the system with 139 of them assigned as "High Needs," 70 as "Moderate Needs," and 30 as "Low Needs." Of the total of 384 juveniles designated as sex offenders, there were 145 youth still in the custody of DYS but not in any sex offender programming.

Of the 239 remaining in sex offender programming, 58% were classified as High Needs. Although bed space is a placement issue, staff asserted that bed availability is not an issue with respect to need classification. Assessment staff stated to Dr. Prentky, "We don't even know what beds are available. We see the worst of the worst, so the fact that 60% are High Needs is no surprise."

Before proceeding to an account of the expert review on our behalf by Dr. Prentky, a few cautionary words by this writer are in order. First, and perhaps foremost, the terms "sex offender," "sexual psychopath," "sexual predator, " and "sexually dangerous" are not clinically valid terms.[23] This means, in part, that there is no constitutional right to treatment based on the disease model that underpins the Eighth Amendment's or Fourteenth Amendment's right to treatment.

The normative terms listed above do not tell us anything about treatment needs, they do not allow us to distinguish offenders based on the nature of the offense, and they say virtually nothing about risk. The unitary terms such as sex offender or sex psychopath tells us much more about the purveyor than the offender. Their use reflects a normative stance that juveniles (and adults) who engage in criminally forbidden, sexually related conduct should be singled out for special attention, perhaps for special programming, and for post-adjudication or post-conviction registration that may last a lifetime.

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[23] See Fred Cohen, Right to Treatment in the Sex Offender: Corrections, Treatment, and Legal Practice 24-1, 24-3 (Barbara K. Schwartz & Henry R. Cellini, ed's., 1995)(Hereafter, Cohen, "Treatment.")

A moral judgment about the nature of an offense or the offender is distinct from a reasonable basis for treatment and a reasoned fear of recidivism. Franklin E. Zimring in An American Travesty: Legal Responses to Adolescent Sexual Offending 67 (2004) writes:

> The 15000 children and adolescents under eighteen years of age arrested for sex crimes each year are a heterogeneous group in terms of their offense severity, their risk of future sexual misconduct, and their degree of psychological pathology. The great majority of youthful sex offenders are unlikely to re-offend, and are not suffering from extensive clinical disabilities. But the few thousand juveniles who are arrested, in contrast to the millions who commit sex crimes, are often involved in behavior that harms people, usually children and adolescents. The palpable harm caused by many juvenile sex offenders requires an official response. The low risk of future sexual misconduct and the low likelihood of serious sexual pathology argue against life-altering interventions and permanent classification in stigmatic categories as routine responses to adolescent sexual misconduct.

The legal issue within this litigation is not a demand for treatment based on sex offender designation. Ohio law and policy, offering mandated treatment or programming is well within the boundaries of legal acceptability but is at the perimeter — and beyond — on the effective use of treatment resources.

We may presume that some juvenile sex offenders have a legitimate, diagnosable mental illness — Professor Zimring estimates that fewer than 10% of U.S. juveniles arrested show any sign of paraphilia[24] — and that group, of course, should be treated. Using Professor Zimring's estimate, for Ohio it may men that some 350 youth received either inappropriate or unneeded treatment or programming.

As for dangerousness or the risk of recidivism, it should be noted that we do not know what proportion of the population of chronic sex offenders have juvenile sex offender records. The few studies on point are not conclusive. Variables that predict

[24] Franklin E. Zimring, An American Travesty: Legal Responses to Adolescent Sexual Offending 64 (2004)

high recidivism in adult male offenders, youth and being unmarried, of course, do not work with a population that is all young and single.

Caldwell's analysis of ten studies on point produced no consistent pattern.[25] Only a few studies even try to identify factors that distinguish juvenile reoffenders from those who do not and the few studies published have conflicting results.

Dr. Robert Prentky, a nationally renowned figure in the field, was retained to assess the Ohio DYS sex offender assessment and treatment program simply because of the emphasis given to it and the resources expended for such care. I adhere to my earlier cautions about the false premises of current policy regarding both the need for treatment and the supposed distinctive threat posed by juvenile sexual misconduct.

At the same time, I reaffirm the desirability of evaluating the Ohio program *on its own* terms and to that end Dr. Prentky is to be commended for he report he prepared for this investigation.

Assessment

Dr. Prentky is one of the developers of the assessment protocol used in Ohio to assign sex offender "Needs" assessments. In his Report to me of October 15, 2007, Dr. Prentky writes:

> Although it was never clear to me precisely how Need classifications are made, the decision appears to hinge on the Juvenile-Sex Offender Assessment Protocol (J-SOAP), a risk assessment instrument development by Prentky & Righthand (2003) for male sex offenders in age range of 12 to 18. Several "J-SOAP social workers," trained by Dr. Righthand, complete the J-SOAP while the youth are at Scioto. Although the J-SOAP assesses risk, it has no cut-off scores for degree of risk. Since Dr. Righthand, in her trainings, is typically adamant that ranges (i.e., Hi, Mod., or Low) not be invented by users and that the J-SOAP should be thought of as a "needs assessment" as much as a risk assessment, it appears that the staff have avoided the use of the word "risk" in favor of "needs."

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[25] M.F. Caldwell, What We Do Not Know About Juvenile Sexual Reoffense Risk, 7 Child Maltreatment 291-302 (2002), we do know that sex offender recidivism is low in the teen years.

I requested and received a copy of a J-SOAP-II Report. The first 3 pages of the 4-page report include the Reason for Referral, Presenting Problem, Sources of Information, Family History, Prior Criminal History, Sexual History, Social History, and Impression and Recommendations. On page 4, at the end of Impressions and Recommendations, the J-SOAP scores are listed, followed by Program Recommendations: High Needs. In the final paragraph, entitled Summarize Criteria for Program Recommendations, it is stated that, "John is appropriate for High Needs Sex Offender Programming for the following reasons: 1. Time frame of sexual offending was more than 6 months, 2. Poor management of Sexual Urges, 3. Multiple types and acts of delinquent behavior, 4. Poor socialization skills, and 5. Poor management of anger." In-other-words, there is no reference to the J-SOAP in justifying classification of High Needs. Rather, there are five factors that are listed to explain the classification. This three-tier system of classification is needlessly confusing, since the use of terms like "High, Moderate, & Low" clearly impart the notion of risk, whether the word Needs is substituted or not. Confusion arises from the fact that there is no clear "line in the sand" marking the boundaries of the three groups, or the precise procedure for placing kids into each of the groups. The J-SOAP-II, a risk assessment scale, is integral to the intake process, but it is unclear *how* the results are utilized. When directly asked what a High Needs youth "looks like" compared to a Low Needs youth, I was told that High Needs kids have (a) 3 or more victims, (b) duration of offending that lasts 12 months or longer, (c) preoccupation with deviant sexual themes, (d) a history of having been sexually or physically abused, and (e) excessive aggression. By contrast, a Low Needs youth would have the following profile: (a) only 1 victim, (b) no weapon used, (c) 3 or less incidents, (d) duration of offending that lasts less than 6 months, (e) J-SOAP scale 1-3 scores, (f) level of aggression (instrumental v. gratuitous) and (g) clinical decision. If there is a structured, uniformly-applied, operational procedure for rendering classifications, this appears to be it.

Ultimately, it appears that classification to High, Moderate, or Low groups is what might be called *research informed clinical judgment.* All of the items listed above appear on the J-SOAP. Thus, it appears that a clinical decision was made to select a few of them for determining classification. It is not clear how, if at all, the J-SOAP scale scores are factored into these decisions. Although the hand full of items listed above *can* be used for this screening purpose, their use can *not* be left to individualized judgment. In- other-words, all of these items would require precise operationalization (i.e., how do we determine *"excessive" aggression* or *"level" of aggression* or "*preoccupation with deviant sexual themes*"?). Staff raised a "regional" problem. Youth from Cleveland arrive with a risk assessment already having been done and all are "high risk." By contrast, youth from other parts of the State arrive with no risk assessment.

Dr. Prentky's concerns in other words, are with the selective and individualized use of J-SOAP classification factors as a means to assign need (or risk). He obviously does not challenge the validity of the instrument itself, only its haphazard use. Some might challenge the instrument's utility for risk assessment itself and argue for clinical assessment of a diagnosable mental illness with the youth's crime or crimes an important factor in such diagnosis.

Dr. Prentky goes on to recommend change here:

Recommendation: Many of these classification problems can be shed by using a system that is transparent, simple, workable, and that places a minimal burden on risk assessment. A simple breakdown would separate these youth into: A. Standard Programming, B. Special Needs (i.e., those presently housed in Ash at Circleville, and C. Low Risk. This eliminates the *most* difficult, and arguably indefensible, distinction between "High" and "Moderate" risk offenders. They would all be provided Standard Programming. The only distinctions that would have to made, and for which *explicit criteria would be required*, would be assignments to either a Special Needs unit (i.e., those kids with severe developmental, social or cognitive deficits or a major psychiatric disorder) or to a Low Risk

placement (e.g., those kids with a single, isolated offense and an otherwise benign history). This type of categorization does not avoid entirely the issue of risk. It addresses risk in a way that is both *programmatically meaningful* (separating out those kids that do not need and are unlikely to benefit from intensive sex offender specific treatment) and *psychometrically reliable* (i.e., classifying the lowest risk kids is something that we can do reliably).

What follows are verbatim excerpts from Dr. Prentky's report to me with particular emphasis on Circleville, which is the focal point of Ohio DYS's sex offender program.

Assessment Protocol at Scioto

The social work staff complete the J-SOAP and Hoge & Andrews' Youth Level of Service / Case Management Inventory. Data for completion of these two tests come from the records and an interview. These results are used to inform treatment planning. In addition, a PREA scale is used to screen out youth that may be particularly vulnerable to sexual assault within the population. This scale is a product from research spawned by the 2003 Federal Prison Rape Elimination Act. A substance abuse screening is done using the JASAE (Juvenile Automated Substance Abuse Evaluation), a computer-assisted evaluation developed by Bryan Ellis. In addition, the Massachusetts Youth Screening Instrument (MAYSI), developed by Grisso and Barnum, is completed.

Recommendations: The existing protocol is fine. I would complement it, however, with a number of additional structured questionnaires that elicit feedback around targets areas of great concern: (a) a detailed abuse / maltreatment history that asks not simply about the presence of a history of sexual abuse (as one example) but about all morbidity factors associated with the abuse, including a complete chronology of caregivers, (b) Briere's Trauma Symptom Checklist for Children / Trauma Symptom Inventory – depending on the age of the youth; evaluating current signs and symptoms associated with abuse-related trauma is critical for

informed decisions about treatment, (c) a comprehensive, structured sexual history inventory, (d) one of several good questionnaires that have been developed for adolescents to assess the experience, intensity, and control / management of angry feelings, and (e) neuropsychological screening that briefly assesses neurocognitive deficits, including functional reading ability and comprehension. All of these areas of assessment are essential for developing an informed, tailored plan that treats all facets of a youngster's functioning.

Availability of resources must be addressed. I heard the issue of resources raised many times by staff. Ms. Williams, social work supervisor for males at Scioto, observed that the number of youth arriving at Scioto has tripled, from an average of 2-3/month to a current average of 10 / month. This past July, the intake was 16. Another staff member commented that, "As you draw up the census, you must draw up the resources. This has not happened." Adding the above suggested testing places the greatest time demand on the youth themselves, with the obvious exception of neurocognitive testing. I would estimate an additional 3 hours of time for each youngster, plus an additional 1-2 hours for a supervised, MA-level psychologist. Realistically, the additional required resources would be another MA-level psychologist who is capable of administering and interpreting neurocognitive tests for adolescents, and the purchase fees for the tests themselves.

Circleville Visit

As noted, I spent two full days at the Circleville Juvenile Correctional Facility. I met with Thomas Teague (Superintendent), Rose Harmon (Executive Assistant to the Superintendent), Larry Alessio (Deputy Superintendent and Director of Security), "Doc" Blackburn (Deputy Superintendent for Finance), Linda Gable (Sex Offender Coordinator), Trecia Holdren (Social Work Supervisor), and Dr. Barbara Scott Johnson. I also met privately with several groups of youngsters representing both the middle age (14-16) and older (17-19) kids, and separately with their

unit therapists. In addition, I met with a range of line therapists and clinicians (e.g., Mr. Smith, Dr. Lagregory, Ms. Brisbine, Dr. Garbrecht). Although the census ranges from 144 to 156, at the time I was there, the census was "down" (133). There are six housing units with 24 beds on each unit, except for Ash, which has 20 beds. There are two housing units per building: Ash + Elm; Oak + Walnut; Hickory + Maple. The first two buildings (Ash & Elm and Oak & Walnut) have three social workers each and Hickory & Maple has four social workers. Hence, the resident to therapist ratio ranges from 12:1 on Hickory & Maple to 16:1 on Oak & Walnut. In addition to the ten social workers assigned to the units, there are four psychologists (two doctoral-level and two Masters-level) who provide "roving" services, as requested, to the residents at large. Psychiatric services are contracted out to Ohio State University.

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Programming

The program at Circleville has three phases. Each phase is described in a detailed 3-ring binder of information that was made available to me. The phases, simply stated, are 1. Informational, 2. Offense/Cycle, & 3. Relapse Prevention Plan. Advancing from one phase to another involves a post-test as well as appearance before a transition panel. The passing score on the test to move to the next phase is 70-75%. Phase III takes, on average 4-6 months to complete, though some motivated kids can complete it in 3-4 months. The entire program is designed to be completed in 12-18 months, though youngsters, if sufficiently motivated, can complete the program in 12 months.   Ordinarily, movement through the various levels of a program, from point of entry to pre-release, is clearly explicated, with concrete goals and objectives for each phase and transitions that routinely follow completion of those goals and objectives. Those goals and objectives must be clearly understood by the kids.

Recommendation: The psychotherapeutic component of the program is consistent with what is provided elsewhere for juvenile sex offenders. It

appears to be well thought out and appropriately implemented. I would only recommend, because of its obvious importance, that the goals and objectives at each phase be addressed with each youngster in group or individually and that the youngster be required to state in his own words what is required of him. The only aspect of the therapeutic part of programming that is neglected is childhood abuse and trauma. I spoke with Dr. Garbrecht, who runs SOS groups. Survivors of Sexual Abuse (SOS) is a time-limited (10-11 weeks), voluntary process group that includes a manual and homework. The group is provided to very few kids and requires a *sexual* abuse history. Everyone who comes to Circleville should be evaluated for childhood history of abuse and trauma of any kind and provided, if deemed appropriate, intensive, focal treatment for their abuse. In addition to appropriate screening (e.g., the TSCC) and process groups, the facility should have at least one FT trained trauma therapist on staff who can recognize symptoms associated with post-traumatic stress disorder and is skilled at treating it (including EMDR).

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Privilege System

The privilege system has three levels: Basic, Additional, and Exceptional. I requested and received a print out of the privilege assignments. Of the 132 kids assigned with privilege status, 37.9% were Basic, 25% were Additional, and 37% were Exceptional. Facility wide, 37% assigned to the highest level of privilege is not unreasonable. If one looks at the breakdown by living unit, however, it is again noteworthy that Ash (and Hickory) have the lowest proportion of kids (22% & 19% respectively) with Exceptional privilege status. By contrast, Elm, Maple, Oak, and Walnut have between 40% - 50% of their kids with Exceptional privilege status.

Perhaps the more meaningful question, however, is the effectiveness of the privilege system. All youngsters that I spoke with who had anything to say about the privileges available to them uniformly reported that the

privileges were trivial and effectively meaningless as external motivators to do their work. It is easy to generate numerous examples of highly coveted rewards for teenage boys, including a recreation room with music, television or a movie-dedicated screen, pool table, etc; wider range of choices of movies, including excellent educational movies that can be serve a dual psychotherapeutic role; a wider range of channels that can be accessed on their living unit TVs; a commissary with a much wider range of sought after products; their own kitchen and the opportunity to prepare their own meals (again, doubling as a practical life skill / training); teenage-friendly meals in the cafeteria, such as pizza and hamburgers, and access to therapeutic community programs.

Recommendation: Because of the potential power of such privileges as motivators, as well as vehicles for skill-building and therapy, I recommend that an entire building be designated as Exceptional privilege. Each building has 48 beds in total. Excluding Ash, there are already 45 kids classified as Exceptional. They could be placed in one building and that building converted into a therapeutic community with many of the above-mentioned privileges provided. The goal should be to convert all units into therapeutic communities and strive to have two-thirds of the kids at Exceptional privilege status.

Therapist Contact Time

The prison or institution-based treatment programs that I am acquainted expect, in some cases require, anywhere from 15 to 20 hours/wk of clinical contact time for therapists. This means that roughly half of the therapist's time is spent engaged in contact with the kids (e.g., running process groups, facilitating "house" or therapeutic community meetings, teaching psychoeducational classes, participating in therapy progress review panels or committees, tutoring those taking psychoeducational classes, doing individual behavior therapy, etc.). I was disturbed by comments from some of the kids about the unavailability of clinicians. A

boy stated, “Some kids will go on suicide watch just for someone to pay attention to you and talk to you.”

<u>Recommendation</u>: Clinicians should be required to log their clinical contact time and demonstrate, as noted above, a minimum of 15-20 hours / week providing direct service.

Release

Release consists of four elements: 1. completing the “judge’s time” (the minimum to serve time given at adjudication), 2. completing all 3 phases of the program, 3. availability of a placement, and 4. a staffing. Staffing, which occurs toward the end or at the end of Phase II, take place at the DYS Regional Office. In addition to a member of the Release Authority in DYS Central Office and a parole officer and placement coordinator from the appropriate parole region, staffing may include a victim services coordinator, the assigned social worker, and parents or guardians.

The Release Plan requires many tasks: 1. linking up with therapy and medication in the community, 2. appropriate housing, 3. job placement, 4. obtaining a copy of one’s birth certificate, 5. setting up MR / DD services, if applicable, 6. obtaining a Medical / Medicaid card, if eligible, 7. obtaining a State ID, 8. obtaining a Social Security card, 9. submitting paperwork for SSI / SSDI, if eligible, 10. obtaining a Learner’s Permit from the DMV, if eligible, and 11. arranging for services from the Bureau of Vocational Rehabilitation. Although Re-entry teams from the community (mentors) visit the facility, most of this work is done off-site at DYS Regional Office.

<u>Recommendation</u>: This entire process appears to be needlessly cumbersome. I recommend that this entire process be accomplished “in house” (at the facility) and orchestrated by a release team at Circleville with the explicit mission of facilitating and streamlining a smooth return and optimally healthy readjustment in the community. It is the youngster’s life that is being pieced together. He deserves to be integrally involved at every step in designing this plan. It should not be done “from

afar" and then handed to him as a *fait accompli.* The bridge from prison back to society must be erected jointly and paved as smoothly and as sensitively (to the needs of the youth) as possible. Additionally, the J-SOAP does not appear to be part of this release process. Since it is administered at the beginning, it would make sense to re-administer it (Scales 3 & 4) at the end. Overall, it did not seem as though the J-SOAP was being used in any programmatic way that warranted its inclusion.

Miscellaneous:

Staff Training and Supervision

Therapists complained to me about the lack of staff training. Apparently, all staff receive a 3 week "pre-service" designed for everyone (i.e., the training is not around therapy). In addition, there is a one-week in-service every year for clinical staff. Several clinicians stated, in no uncertain terms, that this was not adequate and that they often felt that they did not know what they were doing.

Clinical supervision is extraordinarily important in a program such as this, not only because of the challenging nature of the individuals being treated but because of the often disturbing material that comes up in therapy and the conditions under which treatment takes place. A high priority should be placed on good staff supervision, not only to improve the quality of treatment provided but to protect clinicians from burn out.

Recommendation: All clinicians hired to treat kids at Circleville must be minimally prepared at the outset, reaching at least minimal best-practice standards. Therapists should be well grounded not merely in the mode of treatment (cognitive-behavior therapy), but in boundaries, sensitivity (i.e., sensitivity training), normal adolescent development, normal sexuality, and degrees of deviant sexuality. With regard to supervision, I recommend that all therapists have one hour of supervision each week, as well as participating in a supervision group once a week or once every two weeks. I would also recommend that non-therapy staff also be afforded supervision, though on a less frequent basis. The therapists should be

viewed as change agents, and, as such, the efficacy of the program hinges, in part, on their competence, if not their expertise.

[End Prentky Report]

Finally, to the extent that DYS wishes to rethink the extent of its commitment to the current sex offender treatment program, I would suggest that any Settlement in this proceeding include a provision requiring a study of the adjudication and disposition of first-time sex offenders; the presence of sexual paraphilia in the sentenced sex offender population, and the accuracy of assessments of dangerousness for that same population. Ultimately, the questions should be whether those juveniles who are truly dangerous are properly dealt with; are those who need, or would benefit from, treatment receiving it; and may those without a clinical diagnosis requiring treatment be released from current treatment-program obligations.

VI. EDUCATION

What follows, with a few editorial massages, is the summary of the full report entitled, Review of Education Programs Provided to Juvenile Offenders in Ohio Department of Youth Services Juvenile Correctional Facilities, which is appended as part of Appendix D. This obviously is less than the full report and more than the executive summary attached to it.

You will find Ava Crow's summary unsettling, even disheartening. With the exception of kudos for the new Superintendent, there's not much here to provide comfort for readers looking to grasp something positive.

The formula for education in DYS appears to be: Those with the greatest need, receive the least help. There are deficits in teaching staff, failure to comply with state and federal laws on point, limited space, and limited help with vocational training or post-secondary education opportunities.

Teachers are fearful and stress leave is all too common.

No one asserts that teaching these youth in what is a correctional, prison-like setting is easy. Quite the contrary. However, as the "Crow Report" depressingly shows, those with the greatest need continue to be to those with the greatest need.

The full Report is compelling, perhaps mandatory, reading for everyone involved in this litigation. The Summary, which follows, is a must:

Leadership and Organizational Structure

> "Education programs in juvenile correctional facilities are the key factor in assuring that students have the tools needed for successful transition back into the community…Studies have shown that the potential for recommitment drops when students in juvenile correctional facilities seriously address their education needs."[26] "Education is an essential component of treatment and rehabilitation for incarcerated youth and is the foundation for programming in many juvenile institutions (citation omitted). Helping youth acquire educational skills is one of the most

[26] John Stewart, Ed.D, *A Special Edition on Education Programs in Juvenile Correctional Facilities* 53 Journal of Correctional Education #2, (6/02).

effective approaches to the…reduction of recidivism…Higher levels of literacy are associated with lower (rates of) juvenile delinquency, rearrest and recidivism."[27]

Education, historically a local concern, has become much more "federalized." No Child Left Behind (NCLB), an omnibus education statute, and the Individuals with Disabilities Education Act (IDEA) require that educators apply science, rather than instinct, to their teaching. Education is now a scientific profession, and requires the leadership of education professionals.[28] By hiring a new energetic school superintendent, DYS has taken an important step in moving the school district forward, but it has a long way to go. Using NCLB data, the district is designated by the Ohio Department of Education as "in Academic Emergency."[29] To transform this school district into an effective educational agency, the new Superintendent will need much assistance, and DYS must make substantial changes in its organizational structure and management style. [30]

DYS has a "top down" management style that allows some important educational decisions to be made without input from the Bureau or school staff. Information was received that school officials were not consulted in the decision to change from an eight period to a six period day, but this is sharply denied by ODYS officials. School officials are sharply divided on the merits of this decision but unified on its major impact on the delivery of educational services. Regardless of which side

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[27] Peter E. Leone, Ph.D., Sheri M. Meisel, Will Drakeford *Special Education Programs for Youth with Disabilities in Juvenile Corrections* 53 Journal of Correctional Education #2 (6/02).

[28] The NCLB statute references "research" or "research based" more than 200 times. For example, local school districts must assure the U. S. Department of Education that they will take into account "the findings of relevant scientifically based research," and that they will implement school wide reform strategies that "use effective methods and instructional strategies that are based on scientifically based research." IDEA has similarly changed its focus to providing services based on science. "(S) Scientific, research-based interventions may be used as a tool to identify specific learning disabilities. The students' IEPs are to contain "statement(s) of the (student's)… services, based on peer-reviewed research to the extent practicable…"

[29] Department of Youth Services 2006-07 School Year Report Card, http://www.ode.state.oh.us/reportcard

[30] See OAC 3301-30-01(B); 3301-35-11(C).

they may take, all believe that additional input from education officials would have resulted in a better decision.

The non-inclusive nature of top down management extends to the highest levels of DYS. Reportedly, Bureau administrators are involved only by invitation in many agency-wide decisions that directly or indirectly impact school services. For DYS to appropriately serve students, it should ensure that the Superintendent be at every central office meeting where decisions are being made that even tangentially touch on education.

The DYS organizational structure does not give the Bureau direct authority to manage the schools. Despite statutory mandates, the school superintendent does not assign school personnel or evaluate the school principals. As a result, the Bureau has perhaps even less power with individual schools than it has in Central Office. In some instances, there are active efforts to circumvent Bureau directives. One Bureau administrator, in talking about the schools, states, "I am just like a gnat that they swat away."

There is evidence of the truth of this statement. One principal, at staff meetings is reported to say about Bureau directives, "This comes from Columbus. They are only here six days a year, so we won't worry too much about this."[31] In another example, in mid-August 2007, Bureau administrators were alarmed to informally discover the existence of a protective custody (PC) unit. Record review reveals that students had been in this unit since at least July 5, 2007. At the time of discovery, 25 youth resided on this unit, 22 of whom were students, and 15 of whom

[31] The principal denies this statement, noting that he understands how "things can be misperceived." However, a teacher very supportive of the principal, when asked about the statement, replied, "I won't say he hasn't said it," and continued by explaining that staff members were weary of directives from Columbus.

require special education. Not one of these students was receiving educational services until discovery by the Bureau.[32]

In addition to the Bureau lacking authority, interviews establish that institutional interests at the facilities sometimes impair efforts to provide educational programming. If there is a conflict between providing appropriate educational services for students and meeting other institutional needs or preferences, the other institutional needs and preferences prevail all too often. One example is at Luther Ball (Cuyahoga) where space is at a premium and school administrators and guidance counselors share offices. Two unit psychologists have private offices located in the school's administrative hall, and although there are insufficient classrooms to offer additional electives, a large classroom was taken over for medical services. Additionally a four-room module that could be used to provide electives or special education is being used for group. There are also two dorms that have been empty for an extended period of time because of staffing and are currently being used as a game room and for programming. One or both could be opened for career tech classes or alternatively, used for some of the program offices and services currently located in the school. Reportedly facility administrators are contemplating changes, but at the time of the site visit, the situation was as is reported.

In another example, the principal of a school was informed by the facility superintendent that one of his best teachers should report to a classroom that had been set up outside the school building for students on unit restriction. Neither this principal nor any other educator had any involvement in determining an appropriate way to educationally serve these students, in creating this classroom, or in determining which teacher would be most appropriate to handle an alternative classroom setting. No consideration was given to the consequences to the school of moving this

[32] Students on PC require a safety plan. Record review revealed that safety plans were written several days to several weeks after the students had been placed in PC. For example, one student was place in PC on July 5, yet his safety plan was not written until August 7, 2007, shortly before the site visit.

teacher out of the building. Although there is a new director and facility superintendent, the original structure that allowed such a decision is still in place.

As a final organizational impediment, several principals reference institutional responsibilities that detract from their instructional leadership duties. These responsibilities include completing administrative duty officer responsibilities, participating in training not directly related to managing the school, conducting investigations and serving on interdisciplinary committee hearings. While it may not be appropriate to relieve school principals of all of these responsibilities, consideration should be given to limiting them.

In sum, while DYS is to be commended for its ongoing efforts to strengthen education, its organizational structure does not facilitate that goal. Accountability cannot be established if the Bureau remains impotent in addressing educational issues. If DYS schools are to ever successfully measure achievement by the quantity of student learning, the Bureau must be empowered and principals must function as instructional leaders.

While facility administrators need to maintain an ownership interest in school services within their facilities, the Bureau of Education must be in charge of education and be given oversight responsibilities for the schools. Recommendations in the full education report are designed to address these issues.

Full School Day and Staffing

DYS fails to meet its responsibilities as a "parent" under Ohio's compulsory attendance statute and fails to meet the statutory requirement to provide a full school day.[33] Scioto River (Scioto reception for boys) and the Freedom Center offer three hours or less of education to their

[33] There is not agreement on what constitutes a full school day. DYS reports that its SOP providing, "The school day…shall consist of scheduled classes, supervised activities or approved options for at least six hours" means that schools must operate for six hours per day but does not provide an entitlement to individual students for six hours of educational services. Even granting great deference to the agency in its interpretation, OAC 3301-35-06 requires at least 5.5 hours of programming, and for this report, that figure is used as the measure of a "full school day."

students. On paper, it appears that all other DYS schools provide a full school day for all students. In fact, that is not the case. Teacher shortages are an overwhelming issue, and no DYS school is immune. Limited classroom space and the logistics of providing unit instruction are also major problems.

On a randomly selected, given day, through review of student locators, *598 or 43% of DYS youth received less than a full day of school*. To demonstrate the impact on actual student lives one only needs to look at the numbers revealed on the 8/14/07 Hickory Grove (Marion) student locator report. Eleven students, mostly housed on unit six lost 100% of their class time for three days, for a total of 66 missed classes. One hundred and ten class periods were missed by 83 students for whom there was no teacher on that particular day. These students lost 22% of their class time on that day. And finally six students housed on the Marion mental health unit were found to be getting only three 50-minute periods per day; one half the number offered to other students.

Lack of a teacher or substitute is a common reason cited for loss of class time. Teacher staffing is a chronic and debilitating concern. Twenty-three teaching positions were reported vacant in August 2007. Some schools report a chronic shortage of three to four teachers. At Luther Ball (Cuyahoga), multiple classes were cancelled during a six-month period due to teacher vacancies. At the time of the site visit, Hickory Grove (Marion) had four teacher vacancies which included library, science, English and special education. The English vacancy is especially problematic since it has been open since December 2006. Two hundred of the total 270 students are 9th and 10th graders, yet Hickory Grove has not had an English teacher for these grades for eight calendar months. There was no science class at Scioto River for a school term because of a vacancy. The Starkey AOT class at Circleville did not meet for three weeks because the teacher was in training. At Tecumseh (ORV) the short staffing problem is reported to be cyclical. One guidance counselor

observes that the school is fully staffed from January to June and short staffed from July to October or November because teachers leave for the public school systems in June and it takes four to five months to replace them.

When substitutes are not available, librarians, guidance counselors and assistant principals are pulled to cover classes. Additionally, special education teachers are pulled out of their planning periods, and some are pulled from their resource classrooms to cover general education classes. These measures result in classes that are of questionable educational value, in addition to having a detrimental effect on the overall operation of the school. Despite these efforts, many classes must be cancelled due to lack of sufficient staff. Rather than sending the students back to the unit, some school administrators move the students to the library or in the case of at least two schools, move them to a sterile holding room where no educational activity occurs. In one hour at Hickory Grove at Marion, the holding room census soared to 76 (40 graduates and 36 students). Not surprisingly, the holding room was the scene of more than a few disturbances. On a day at Indian River when four teachers were absent, the shortage of substitutes necessitated one teacher's class reporting to the holding room throughout the day.

School administrators report that teacher stress contributes dramatically to their inability to staff a full educational day. At more than one school, principals explained that they fully expect teaching staff to use all their leave days due the stressful working conditions, and some teachers then obtain extended leave through the Family and Medical Leave Act or unpaid leave. Assaults of teachers requiring hospital care are not unusual at some of the facilities, and the stress and physical injuries combined result in extensive teacher absences that must be covered. School budgets do not cover the actual cost of necessary substitute teachers.

An additional contributory factor causing short staffing is the inordinate length of time from hiring to the actual day that a teacher begins to teach. Principals estimate that the whole process of recruiting, hiring, and pre-service training takes no less than three months and can extend to five months. Education administrators point out that much of the pre-service training is of limited relevance to school staff. Valuable time spent in this orientation could be more effectively spent to meet school staffing needs.

Lack of school space at some facilities is an additional contributory factor in failing to provide all students with a full school day. Tecumseh at ORV is currently almost 70 students over school capacity, meaning that few, if any, students are receiving a full school day. An administrator at Tecumseh explains, "We don't physically have enough seats or teachers to give everyone six classes (of 50 minutes each). If the number of classes for any youth drops to four, he goes on a waiting list until he can get what he needs. Right now there are 3 new youth on the waiting list who need 10th grade English. English is full. Four youth that came in July did not have the necessary five classes[34] and they were also on the wait list." The new classification system continues to overload Tecumseh at ORV and Hickory Grove at Marion, contributing to a decreased school day at each facility.

Students with challenges such as mental illness or severe behavior problems are often housed on specialty units or in isolation. The educational experience for many of these students often consists of no more than a worksheet slipped under a locked cell door. By even the most optimistic estimates, the educational day on these isolation units does not come close to meeting the requirement of a full school day.

There are occasions when even token education does not occur for students in isolation or on the units. Hickory Grove (Marion) students lost

[34] This official believes that 250 minutes of instruction is the minimum requirement. As discussed at Note 8, it appears that the law requires at least 5.5 hours of instruction.

3,725 hours of education in a school quarter because of students being placed in isolation. In addition, the students in the Marion mental health unit receive only three hours of instruction per day, and this is decreased when the special education teacher is pulled to cover general education classrooms. At Luther Ball at Cuyahoga Hills seven students have Special Management Plans (SMPs) that require them to remain on the unit, usually for five days, with school work dropped off. To the extent there is any "instruction," it is provided by a JCO. At Tecumseh (ORV), 18 students housed in the Grant Unit receive only four classes per day.

"The education of our youth is intimately tied to crime and delinquency rates."[35] Since it is likely that many or all DYS officials would unequivocally agree with this statement, it is incomprehensible that these same officials would tolerate anything less than a full day of school for all the youth entrusted to their care.

Special Education

The current version of the federal special education statute, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), reflects 30 years of pedagogical advances and refinements in the process of providing educational services for students with disabilities. Over half of DYS students are protected under this statute, yet teachers often view IDEA as yet another paperwork burden. Minimal regard is given to the substantive provisions of the statute. This view and the antecedent failure to fully implement Individualized Education Programs (IEPs) are two of the most disturbing facets of DYS non-compliance with the IDEA.

For the special education student to receive the benefit of the IEP, the document must provided individualized services. All education professionals must commit to implementation, to detailed monitoring of progress, and to using the monitoring data to evaluate progress. Review of IEPs and interviews with DYS teachers reveal that "special education" is

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35 Marisa Ostroff, Ed.D., *Educational Attainment and Delinquency: What Goes Up Brings the Other Down* 7 Juvenile Correctional Mental Health Report #2, p. 21 (Jan/Feb 2007).

almost solely limited to "extended time" and "small group instruction." These benefits are provided to all DYS students. Only a very few teachers supplement these modifications or provide additional supplementary aids and services in accordance with a truly individualized education plan. The following comments by DYS teachers reflect the predominant attitudes about special education:

- At Indian River, a special education teacher states, "I don't always go look at the IEP when a student gets here. There are 8-10 coming and going every month." The teacher continues by noting that in teaching, "I shoot for 3rd-4th grade level; you can't individualize." Regarding monitoring data, a special education teacher states, "I ask the regular education teachers, "What is he doing and how is his behavior," and this information is requested "only when a new IEP is due—I don't have enough time to do it any other time." A general education teacher notes, "I think the special education teachers spend a lot of time writing IEPs that do not get read."
- At Tecumseh (ORV), a general education teacher states, "I have never been asked for progress on IEP goals." Another general education teacher states, "Progress may be general or specific." A special education teacher notes, "Probably now progress data is (sic) based more on lesson plans, but we're moving towards IEP goals."
- At Luther Ball (Cuyahoga), a special education teacher notes that there are general education teachers "who don't know their special education students." A general education teacher explains that he "didn't typically get IEPs," doesn't know if he can access them electronically and has never been asked for progress data.
- One particularly challenged general education teacher states that "generic concepts" are taught in the class; noting that all youth "get the same folder that is not on their level" because individualizing student work is too difficult. This teacher notes that students will, from time to time, argue about the work and what their IEP goals require, but the teacher explains that it is simply too difficult to address these issues.

- Another particularly challenged general education teacher, found in the hallway, explained his presence by stating that a collaborating special education teacher was currently with his class. He then stated that he "didn't really know if it was his class" noting that "the special education teacher acted like it was her class, so maybe it was," but he thought it was his.
- Several general education teachers, although aware of their students' IEPs nevertheless teach those students from the class lesson plans. A couple of these teachers note that they make sure their students "get their special education—extra time to complete work and a small group."

Another *significant* area of non-compliance relates to the federal statute's mandates related to behavior and changes of educational placements. To shape student behavior, schools use SMPs rather than the federally mandated behavior intervention plans based on functional behavioral assessments. In clear violation of federal law, DYS IEP teams never use the mandated procedures for disciplinary changes of placement.

At Tecumseh (ORV), school administrators or teachers make placements into the Alternate Learning Center (ALC) for school-related behavior. After 10 days of compliant behavior, the student returns to the regular school setting, but if a YBIR is written within a specified period of time, the student automatically returns to the ALC. Tecumseh is under the misperception that placement in the ALC is not a "change of placement" because the students' general education teachers bring work over to the ALC each period and the students remain on the general education teachers' class rolls. The teacher in the ALC is a highly qualified teacher (HQT) special education teacher. While this situation presents a good effort to stay within the change of placement rules without actually using the required process, it does not comply with IDEA. In determining whether the rules apply, the issue is whether the student's learning experiences are significantly changed. ALC students are forced to leave the general education classrooms at the school building and move to a unit

classroom where their interactions are limited to the other students placed there. They do not change classes and although a general education teacher is present each class period, s/he is also serving the students in individual cells, and the primary responsibility for instruction in the ALC rests on the HQT special education teacher. The ALC is designed to be more restrictive than the school building, and thus, by definition, placement constitutes a "change of placement." Calling the ALC teacher a collaborating teacher and leaving the students on the rolls of the general education teachers do not change this fact.

Each "change of placement," when accomplished for school-related behavioral problems and cumulating to more than 10 days in a school year is almost always an occasion when institutional correctional policy is being used to override and violate federal education law.

Not only is the IEP team the sole "decider" of educational changes of placement, if the change is a disciplinary change resulting from the student's behavior in the school, a specific process must be followed. This process is designed to ensure that students not be excluded from the school building for behavior related to their disability. Generally, a student cannot be moved to a disciplinary educational placement for more than 10 days unless an IEP team meeting is convened and a determination is made about whether the student's behavior in the school results from his disability. The IEP team must consider the completion of a functional behavioral assessment and a behavior intervention plan for the student. If the IEP team determines that the student's behavior *is* a manifestation of the student's disability, the student usually may not be suspended from the school program for more than 10 days per school year; the student must remain in or be returned to the educational setting where the behavior occurred; and the student's behavior must be addressed by modifying the specially designed instruction and supplementary aids and services provided to the student. The disciplinary changes of placement rules are complicated, and a Flow Chart is attached as Appendix II to the full

education report. The only thing immediately crystal clear is that these changes of placement decisions are education decisions *to be made by IEP teams* and are not decisions to be made, as they now are, by facility administration, IATs, treatment teams or psychologists. Although several interviewees present persuasive reasons for the existing change of placement practices, they nevertheless violate IDEA. DYS must address these placement issues in a manner consistent with federal law.

The failure to provide students with individualized IEPs that are collaboratively developed in IEP team meetings with appropriate members present violates IDEA. The failure to teach to the IEP goals and the failure to appropriately and accurately monitor progress violate IDEA. The failure to use positive behavioral interventions in behavior intervention plans and the failure to use the mandated procedures for disciplinary changes of placement all violate IDEA.

Other major areas of non-compliance with the federal statute are discussed in the full education report, and recommendations are made. The DYS school system has made substantial progress in addressing minimal legal compliance with some IDEA mandates. But to effectively educate the special students protected by IDEA, partial compliance is certainly not enough.

Instructional Practices and Discipline

The entire DYS school system struggles with the problem of inconsistency in discipline. Effective teachers have far fewer discipline referrals than the less effective teachers. Additionally, administrators express frustration at the "quick trigger" of some teachers, who invariably are the more challenged teachers. After seven weeks of an eight-week grading period at Indian River, the number of In School Suspension (ISS) referrals ranged from one to five for some teachers up to 60 and 70 for others. The total of ISS referrals for those weeks was 917. The principal of Luther Ball (Cuyahoga) related that four teachers call for help more

often than the rest of the combined teaching staff. These trends are mirrored throughout the DYS system.

Administrators were asked to identify their most and least effective teachers, and these teachers were then observed and/or interviewed. Those identified as successful teachers issued the fewest YBIRs and ISS referrals. These teachers followed detailed lesson plans and employed a variety of methods to present the material to students. Their students were engaged and appeared to be content.

The less effective teachers issued the most YBIRs and ISS referrals. Their lesson plans often consisted of no more than a page number and an assignment. These teachers were observed to have the least amount of content in their lesson. The majority of these teachers relied on individual seat work, with worksheets and little or no instruction. In these situations, each student got his own folder and when he had a question, he was to wait patiently until the teacher had time to help him. This method delivered information to students who already understood the subject matter. They were observed to work through the lesson in the first 20 or 30 minutes and then they finished and were ready to get into mischief. For students who were having difficulty or appeared totally lost, the experience was extremely frustrating. When help finally arrived, the teacher frequently was observed to share a few words with the student (often, the answer to the worksheet question, with minimal, if any, instruction as to why it was the answer), and the teacher would then move to the next student who was calling out or raising a hand. The student often appeared to be as perplexed as before the "help" arrived.

Through its Character Counts program, DYS encourages the use of positive reinforcement. However punitive actions far outnumber any positive rewards. During the month of April, Indian River identified a total of 766 violations and wrote only 49 Commendable Conduct reports. In July 2007, Hickory Grove (Marion) reported 1323 violations while only one Commendable Conduct report was written. Tecumseh (ORV) also

reported over 900 YBIRs in one month and a very small number of Commendable Conduct reports.

Interviews with principals and review of professional evaluations reveal that school administrators are fully aware of the ineffective teachers. With some exceptions, principals utilize evaluations to put teachers on notice of needed improvement. If quality instruction is to be delivered to students, it is imperative that administrators' focus concentrated energy on improving the instructional practices of teachers already identified as ineffective.

While school culture and classroom management skills have a dramatic impact on student behavior, other institutional factors contribute to the safety concerns of teachers. Chaos and unrest initiated in areas outside the school were observed to carry over into the classroom, to the detriment of all students. Sixty-two percent of all teachers express dissatisfaction with school safety.[36] Interviews with staff reveal widespread concern about the increasing prevalence of gang activity in the student population. When questioned about the nature of the gang activity, one assistant principal familiar with gang dynamics, explained that the gang leaders remain in the background, giving assignments to youth wishing to be identified with a certain gang. A typical assignment may be to perform a "hit" on another youth. An especially competent English teacher at Tecumseh (ORV) expressed her frustration at the number of "hits" that occurred in her classroom in one month. Each of these incidents occurred during hall movement when a fledgling gang member would dart into her classroom and hit another student. The teacher explained that when these disruptions occurred in her classroom, the first ten minutes of the class were spent with the JCOs breaking up the fight and cleaning up blood. She knew that the students would not be, shall we say, quite as focused as she would like for the balance of the

[36]Ohio Department of Youth Services, 2007 District Plan, 7.

class. Her experiences were not atypical of other incidents related by school staff.

The prevalence of gang behavior is a growing concern that schools cannot address alone. Realistically, a certain number of these incidents will occur in a correctional facility, and will increase with overcrowding. The new superintendent at Marion referenced the great need for a culture change, and the Indian River superintendent states that they are working on a culture change in her facility. It is critical that school and facility staff coordinate and work together to solve this problem with structured communication and cooperation between the schools and units.

Educational Assessment, Guidance Counseling & Reentry Services

DYS fails to adequately provide a system of academic and career technical counseling and initial screening. Guidance counselors and teachers report that standardized tests given at the reception center often result in unreliable scores due to a number of factors related to emotional and physical adjustment to incarceration. At least one school retests all of its students because of the unreliability of the data received from Scioto reception, and staff in several schools suggests that it would be more reliable to test the students after they have had time to adjust to new surroundings.

Counselors do not provide an adequate system of academic, career technical and postsecondary counseling for students. If a student approaches the guidance office with a request for guidance in any of these areas, the counselors will assist the student, but there is no system in place to inform students of these services, nor is there a systematic effort to encourage students to seek postsecondary education.

Counselors cite time limitations as reasons for not fully performing duties that are additional to scheduling and transcript issuance. In theory, scheduling should become easier once the new computerized learning system is functioning. However, this theory has yet to be tested. In the meantime, two DYS schools have devised methods to extend the reach of

existing counselors. At Scioto reception, the TO provides that four teachers, rather than guidance counselors, perform assessment duties under the supervision of one guidance counselor. At Hickory Grove (Marion) where the guidance position is vacant, these duties have been performed by a teacher relieved of classroom duties and a permanent substitute teacher under the supervision of an assistant principal. Adapting these models, under the supervision of a guidance counselor, all DYS schools could utilize competent administrative assistants, much like the special education assistants, to perform technical duties. This would free up guidance counselors to provide intensive counseling on career tech and postsecondary issues.

The Bureau's mission is to provide educational programs and services to help students develop competencies necessary for successful reentry into the community. However, funding for postsecondary options has been removed; a counterproductive action that likely ensures that achievers in the facility rise no higher. Additionally, opportunities that were once available to selected students off-grounds, such as work opportunities and even, at one facility after assiduous efforts by an AOT teacher, a college visit, are no longer available. Reentry efforts are additionally hampered by restrictions on intranet access for students who are not able to access hometown newspapers to survey job and housing options and are not able to access a wealth of information about postsecondary options. All of these restrictions make successful reentry a challenge for even the most motivated student.

There are creative ways to bridge transition to the community. The Indian River AOT teacher brought postsecondary options into the school by bringing in a nearby college class to complete a joint project with students. This project culminated in program where every student, dressed in a suit and tie, made a presentation to a group of more than 100 people.

Each participating DYS student obtained college credit for the work.[37] This effort should be replicated, and other facilities should be encouraged to develop similar outreach efforts.

Career-Technical and Job Training

DYS convened a Job Skills Committee in 2007 which identified the strengths and weaknesses of the career tech programs. The recommendations of that committee do not go far enough to address the lack of an effective career tech program in the DYS school system.

The vast majority of students do not receive systematic career counseling. At reception, all youth take the career interest inventory which helps the youth identify personal vocational interests and skills. The results of this inventory resemble a wish list and do not provide a basis upon which to individualize the educational plan for the youth. For many students, the inventory will be helpful only if they are also provided systematic academic and career technical counseling to assist in developing realistic goals.

Career tech administrators acknowledge that there have been zero completers of any of the two-year career tech classes "in several years." The administrator attributes this to the short terms of commitment for DYS youth. This explanation ignores the substantial number of DYS youth incarcerated for two years or more, none of whom has completed a career tech program. The stated mission of DYS is to provide educational programs to help youth successfully reenter their home communities.[38] Youth cannot achieve successful reentry without job skills.

Discussions with Bureau administrators about the career tech programs reveal that some of the problems of the program are related to the apparently inflexible requirements of the Ohio Department of

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[37] The college students working on the project wanted to provide gifts to the facility students at the end of the project—the AOT teacher recommended dictionaries which, she noted, students will steal. Interestingly, the assistant principal at Hickory Grove also provides rhyming dictionaries as rewards, noting the students' intense interest in these. There is a message here about students' interest in learning.

[38] Ohio Department of Youth Services, 2007 District Plan, 2.

Education (ODE), through which career tech programs are unit funded. A frustrated career tech teacher shared this insight:

"In the public schools, virtually every DYS youth would be a viable candidate for career tech. Youth with behavior problems that don't do well anywhere else often do well in career tech classes. Even the smallest school should have career tech classes that are full. However, current requirements related to funding units through ODE prevent this from happening."

Youth are placed in DYS according to security and treatment needs. While there are several career tech offerings in the system, it is only by happenstance that a youth's placement will match his actual interest and aptitude. For example, Indian River offers a strong auto body repair class, but a student with aptitude for auto body repair may be assigned to Luther Ball (Cuyahoga) where there is no class. Students with aptitude for anything other than office technology have no substantive options if placed at Luther Ball (Cuyahoga) or Willis (Scioto).

The classification system and ODE's inflexible requirements are not the only challenges to a robust career tech program. Each school has numerous high school graduates and GED completers that would benefit from attending career tech classes while also boosting the census of endangered classes. However, ODE requires that a graduate or GED completer take two additional classes when enrolling in career tech. This requirement virtually eliminates the possibility that a youth in either of these categories will opt for career tech preferring, instead, to sit in a holding room or on the unit.

Another substantial road block to successful career tech programming involves limited space. Space limitations play a significant role in the electives that may be offered. Tecumseh (ORV) and Luther Ball (Cuyahoga) are bursting at the seams with virtually every square inch utilized. An annex at Tecumseh was planned to house additional career

tech offerings, but this facility has not materialized. Luther Ball has empty dorms but they have not been converted to school space.

Educational Programs and Support

Several identified student populations are not receiving instruction of high quality designed to meet their needs. One such group is the students whose reading scores are so low as to result in their exclusion from the Striving Readers (Read 180) grant awarded to DYS in March 2006. These are "beginning readers" and on October 30, 2007, they comprised approximately 7% of the DYS population. Guidelines for Read 180 specifically exclude students whose reading scores label them "beginning readers," thus excluding the students with the most severe reading deficits. Compounding the problem for these unfortunate students is the decision at all schools except Indian River to convert Title I reading positions to math. Therefore, students with the most severe need for remedial reading are receiving the least amount of direct services—their Title I reading services have been eliminated and they are excluded from direct services in the Read 180 classrooms.[39] Although Bureau officials believe that the mandated P.D. for all teachers under the reading grant will improve reading in the general education classrooms, no evidence of that was seen during observations. To make matters worse, it is reported that the new computerized learning system will not have instructional software to teach pre-literate students to read. Thus the students with the lowest reading scores have no targeted direct programming to assist them in learning to read, and no remedy is in sight.

This regulation is also not met for some other groups, including the limited but growing number of 12- and 13-year-old students in the custody of DYS. DYS has no middle school to serve these students. They are sandwiched in to high school classes, sometimes with 20-year-old students. These classes simply are not "appropriate to the students' age

[39] The elimination of the Title I reading teachers also negatively affects those students who are slightly better than "beginning readers" but who are in the roughly 50% of students randomly selected to *not* participate in Read 180.

(and) developmental needs." The older, often toughened students become the role models for these 12- and 13-year olds.

Physical Plant

Luther Ball at Cuyahoga, Tecumseh at ORV, and Scioto River (boys' reception) have classroom and office space problems. Luther Ball at Cuyahoga Hills and Hickory Grove at Marion additionally have issues impacting safety, and Luther Ball has sanitation concerns. These problems interrelate with other challenges in the facilities, compounding difficulties for staff and impairing the quality of education provided to students.

Luther Ball at Cuyahoga Hills is overcrowded. The lack of classroom space limits the number of electives students can be offered, negatively impacting student scheduling, student idleness, and educational outcomes for students. Career tech classes are almost non-existent because of lack of adequate space. At Indian River, students are placed in classrooms, "based on wherever there is a seat." Hickory Grove at Marion uses its IAT to make educational placement decisions for students being considered for placement in the mental health unit classroom, and it was explained that if there are no seats, "we just don't start up the IAT process until there's an open slot."

Although reportedly shared space has now been found for the contract Speech Language Pathologist (SLP) at Luther Ball, for months she often had to hunt for a work space upon arrival. She reports that this search for an area where she could work with a student could take as much as half an hour each day she arrived. This is contract time that could otherwise have been productively spent on student services. While school space is occupied by non-educational staff and services, special education classes are splitting a classroom, an assistant principal shares an office with another staff person, two guidance counselors share a large room with an administrative assistant, and special education teachers are sharing

work space with the SLP. All of these limitations negatively impact the quality of youth learning.

Ceiling tiles are broken or missing in at least one classroom and the ISS room at Luther Ball. Reportedly students have used the missing tiles to attempt to crawl into the ceiling for whatever egress that might give them. Despite requests extending more than ten weeks to repair these tiles, they remain missing or broken. Additionally, there is a serious bathroom issue at the school affecting facility conditions that impact student learning.

A Scioto administrator notes that there is a “lack of space to educate both boys and girls for a full school day; a lack of space to work with students 1:1; a lack of space for administrative staff.” The Scioto River (boys’ reception)) guidance counselor shares a cramped office with a special education teacher and the school secretary. There is no space for private conferences or telephone conversations. Finally, the most crucial space limitation at Scioto River is that the shortage of classrooms limits the students to only three hours of class per day.

Tecumseh at ORV is also suffering severe space limitations. Common areas in the school, such as hallways, cannot expand to accommodate the additional students that have arrived. During the site visit, there were 240-260 students moving in the hall at any one time, and there were 36 to 50 students *per period* who had no class because there are insufficient numbers of classrooms and teachers. Since the site visit, the classification system has resulted in even more students at Tecumseh, with students now receiving even fewer classes.

During the Tecumseh visit at ORV, when the temperature was in the high 80s and low 90s, an air conditioning unit was not functioning in the building housing the Intensive Programming Unit (IPU) and the Alternative Learning Center (ALC). Although fans were operating, they were not reaching the individual cells nor were they serving the ALC. On the next day, this air conditioning unit was still broken and the units

serving the school building proper were also down. By mid-afternoon, all teachers had their doors open and there was discussion of canceling classes. Tecumseh school officials report that this experience is not an anomaly; there are frequent problems with both the air conditioning and heating systems.

There are also security and safety issues at some schools. Within the last few months, gang-related assaults on students have been reported at Tecumseh (ORV) and Hickory Grove (Marion). Since January 2007, student assaults on staff members have been reported at Hickory Grove and Indian River and there may be additional incidents at these and other DYS schools. Deficiencies exist in the security systems. There is a need for security cameras. The man-down system at Hickory Grove at Marion requires parts ordered from overseas. Thus, when it was hit by lightening during the site visit, it could not be immediately repaired and teachers had no classroom security.

The fire alarm cannot be heard in two classrooms at Luther Ball at Cuyahoga, and the "man down" hardwired buttons on the walls do not function in any of the classrooms. Staff members have radios, and the principal explained that on occasions when they are short on radios, she and/or the Program Deputy relinquish theirs. At the time of the site visit, a work order had been in place for an extended period of time to fix the doors to the gym. That had not happened, and students were popping the doors open, contributing to already existing problems in gym class.[40]

Supplements

Supplements about the school programs at Marion, the Freedom Center and Willis (the program for girls at Scioto) are attached to the full education report. The Willis program is substantially improved from 2004. There are significant problems with the Freedom Center education services. The school program at Marion also has serious problems, and

[40] This class is substantially over cap because there are no other electives available. The class is already the source of many, many behavioral issues without the complication of additional youth coming in and out.

many of the CRIPA issues identified by Dr. John Wills Lloyd's September 26, 2005 report continue to be areas of great concern.

To supplement Dr. Lloyd's findings:

- Child Find efforts appear to be improved, but it is recommended that the Bureau of Education continue to monitor this area.
- Issues remain with IEP team membership and the collaborative drafting of IEPs.
- Significant issues remain with changes of educational placement to an alternative learning center and to unit instruction; with individualization of student services on IEPs and the monitoring of progress on IEP goals; with the effective use of positive behavior interventions; with the use of functional behavioral assessments and behavior intervention plans; and with the quality of instruction and classroom management.
- Dr. Lloyd expressed concerns about limited professional development being made available in many of these areas. The Bureau and school have made professional development available, but this has not ameliorated many of the concerns it was apparently designed to address.

Conclusion

In sum, it will be a daunting task for the DYS school system to bring itself into minimal compliance with federal and state law. It will take organizational commitment, increased resources and focused energy. Anything less will merely maintain the deficient status quo.

[End Crow Report]

ADDENDUM [41]

Section VI, Education

Improving Education Opportunities

- ODYS secured a 5 year $14 million grant from the U.S. Department of Education. This grant allows us to provide intensive literacy intervention to a subset of our population who are deficient at least two grade levels. This grant has also provided DYS the opportunity to train our education professionals to infuse literacy into every subject. The program is an intensive daily 90-minute class, in which a group of 12-15 students rotate in to different stations for short blocks of time. The stations include video software, student / teacher one-on-ones, audio books and paperbacks to ensure that students, regardless of learning method, are able to benefit.

  ODYS will collaborate with the Ohio Department of Education to provide a training curriculum for DYS instructors. The Ohio State University's Center for Learning Excellence will develop the research evaluation component of the project. Since DYS was the only correctional system in the nation to apply for this grant, the results of this study could be the benchmark for literacy programs in juvenile justice systems nationwide.

- All teaching positions in the ODYS school district requiring a Highly Qualified Status are filled with teachers who are Highly Qualified in the subject matter under the No Child Left Behind Act.

- In 2008 the ODYS school district will move to provide individualized learning environments for all youth via the student learning system. This web-based program will allow each student to be assessed in all core academic areas and will then design an individualized learning curriculum for each student. This will allow each student to work at his or her individual ability level and allow the district to accurately assess student progress. The program also provides the potential for accelerated credit recovery, improving a youth's chances at achieving a diploma.

[41] Submitted by ODYS to Fred Cohen on December 21, 2007. Fred Cohen excised some of this submission and slightly edited other parts.

VII. OVERCROWDING & STAFFING: TRAINING AND PROGRAMMING

Overcrowding

The general population juvenile correctional facilities (JCF) (IRVCF, MaJCF, ORVJCF, and SJCF) are overcrowded. These facilities operated at 141% of rated capacity on the dates of our assessments. Only the treatment-oriented facilities (Mohican and Circleville) operated below rated capacity (see Roush Report, Table 2).

Research and experience indicate that there are no benefits and many liabilities to youth or staff in crowded institutions. Indicators of safety and programming suffer during periods of crowding, and this level of crowding is sufficient to have a clear and negative effect on those indictors. Levels of crowding co-vary with the Performance-based Standards (PbS) measures of safety and program effectiveness (see Roush Report, Table 3).

Expert David Roush asserts that overcrowding creates social density problems associated with adverse effects that are particularly aggravated with children and youth.

When crowding or density increases, studies have found:

- Decreases in the ability to classify and treat; incarceration becomes warehousing.
- Effects apply to not only residents but also staff.
- Increases in the frequency and rate of disruptive behaviors; effects are aggravated with juvenile and young adult offenders.
- Decreases in residents' perceptions of order, organization, and staff support.
- Decreases in involvement with peers; decreases in classroom cooperation, and lower school grades.
- Decreases in perceptions of safety.
- Increases in aggressive behaviors in boys; girls were unaffected.
- Increases in the rates of social withdrawal, of avoidance of eye contact, and of solitary play.
- Increases in the rates of juvenile-on-staff injuries.
- Increases in the rate of suicidal behaviors.

- Increases in the rate of isolation (room confinement) less than 24 hours in duration.
- Increases in the rate of injury.

Overcrowding negatively affects privacy. For example, youth we spoke with requested more supervision for the bathroom area. Because of double occupancy or a doubling of the capacity, it takes longer to shower in the living unit, so several JCFs modified the bathrooms to make more room for group showers which, in turn, impinge on privacy. Additionally, there are no surveillance cameras in the bathrooms, and residents state that the absence of cameras makes the bathroom dangerous.

The need for time-phasing or sharing of recreational space means that it is not uncommon for groups or living units to participate in the large muscle exercise period immediately following a meal. At two JCFs, the large muscle exercise (recreation) occurred at 7:50 a.m.

The IJA-ABA, Juvenile Justice Standards: Corrections administration, Sec. 7.2 (1996), drafted in the early 1970's, adopted the "smaller is better" philosophy and promulgated a limitation on the size of residential facilities in the range of 12 to 20 occupants. Table 2 of the Roush Report describes rated and actual capacity for the facilities visited.

The Boone Unit at Scioto was found to be 262% over capacity, Building 6, Unit D at Marion was at 192% of capacity, and Aviation-Rickenbacker at ORV was at 205% of capacity. Circleville had only one unit slightly above capacity because the facility itself went from a two-person to a one-person celling arrangement in light of recent litigation.

When facilities are overcrowded and staff size is not adjusted accordingly, the potential for exacerbating the negative consequences listed above increases dramatically. At a certain point the crowding-harm to youth calculus is such that DYS violates its constitutional obligation to provide youth with a safe environment.

Staffing

Whether this Report speaks to education, mental health, or security, there is a common thread to our findings: Staffing is inadequate. The normative term "inadequate," in turn, takes on meaning only in the context of the objectives to be

achieved. In this section, I will speak primarily of security and safety. Term member David Roush, in his report, states bluntly, "DYS is severely understaffed at the JCO job classification. Current staffing is below a basic level to ensure safety, order, and programs."

This finding, of course, relates understaffing to violence: youth-on-youth and staff-on-youth. The ripple effect of the JCO shortage reaches powerfully into what appears to be the primary job irritant for the JCOs: the dreaded mandation.

I personally interviewed JCO, union representatives in each of the six facilities I visited (25 people). Their chief complaint was being required to work mandatory overtime. Marion JCOs represent that the average workweek for them includes 24 hours or more of overtime per week.

I interviewed one JCO who took pride in working 80 hours for as long as he could remember. He put two daughters through medical school by following this work schedule. He did not complain about mandation nor did he distinguish to me mandated overtime from voluntary overtime.

In Section V, discussing mental health issues, we noted that the JCOs function primarily as custodial staff when they might be much more effective as a part of a treatment-rehabilitation system and team. Their job descriptions would appear to support the role of JCOs in facilitating group discussion and assisting youth in the development of goals and acceptable social behavior.

The team found no evidence that JCOs accept or perform this more expansive role, certainly not in any systematic fashion. However, even if the expanded role were to be embraced it simply could not be performed with the current numbers of JCOs and their educational background and training.

We were unable to acquire precise data on the incidence of mandated overtime. However, we have sufficient confidence in the data and anecdotal material we do have to describe mandation as a serious systemic problem in need of early resolution.

Additional JCO staffing, if done properly should enhance safety and security in the facilities and also solve the most nagging problem as universally expressed by JCOs: mandated overtime.

In analyzing JCO staff shortfalls, the investigative team strongly believes that it would be a fundamental error to begin hiring JCOs without first reviewing and determining what role, if any, there should be for JCOs beyond security and safety. An expanded role for JCOs, in turn, would make sense in the context of a review and possible reconstitution of the architecture and objectives of the agency itself.

Working within the framework of a safety and security mission, team member David Roush asked: What is an appropriate staffing ratio? What follows is his approach to answering that question. This is a difficult question because of multiple perspectives. Roush referenced an Ohio ratio of 1:12, which may not be directly applicable here, as one of his basis for estimating JCO needs. There is a real ratio based on current practices (1:24). There is a ratio based on practitioner experience (1:10). There is a best practices ratio derived from a review and summary of research and professional writings on the topic of staff sufficiency (1:8).

Based on evidence acquired to date, the current DYS staffing patterns have been able to accomplish only one of its affirmative duties, security. Perceptions of safety are substantially low among residents and staff. Both express substantial levels of fear for their personal safety (see Roush Report, Table 3). Over 60% of the teachers in the DYS education system report that they fear for their safety.

The fiscally responsible staffing goal should be a DYS operation that is adequate in numbers and possesses the skills necessary to do the job. "Adequate" means that the staffing ratio (number youth per JCO staff) should be at the point where safety, security, order, and programs operate effectively. The skill development function brings with it the expectation that staff perform their job duties competently within a viable system that provides quality leadership and supervision.)

The perspective on "adequate" staffing differs between the adult corrections and the juvenile justice viewpoints. At the core are the differences with adolescent development. From the adolescent perspectives (safety, security, order, and programs), an adult corrections expert's tour of the JCFs may prompt only a mild concern or comment about inadequate staffing. However, from the juvenile justice expert's perspective, the same tour literally takes one's breath away. Explaining the severity of the understaffing

to those with an adult corrections model prompts the use of exaggerated analogies and metaphors.

The current staffing levels (Tables of Organization or Matrix staffing numbers) likely derive from staffing estimates calculated on a ratio (1:12) when institutional capacities were substantially less. Therefore, the alternative way of addressing the staffing ratio without adding staff is to reduce the population of DYS institutions and maintain the present “law and order” model.

JCO staffing levels now are so low that they likely covary with other indicators, especially those that measure safety and bureaucratic dysfunction. This is the case when comparing the staff shortage numbers per JCF with corresponding PbS measures of safety and program outcomes. From a methodological perspective, caution is warranted since support for bureaucratic dysfunction might simply be another measure of inadequate staffing.

If the 1:12 ratio is used as the definition of “lean” staffing, will require 188 new FTE JCO positions (not including those Matrix positions that are currently vacant) and an increase in the personnel budget of $ 7.8 million annually based on a starting salary of $15 per hour. (For the 1:10 ratio, the annual increase is $ 10.6 million and, for the 1:8 ratio, the annual increase is $ 14.2 million.) This remedy is expensive. Hence, a workable alternative could be a plan that incrementally expands JCO staffing and responsibilities while reducing institutional populations and increasing reliance on community resources.

This Report offers no firm recommendation on JCO staffing other than to assert that current staffing under current conditions is too low. Settlement discussions might focus on 90 new positions as a low and 188 as a high with a final number subject to negotiation and the possibility of an objective post-settlement study.

Without addressing this issue, the JCOs will continue to struggle with the fallout of mandation while security and safety will remain problematic.

Training

Training differs from education in that training is focused on skills and task/job performance. While there clearly may be some overlap, educational enterprises seek to convey ways of thinking; acquisition of data; and broad, general concepts. Education is to architecture what training is to carpentry.

Team member David Roush found no evidence of educational programs at the Training Academy (TA) and had serious questions about the training program for DYS staff.

The TA itself has excellent physical space, adequate training staff, and some acceptable training materials. Evaluations of trainees, however, are too subjective. Due to the shortages of JCOs, trainers work individually and prompt trainees on how to answer post-test questions correctly, thereby increasing the numbers that pass the training and move to the JCFs for work assignments.

Once a fledgling JCO completes the TA training and moves on to a JCF there will be only one training officer who, in turn, must use fellow JCOs and other staff as trainers. With 30 of the 40 hours of annual mandatory training prescribed by DYS, this leaves litter time for facility-specific issue training.

A theme that emerged from the interviews with training officers was the concept of "temporary proficiency." Two training officers used the term when discussing physical restraint training. Their belief was that most JCOs do not remember the Response-to-Resistance (R2R) protocols and techniques. Without an ongoing annual refresher course, there contention was that staff have only a temporary proficiency in the approved restraint strategy following the Pre-Service Academy. This, of course, was independently described by team member Steve Martin.

On-the-job-training (OJT) is the main influence on JCO behavior according to JCOs and training officers. It is correctional, custodial, and security-oriented; and it reinforces the harsh staff climate in each JCF.

The OJT is an 80-hour process that reinforces most of the poor practices in the job performance of JCOs. None of the training officers reported regular meetings with the mentor JCOs to discuss, review, or evaluate the OJT process. Furthermore, training officers indicated that they do not get training or guidance from DYS regarding OJT. No one mentioned a recent meeting of training officers to discuss or evaluate OJT.

The system avoids information and concepts from the childcare and adolescent perspectives. The heavy emphasis on the correctional aspects (security, staff safety, and control) seems to preclude information about adolescence and the legal rights of juveniles that could be helpful in altering behavior. This preoccupation creates a condition where

the absence of a broad-based training experience and the lack of openness to the uniqueness of adolescence, combine to enforce the culture of violence we have observed.

As if moving lockstep with adult corrections, JCOs receive training and information on STG (security threat groups) without clear differentiations with mental health behaviors. To use Maslow's hackneyed adage, "When a hammer is the only tool in your toolbox, soon all of your problems begin to look like nails," it seems as if security is the only tool in the JCO toolbox and all misbehaviors look like a security threat.

The training philosophy we observed contributes to the adultification of Ohio's juvenile corrections system.

Based on the training and job shadowing provided to the new JCO, he or she likely goes into a situation assuming that the youth want to fight. Youth see a JCO's hostile, menacing appearance (stern looks, tough and confident demeanor) and respond in kind with a hostile display (or bravado for peers). New staff conclude that their original expectation was correct: The youth do want to fight. It never dawns on anyone that perhaps staff that look for trouble, create or sustain the hostility.

Whatever its origins, the adult corrections metaphor is a bad choice for use with juveniles but an even poorer choice when used alone or without a treatment strategy. Not insisting on a duty to perform rehabilitative functions from the JCO allows, even encourages, JCOs to entertain a very limited set of solutions to solve any problem and a very limited set of ways to organize themselves. JCOs solve problems by sanctioning inappropriate behaviors (tickets, behavioral incident and discipline reports), tightening controls, introducing more discipline and structure, sending for reinforcements (signals or codes), or clarifying responsibilities, i.e., holding youth accountable by focusing greater time and attention on the relationship between misbehaviors and sanctions.

Application of an adult corrections philosophy to juvenile corrections usually means (a) a diminishing of the roles and responsibilities of line staff (JCOs), i.e., they would no longer be viewed by youth or the system as adjuncts or partners in the behavior change or rehabilitation process, and (b) an increasing emphasis on safety, security, and control in the job description. These safety, security, and control functions are viewed by administration as much less complex, requiring fewer skills on the part of JCOs and, therefore, based on extrapolations from the adult corrections experience, capable of being

accomplished with fewer numbers of staff with lower pre-employment qualifications and pay grades.

The architecture of Ohio's juvenile corrections has taken on prison-like qualities, i.e., harder construction, increased and enhanced security technology, and the ability to lockdown quickly various areas of the institution from a central surveillance location. The exemplar of this architecture is, for example, the Marion Juvenile Corrections Facility.

Staff are trained to find problems and to sanction them, i.e., hold youth accountable. PbS data suggest this confrontational approach disproportionally affects outcomes negatively. Staff functioning with this approach appear to far outnumber the positive ones mentioned earlier, and they have the dominant influence in most of the general population JCFs.

Many of the staff interviewed expressed a sense of moral outrage about the youth in their care, of a need to enforce accountability for the derelictions of the youth in their charge. Certainly nothing in the training was designed to even challenge these beliefs; beliefs that when translated into action creates a battlefield mentality.

Staff repeatedly raised the same question, "What about the victim?" References were made to the sexual abuse of children, and then someone would ask the hypothetical question about how you or anyone would feel if one of these youth had raped your child. In each interaction, staff cynically juxtaposed heinous behaviors with "official" DYS consequences of playing video games, watching TV, or having pizza parties. These JCOs are angry that an adequate or sufficient punishment had not yet been inflicted upon these youth. They expressed a sense of moral outrage that DYS would allow youth to continue to get away with disgusting behaviors.

Armed with the righteousness of moral outrage these staff members are quick to move to a physical restraint or excessive force, and often are strategic in the location to avoid cameras or to shield cameras from the view of the force. Their behavior, then, is not viewed as improper; it is the hand of the righteous combating evil.

One ORV resident interview group (six youth) was unanimous in its allegations that it had witnessed staff assaulting youth. Several youth in the group described different ways that staff would physically abuse them. They indicated that staff would initiate a

restraint and then call for an administrator. The abuse occurs between the time of the call and the arrival of the administrator. Youth claim that JCOs tell the administrator that the youth acted out or attacked them, so they were forced to initiate an immediate restraint. The youth then claim that the official response from administration is that they arrived on the unit after the restraint was initiated.

In response to the question about how staff get away with excessive force in areas with cameras, the group described a process where JCOs would stand between the offending staff member and the camera while excessive force was applied. They indicated that an example of this strategy occurred the evening before at about 8:00 p.m. on their unit.

Following the interview, interviewer David Roush asked to see the digital recording from that particular unit. It seemed a simple request since on the previous day he had watched as one management person located and showed the digital recording of my tour of the same living unit. For this request, a series of technical problems and omissions prevented anyone at the facility from being able to retrieve the video. Staff did find the incident report and one administrator indicated that he had direct knowledge of the restraint. He qualified his comments by stating, “The restraint had already occurred by the time I reached the unit.”

Expert Roush made several other, equally unsuccessful attempts to see the camera recording of this event. DYS has not refuted the claims of these youth despite the existence of a camera system designed for that very purpose.

Staff training overemphasizes the prevention of problems. “No problems,” “no tickets” become the primary indicators of a youth’s success as opposed to exhibiting progress, appropriate behavior, and learning. As mental hospitals found “success” in the silence of their residents brought about by the newly discovered psychotropic medications; as prisons take pride in no escapes, no suicides, and no “tickets” for inmates, JCFs follow in their wake.

Training appears to strengthen the JCOs’ ability to spot misbehaviors and to determine the appropriate amount of sanction, consequence or force required to induce compliance. A competent youth behavior management training program would teach staff members (1) how to weaken or eliminate misbehaviors and (2) how to expand and

strengthen appropriate behaviors. The DYS adult corrections bias focuses on only one-half of the process and thereby contributes to the overall malaise.

As one example of a standardized omission of the positive aspects of youth work, the "On-The-Job Training Manual" provided us for our assessment contains 52 pages of performance objectives and steps (activities) that constitute a checklist of training activities for new JCOs. All of these activities must be demonstrated to the new JCO, and the designated staff member then ensures that the new JCO performs each activity. *Nowhere in the 52 pages is there anything that addresses the importance of reinforcement, encouragement, or praise. Nowhere is there a step or activity that teaches a skill of recognizing what youth do appropriately.*

Training staff understand this problem, and most indicated that they or their trainers do try to talk about the importance of a positive approach. At IRJCF, the trainer provided a PowerPoint presentation about reinforcement of positive youth behavior. There were no indications that the materials are part of the training curriculum, or a lesson plan, nor a record of its use.

Staff training currently lacks clarity on the fundamental distinctions between legal rights and duties. For every right possessed by youth, there is an affirmative duty placed on staff. Where law is mentioned or taught it is by non-lawyers and too often as a device to avoid liability.

Each area of juvenile law on point has its own substance: use of force, isolation, mental health, and so on. Staff, of course, must know when and how to use force. They also should know why the law is different for youth; the long history of legal distinctions based on youth; the law's implicit and explicit adoption of reduced culpability and salvagability based on youth; the law's commitment to reformation.

To that end, we would urge the creation of introductory and advanced courses on juvenile law and custodial obligations with regard to youth. This writer would be pleased to prepare such materials, pilot them, and "train the trainers" for the future.

Training Remedies

What follows is a series of suggestions for consideration of the parties in revising and improving existing DYS training programs:

- All training topics should have a lesson plan that exists separate from PowerPoint slides and contains training objectives, useful participant handouts, and an evaluation experience that identifies participants who have not acquired basic skill levels because of the training.
- More trainers are needed. There should be a full-time trainer for every 50 FTE staff members.
- DYS should upgrade and expand its training materials, particularly audiovisual resources that are juvenile specific. The Training Department should consider establishing a relationship with the juvenile justice training staff at the University of Illinois at Springfield.
- DYS should improve the content and quality of staff training by embracing a balanced approach to juvenile corrections, specifically a strengthening of the JCOs skill development from a strength-based or positive perspective. The current training program is out-of-balance and overemphasizes discipline and control. Safety and security are strengthened, not compromised, by a strengths-based component.
- Changes in the philosophy of JCO training must be reflected in the recruitment and selection of new staff. It is far easier and more effective to teach someone who likes youth how to do safety and security than it is to teach someone who does safety and security well how to like youth.
- DYS needs to change its training strategy and materials away from a adult corrections philosophy to a juvenile corrections or juvenile careworker model.
- DYS should collect feedback and information from each JCF regarding local training needs for JCO staff.
- DYS should conduct focus groups to evaluate and improve OJT.
- DYS should infuse a positive and strengths-based perspective into line staff training materials whenever possible.
- Courses in juvenile law and recognizing and dealing with mental illness should be developed and initially taught by recognized experts in the field who would then “train the trainers.”

VIII. HEALTH AND DENTAL SERVICES

Health Services Overview

The physical health care needs of incarcerated youth rest on the same principles of cognitive, developmental and associated disabilities as the provision of mental health care. There is no question that incarcerated youth have a legal right to appropriate physical as well as mental health care.[42]

As Michael D. Cohen, M.D. et al point out:

> Although there is a pervasive impression that adolescents are "basically healthy," this is not always the case. There are many chronic conditions that are present from childhood, and many of the chronic diseases of adults, such as hypertension, Type-2 diabetes, and coronary artery disease, have their onset in adolescence. Although youth may not yet be symptomatic or disabled, they still need care to prevent long-term complications of these conditions. Asthma is the most common chronic medical conditions, but there are a multitude of childhood chronic illnesses with a prevalence of 1 per 1,000 or less, which are found in youth served by juvenile justice programs. Recurrent or persistent symptoms in an apparently healthy youth may be the initial presentation of a serious chronic illness.
>
> Several studies have examined the prevalence of chronic conditions in adolescents and delinquents. An analysis of the 1984 National Health Interview Survey showed a prevalence of 6.2% for all types of disability. The four most common disabling conditions were mental disorders; respiratory conditions, principally asthma; nervous system disorders,

[42] There is no clear line of cases distinguishing the right to correctional health care for juveniles from the same right for adult inmates. William J. Rold, The Legal Context of Correctional Health Care for Juveniles in NCCHC, Standards for Health Services in Juvenile Detention and Confinement Facilities 14-5 (2004), correctly posits the Fourteenth Amendment to the U.S. Constitution as the juvenile's constitutional basis for the right, but his discussion of the right itself simply parallels the adult's Eighth Amendment rights as initiated by *Estelle v. Gamble*, 429 U.S. 97 (1976). This would mean a medical need must be "serious" and the poor medical care must be traced to a provider's or custodian's "deliberate indifference."

principally seizures; and disorders of the ear and mastoid, principally hearing impairments.[43]

The modifier "appropriate" refers to the special medical considerations dictated by youth. Issues of delayed puberty and short stature, nutritionally adequate diets, health promotion, and disease avoidance may not be entirely unique to the juvenile population but they are of transcendent importance.

A medical record either is or is not fit for its intended purpose and has no special requirements for youth. Continuity of care concerns are crucial for adults and juveniles.

Injuries, in turn, are quite common in juvenile facilities whether caused by youthful exuberance, staff or youth assaults or athletic activities. In turn, there must be clear guidelines for clinical assessment and physician referral.

Juveniles in custody have at least the same constitutional right to medical care as their adult counterparts serving time in prison.[44] This means that only serious medical conditions *mandate* care and that care is evaluated by the standard of deliberate indifference; a standard less demanding on providers and system functionaries than malpractice. In my view, the fact that juveniles in the custody of DYS have not been convicted of a crime, that the source of the right is the Fourteenth Amendment's Due Process Clause, and that the consequences of medical failures for youth can be more serious and certainly more long-lasting than for adults argues for a wider net of legal responsibility.[45]

I used a similar approach in discussing a juvenile's right to correctional mental health care. That is, one can use the Due Process foundation for juveniles' rights as a springboard to broadening the medical conditions requiring care or one can accept the more narrow Eighth Amendment-*Estelle v. Gamble* base but argue that "serious" and "deliberate indifference" have a different, more expansive, meaning in the world of juvenile corrections.

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[43] Michael D. Cohen, Larry Burd, & Mary Beyer, Health Services for Youth in Juvenile Justice Programs in Clinical Practice in Correctional Medicine 120, 135 (Michael Puisis, ed., 2d ed 2006).
[44] See note 41, supra.
[45] See American Public Health Association, Standards for Health Services in Correctional Institutions, Standard VII.B (2003).

Juveniles, of course, are not placed in official custody *for* medical care; the right to medical care arises from conditions detected when custody is assumed. With mental health care, one might argue that juveniles are placed in official custody, if not exclusively, then importantly, for rehabilitation and that mental health treatment is a significant subset of rehabilitation. Thus, the expansive legal argument for mental health care may be somewhat easier to sustain than the one made here for medical care.

As this Section unfolds it will become apparent that the DYS system is riddled with serious deficiencies. For example, the medical assessments performed at Scioto JCF are not monitored for quality or accuracy and do not "connect" the youth to the receiving facility. Medication administration does not meet current nursing standards, laboratory services have been subject to serious delays and inaccuracies, medical records are incomplete, preventive care is dubious, and chronic care clinics simply do not exist.

The Medical Director clinically manages the Central Medical Unit at Scioto, spending between 600-800 hours annually on site. This hardly leaves time for peer review, quality assurance, policy development or any other activities associated with medical leadership and administration.

As will be developed, this is a system in search of system and in need of fundamental change in order to provide legally obligated medical care.

Current Structure of Medical Services

DYS has one civil servant physician who serves as the Department's Medical Director. This position is considered a Bureau Chief and reports to the Deputy Director for Treatment and Rehabilitation Services. All other physicians are employed by contract for a maximum number of hours per fiscal year. Dental services are also provided by contract and are addressed under Dental Services in Section VII in the main report.

Consultation (technical supervision) for complex cases is provided by the Department's Medical Director and direct supervision is provided by the Program Deputy at each facility. The Medical Director currently conducts no peer review. This should be a requirement of the position to insure that medical practice standards are being met. Policies that govern the practice of medicine in DYS facilities should be promulgated through this office and the Medical Director should have recognized authority in this area.

There is a Director of Nursing at the Bureau Chief level and all Health Care Administrators report to this individual as well as to the local Program Deputy. The collaborative relationship between the Medical Director and the Director of Nursing is not currently defined and ultimately must be. For example, nurses are responsible for completing initial health appraisals and physicians should have a role in designing those appraisals so that critical areas of adolescent development and health history are adequately addressed along with family history and personal history of medical and mental health.

The Medical Director and Director of Nursing should drive policy/procedure development for all medical matters and submit that material for Departmental approval through the Deputy Director for Treatment and Rehabilitation Services. Each should, as appropriate, participate with the Program Deputy in the assessment and evaluation of physicians and healthcare administrators at the facility level based on clinical practice requirements and current position description specifications.

Medical Assessments

Initial assessments are completed at Scioto Juvenile Correction Facility and the information contained in these documents sets the parameters for care and treatment of youth during his/her stay at ODYS. Timeliness of the completion of all initial assessments (medical, mental health, education etc.) is monitored at Scioto and reported to institution administration and central office managers.

Timelines currently are being met for the majority of cases. There are no penalties, except incidentally for the youth, if the work is not completed in a timely manner. Those penalties include delays in enrollment in the educational program and the provision of medical and mental health treatment.

The quality and accuracy of these initial appraisals is not being monitored. This quality improvement process must be added to the Scioto protocols and rigorously pursued. The history provided by families is not correlated with the initial or subsequent medical and mental health assessments completed at parent institutions. Also absent from the initial appraisal are assessments of physical and sexual development based on age and the youth’s current nutritional status. Hearing and visual tests are to be

completed as parts of the initial physical examination process but often were absent from the medical file.

As part of the transfer process, physicians' review the initial and transfer documents, if available, and document the review in the progress notes section of the individual youth's file. These notes give no indications of the physician's conclusions based on the information available. No health status is included; for example, healthy male, immunizations complete, no significant youth or family history of chronic disease or mental health issues noted. When a medical problem has been identified there is no physician note indicating the status of the problem or response to treatment, or even a timeframe for actually examining the youth.

Youth are not present during these initial physician record reviews. When the youth is seen there is no correlation of information documented to confirm the physician's impressions from the record review. The lack of documented information results in delays in needed, and at times, vital treatment or the recognition of chronic disease. In some cases, acute conditions also were missed, or treated but not documented. The only penalty we could detect is suffered by youth who have not received adequate medical care.

The failure to document the use of available information and connect that to the youth's current health status must be immediately corrected. The policies on Health Care Appraisal and Examination (403.11) and Special Needs Health program (403.15 III and IV) should be revised as well as the Transfer Health Appraisal (403.12). The failure to document clinical impressions and integrate information that is available results in the provision of inadequate or incomplete care that may then require a higher level of care, e.g. emergency room care or hospitalization at a later date accompanied, of course, by needless pain and suffering.

Recommended Improvements

1. Initial health care appraisals should be completed by RNs' and there should be an area for the physician's signature and comments. These appraisals must include an assessment of the adolescent's physical and sexual development, nutritional status as well as the areas of mental health etc.

2. The transfer health appraisal must be completed by the sending facility and accompany all youth at the time of transfer. These must include: a summary of findings, a summary of care and treatment provided with the youth's response, a list of current medications and compliance and a list of specialty appointments completed or pending.
3. The receiving facility, RN and physician should document a review of the materials received and correlate that information with the youth's health status on arrival and at the time of the initial examination by the physician.
4. Chronic care clinics should be established for youth with chronic diseases. Monitoring of the youth's status should be consistent with nationally established guidelines for adolescent care. These same standards should be used to develop institutional procedures driven by ODYS policy. *There is currently no chronic care program*! Youth with chronic diseases are not seen regularly for status checks and the assessment of the efficacy of the current treatment regime. This basic lack of care leads to episodic treatment at higher levels than might have been required. The lack of chronic care clinics for those who require them illustrates systemic failure to engage youth in their own effective disease management and care.
5. Policy and procedure must require an active system of care with youth seen at the first available physician visit following an acute episode of illness, a specialty appointment, hospitalization, etc.

There must be better integration of all available medical information. The diagnostic conclusions and consequent care based upon this information must be clearly and specifically documented and maintained in the medical record. Failure to correlate and validate information as received and used by qualified clinicians leaves the youth at medical risk and DYS at risk for failure to treat, or properly treat, when the information is, and has been, available but not been used.

Determining that an acute or chronic disease is not present should also be consistently documented.

Medical information and its use while at the reception center sets the course of care for youth during his/her entire DYS stay. Qualitative reviews of the material

collected and used should be routinely monitored. Corrective action, including policy and procedure review, education and training, should be taken in cases where assessments are incomplete; accurate information is not relayed in a timely manner or follow up is not documented.

Infirmary Care

DYS has a central medical unit (CMU) at SJCF that is clinically managed by the DYS Medical Director requiring 600-800 hours of his time on site annually. This unit is used primarily for convalescent care and appears to have an adequate number of beds (10). Each facility uses a local hospital for emergency care, local specialists may be used for chronic and acute disease and/or providers utilized prior to incarceration may continue to provide care as required.

A review of four infirmary cases, all involving recent surgery, revealed gaps in the medical records. In one case, the record from the parent institution had not been sent and was never available during the youth's stay even though he was not to return to the same institution. Medical staff were providing care having no idea of the youth's history or needs beyond the immediate post-operative state.

Three of the youth had abnormal blood pressure readings that were never reported to the physician, noted by the physician or assessed over time. A youth with asthma used his inhaler three times in one week; these were not reported to the physician nor were peak flow values recorded by the nurse. Team members brought each of these cases to the attention of the Medical Director.

The amount of time the Medical Director spends on the provision of direct care must be considered in relation to his administrative responsibilities of peer review, policy development, and quality improvement initiatives etc. It appears that the amount of time spent in direct care at the CMU and as consultant/provider at other facilities severely limits his ability to conduct these activities in a timely, consistent and meaningful manner. As DYS assesses the ongoing requirements for an acceptable level of medical care, the overall requirements of the Medical Director position and support staff for this position must be seriously considered and then clearly defined. Performance consistent with these requirements should then be monitored as with any other DYS position.

Medication Administration

Medication administration in the majority of DYS facilities did not meet current nursing practice standards. Medications were prepared in advance and not always administered by the nurse who prepared them, a serious misstep. Medications also were recorded before they were administered, not recorded at all or recorded at a time other than when administered. Blank spaces on the medication administration records (MAR's) were not reported as medication errors as required by DYS policy.

DYS recorded a total of 35 medication errors for a 12-month period for all facilities. Reviews of MAR's at every facility showed that one facility easily could have that many errors in one month with omissions (medications not given as ordered) alone. There is no assessment of the impact of the medication error whether it's the wrong medication, medication administered to the wrong person, effects of a double dose due to recording errors, or not giving the medication because it was not available, and so on. There are several layers of risk involved: not giving medications as prescribed may contribute to worsening of the illness and require more complex treatment as a result; and overdosing can result in an extreme response requiring emergency care or hospitalization.

DYS is also at financial risk for the medications as ordered and the cost of additional care and treatment.

Medications can be ordered on an as needed basis; to deal with recurring pain is one example of when this usually occurs. The physician's order usually specifies the number of hours that must lapse between doses ("one dose every three to four hours") and may also include the maximum number of doses that can be administered within a 24- hour period (for a maximum of eight doses). DYS currently makes this type of medication available upon request (as it should be) at breakfast, lunch and dinner-regular medication times. The purpose of as needed or "PRN" medications is to effectively control or maintain a manageable level of pain or to diminish the acuity of an asthma episode. These medications must be available by request and consistent with the assessed need for them 24 hours per day, as ordered.

One facility has self-administered medications for all youth. Individually labeled medications, including the youth's name, the name and dose of the medication and the frequency of administration identified are provided for each youth. The youth and

supervisory staff member both sign that the medication was administered, refused etc. This is evidence of a program that provides education on the importance and purpose of the medications as ordered and engages the youth in the management of his care. All failures to comply with medications as ordered are immediately addressed by the nurse and documented. Such interventions are rarely required as reported by staff and youth and confirmed by record review.

Pharmacy services, especially for those facilities contracting with ODMH, are not routinely monitored for timeliness and accuracy of deliveries. Delays in providing medications as ordered results in potential harm to the youth. Delay can also result in additional cost to DYS when medications must be purchased from the local pharmacy to cover the gap.

Joint monitoring of the pharmacy contract and its provisions should be conducted not less than quarterly with facility staff and the pharmacy provider. This process was being considered as we completed our visits but action had not yet been taken.

Laboratory Services

Nurses complete blood draws and prepare samples for laboratory testing ordered by the physician at all but one facility. Those facilities that use the ODRC, CMC lab have experienced delays and inaccuracies in test results. These issues are being addressed by ODRC and recent improvements were noted. Those facilities that utilize local or private laboratories have had no difficulties with the timeliness of results or the accuracy of values as reported.

Phlebotomy services should be considered for the reception center due to the number of tests routinely required.

Physicians initial and date lab results as they are reviewed. There is, however, no progress note that addresses variances from the lab norms and the impact, if any, on the care to be provided. This is both a documentation issue and an integration of care issue, as other members of the treatment team may not recognize the impact of lab values on the youth's current health status.

Infection Control

Infection control is not routinely addressed at the facility level. There is an educational program on infection control strategies included in pre-service training and a

one-hour program during annual training sessions for all categories and levels of staff. Youth and staff are encouraged to wash hands frequently and all facilities have educational posters and reminders posted on this specific topic as part of the universal precautions program.

There is no Infection Control Coordinator and there is no tracking or monitoring of infectious diseases. This area should be developed by the DYS Medical Director, or by someone under his supervision, and be instituted as a recognized institutional program. Infectious diseases must be tracked and many are required to be reported to the local health authority, e.g. sexually transmitted diseases.

The occurrence of Methicillin resistant staphylococcus (MRSA) and Methicillin sensitive staphylococcus infections should be tracked by facility and across the system. None of this work currently is being completed. The lack of attention to infection control poses a threat to youth and staff alike. Sexually transmitted diseases can be treated but may require life long medication and special precautions to avoid transmitting the disease to sexual partners. MRSA is treatable but can be life threatening and approximately 18,000 die of this infection annually.

Medical Equipment and Space

Medical equipment and clinic space is adequate overall. Space for the storage of medications at the smaller facilities compromises the presence of hand washing facilities and infection control practices for the preparation and administration of medications. The area for storage of medical and dental files at many of the facilities is inadequate and seems to encourage dismantling the file to "make things work better"; a dilatory practice that should be prohibited. There are no medical records technicians; nurses are responsible for maintaining the medical records, which takes time away from clinical duties. All areas, we are pleased to report, were clean and well maintained.

Medical equipment is consistent with population needs and is maintained in good repair. Dental equipment with the exception of Cuyahoga Hills also was consistent with population needs and maintained in good repair. The status and use of medical equipment should be regularly reviewed so that adequate planning and timelines for replacement can be established.

None of the facilities have room for infirmary or convalescent care in the medical area. The use of the ten beds in the central infirmary located at Scioto seems to be working satisfactorily despite the transportation logistics that must be considered from both time and cost perspectives. Youth are transported to OSU, Columbus Children's or a local hospital for emergency or scheduled care and then to the central medical unit (CMU) for convalescence, if required. One example of this is youth with a broken jaw who have corrective surgery and then spend six weeks at the CMU. Frequently youth are not to return to the sending facility and are transported to a new parent facility upon discharge. At this time, other than improving the consistency and quality of care in the central medical unit there are no recommendations for change.

Documentation

DYS policy requires documentation in multiple places and formats. There are electronic files which must be completed and then added to the paper file, there are the required shift logs, nurse sick call logs, doctor sick call logs, et al, and the medical file itself with S (subjective) O (objective) A (assessment) P (plan) (SOAP) notes. Much of this information is duplicative and results in gaps or incomplete documentation in each of the formats required.

The medical record is to be a chronological and complete record or 'story' of the youth and all aspects of care provided. This includes each element of history (medical, psychiatric, developmental), each complaint, problem or need identified and the assessment and diagnosis in each instance through the treatment and response or outcome of care as provided. DYS has improved the order and organization of the medical file but much remains to be done to make it a complete document that is an effective means of communication between shifts and disciplines.

Problem lists should be located in the same area in each file and readily apparent or available in the file. Those lists should be current and list all problems of significance; issues that have been treated and resolved should be so identified as indicated on the form in use. Medical records should be reviewed quantitatively and qualitatively to insure that information is complete and accurate. The youth's current status with regard to chronic disease should be clearly identified on the problem list and in the plan of care.

The history reflected by the problem sheet is important to the overall care of each youth and especially important to the care of those with chronic disease. The medical history of each youth must be as complete as possible, consistent with identified problems or needs and available to all members of the treatment team. The medical history that is established initially by the physicians at SJCF sets the parameters for care throughout the youth's stay so complete integration and accuracy of all data available is required. The current reception process does not insure that this will occur and must be addressed by the Medical Director and Director of Nursing.

Physician notes were found to be incomplete. They must be comprehensive and include the course of care, the problem, the treatment, and the outcome of each treatment provided. Notes should address the history and testing used to reach a diagnosis as well as a complete description of findings upon physical examination. The degree of control should be identified for chronic diseases and the level of acuity should be clearly stated for new diseases.

Examples of inadequacies are as follows: A youth with a history of asthma and receiving medications was received at the parent facility and while the chronic disease and medications were noted, there was no statement of health status by the physician. Medications were not ordered, again without any documentation on why, until six days later.

Another typical example is that of a youth complaining of urinary symptoms. A urinalysis and testing for sexually transmitted diseases (STD's) was completed. One week following the initial appointment an antibiotic was prescribed for two weeks. The physician's note did not indicate that he had seen the youth or the reason for medications. The urinalysis was normal and the STD testing was negative. The physician did see the youth several days after the antibiotic was started but for a new problem and made no mention of the youth's response to the antibiotics or that testing had been completed and was within normal limits or negative. The note indicated only that the exam was normal.

Another youth was noted as vomiting blood, an endoscopy was ordered and treatment followed. Subsequent episodes of hematemesis followed along with trips to the hospital and orders for additional testing. There was no information available in the

medical file regarding the hospital visits, the results of testing or any effort by the physician to follow up on these findings.

These examples are representative of what was *not* found in physician documentation across the system of medical care. One need not be a clinician to be disturbed by our findings. In the scheme of things, these omissions move medical care on line with mental health, use of force/safety, and education in the frontline of remedial concerns.

Vital signs that are significantly above or below the normal range for adolescents should be assessed for a defined period of time with guidelines for the frequency of reporting results/findings to the physician. The physician's review of these results should identify the relationship to an existing or new problem or disease. Consistent with the information previously noted, there is no documentation in the file to indicate the assessments either have been completed or considered by the physician in the provision of care.

All off site evaluations and appointments require a face-to-face appointment with the physician and youth to present and discuss the results and the plan of care. Documentation of this meeting should be available in the progress notes as well as the individual plan of care that has been documented. This process, if it occurs, is not being documented.

Youth injury assessments must include a description of the activity or event that led to the nurse's examination as well as the description of injuries and the action taken. Symptoms reported by youth should be verbatim and without interpretation. Assessments that are incomplete or documentation that is incomplete regarding the signs and symptoms described by the youth may result in inadequate or improper treatment. There were numerous examples of youth who complained of symptoms consistent with urinary tract infections. These youth, depending on the nurse's note or the verbal information provided over the phone but not documented, were not seen by the physician. Those youth who continued to complain of symptoms were eventually seen, 2-3 weeks after the initial complaint, and testing was then completed. In one of these cases, treatment was initiated only after identification by a team member, despite test results

that clearly identified a urinary tract infection requiring treatment had been available in the medical file for approximately one month.

Interval histories, contacts with medical services, need to be made available for physicians at the time of appointments. This is especially important for youth with chronic diseases. Failure to report or note interval histories resulted in medications being continued as usual when data indicated a change was required or should have been considered. The continuing lack of effective communication and documentation compromises the quality of care being provided.

Quality Improvement

Quality improvement is identified as an initiative encompassed by DYS but there is no evidence that the techniques are currently in use. Statistical data is collected and submitted to a variety of central office areas but there is no evidence the information is used in any fashion. There is no quality assessment and monitoring program for facility clinical and program services; no needs assessment of the population to insure that programming exists to meet those existing needs; and there are no outcome measures for individual levels of treatment or any aspect of medical or mental health care.

Nursing staff at the privately contracted medical services at Marion complete monthly quality assurance forms as required by the parent company. These requirements do not appear to have been adapted to an adolescent population rendering their usefulness questionable. Completing questionnaires on adult standards of care, the care typically provided by employees of the company, does not address the identified needs of an adolescent population. Even if the criteria for review were to be made consistent with adolescent standards of care, the topics change monthly. The change in topic makes it impossible to determine if the criteria used (the previous month) are pertinent to the actual provision of care or to determine if any change or trend has been noted based on information previously collected.

In the case of dental quality assurance, which had been completed for one month as required, there was no evidence in the dental or medical files to support the findings that had been submitted. The areas being monitored included the nurse's assessment of complaints of dental pain, the treatment initiated and the follow up assessment and care provided by the dentist.

An active quality improvement program should be established at each facility and the provision of care should be monitored and assessed on a regular basis. The program should include peer review at regular intervals and qualitative and quantitative medical record reviews at a minimum.

Education on Health Issues, Medication, Nutrition, and Personal Hygiene

DYS nursing staff have developed educational modules for pregnancy, chronic disease, nutrition and personal hygiene classes. Nurses complete these modules with youth during intersession and, as required, on a one-to-one basis. Youth seem to enjoy and learn from these sessions. Youth frequently identify topics to be included in the curriculum. The success of the program is based on verbal reports from youth because documentation of the key points presented and the youth's comprehension and ability to apply the information to his/her care is not consistently available. Many of these topics could be considered for inclusion the educational program in the Science and Health classes. The advantage of adding these topics to the education curriculum would make the information available to a larger population and qualify for educational credit for the youth participating.

There is an informed consent form and notification process for youth and family when psychotropic medications are ordered. Mohican has a program developed specifically for adolescents with pictures and uncomplicated terminology that can be understood and used by youth. This program reportedly was shared with other Health Care Administrators but it was not in evidence in any other facility. Notification to parents/family was months behind at one facility. Notifications at another facility were completed only with the appointment of a psychology supervisor and immediately prior to a Cohen team visit.

Youth should be engaged in mental health care and the psychiatrist does document the risks and benefits of the medications as ordered in her appointment summary. Family members should also be engaged in this care and have this information made available in a timely manner. Medical nurses are responsible for the administration of the medications as ordered and should also be confirming that the consent process has been completed. This does not routinely occur.

There is no educational requirement or process used for medications ordered for medical purposes. Nurses' report providing a basic description of what the drug is intended to do but there is no documentation to confirm that this has occurred. Classes on similar medications, the purpose, use, risks and benefits should be considered. Documentation should include the participants, the information presented and the individual's ability to use the information in a meaningful manner.

People who understand a disease process and the impact of the disease, now and in the future, are more likely to participate in their own care and address medical needs in a more timely and responsible manner. DYS has a captive audience and the opportunity to develop a program and relationships with medical providers to enhance the provision and quality care for youth. They also have, but do not use, these opportunities to develop positive medical relationships with the limited numbers of youth with chronic disease.

Mental Health Treatment Plans[46]

Youth engaged in mental health programs are seen by and involved with educators, nurse, and physicians. These individuals should have a working knowledge of the plan of care for these youth and any special needs that have been identified. Currently, mental health treatment plans are not individualized or completed by a multidisciplinary treatment team. The psychiatrist addresses future plans and any education provided in a narrative summary following each individual session. This information is available in both the medical and mental health file, usually within seven days following the appointment.

No other mental health information, beyond the initial intake screen, is available to medical staff. It would be preferable to have one medical record that housed all information but short of that there must be some form of communication so that nurses and physicians can respond to behaviors as prescribed in the individualized mental health treatment plan and in concert with mental health staff members. Medical staff should be represented on the interdisciplinary treatment team.

The plans that are in use are restrictive and concentrate on extinguishing behaviors without offering acceptable behaviors or developing new skills to resolve

[46] Despite the potential redundancy with Section IV on mental health, I elected to retain these comments since they come from a nurse and a physician.

problems effectively. Mental health services require immediate and ongoing attention and they require integration with medical services.

Special Management Plans

Special management plans are used as a disciplinary tool for youth who frequently aggressive or flagrantly violate institutional rules. There are three levels of special management plans with the least restrictive generally used for youth receiving mental health services.

These plans, like current mental health plans, are based on extinguishing behaviors without offering acceptable alternatives. There is a team approach to special management plans usually including the Superintendent, Psychology Supervisor and Custody staff. Excluded medical staff should be represented at these meetings to coordinate elements of necessary medical treatment. There does not appear to be any assessment of facts beyond the immediate charge or violation. There is no review of the outcome of the plans when used previously or the frequency of use of the same plan for the same youth for the same problem. All this data would be useful in developing a meaningful plan. For example, the special management plans in use at Indian River uses the guidelines that were developed for these plans as the plan itself. The guidelines were intended as a starting point to the development of a plan that would meet individual youth needs even when the only consideration is discipline or correction of a recurring problem behavior.

Staffing for Physicians and Nurses and Related Areas

Staffing allocations for nurses and physicians, and related support staff, medical records technicians, phlebotomists and secretarial support are inadequate for the current number of youth housed in DYS facilities requiring a safe environment, education and treatment for medical and mental health issues.

The number of positions allocated for nursing staff does not appear to have included a relief factor for these 24/7 positions that is consistent with DYS benefit/leave policies. If professional competency were maintained at the highest levels, the current numbers of staff without consideration for days off, vacation and sick leave, disability and occupational injury leave would still leave a deficit and create problems for youth and staff alike.

Mandated overtime is being used less in this staffing area because staff members now have the opportunity to schedule overtime in advance. Mandated shifts do occur with regularity to meet institutional minimums although nursing staff at most of the facilities make every effort to work out leaves in advance and minimize the need for mandated overtime to occur. These efforts should be recognized but do not eliminate the need for a relief factor to be included in identifying staffing allocations.

Concerns about actual numbers of staff available must be tempered by the time now utilized for programs and individual or group services. The educational program, for example, takes priority over many daytime hours and suggests that clinical staff should have non-traditional schedules. Staffing dynamics and priorities should be examined and an overall approach to staffing then developed.

Before the numbers of staff required for clinical service can be realistically evaluated the roles and responsibilities of these care providers and support personnel need to be clearly defined. The priority is to provide a safe, healthy environment with zero tolerance for aggression from youth and staff alike. Within the context of no verbal or physical aggression, staff members have to learn how to lead and provide behavioral values in the course of daily tasks. Youth and adults need to understand that behavior has consequences but that proper consequences do not insure proper behavior. Rules should be simple, clear and enforceable but not designed to delay or remove access to care. Enforcing the rules should be completed in a consistent and dispassionate manner-not by manipulating rewards and punishment. The repetitive nature of explaining and enforcing (saying what you mean and meaning what you say) rules should be a responsibility not only of staff members but of youth who can take on leadership roles within their own peer group to aid in the management of day to day activities. (Lighthouse Youth Center at Paint Creek is an excellent example of this approach.)

Clinical services should be clearly defined and provided in a timely and professional manner while incorporating the goals identified for each youth in education, mental health care, and in concert with medical care. DYS had adequate policies in most of these areas and encourages or requires facilities to develop local procedures or protocols for many of these policies and yet the deficits and lack of timeliness continue to occur (e.g. medication administration, documentation, integration of available

information). As noted above, the rules should be simple and clear. These same rules should be enforced consistently and dispassionately. The quality of care and services should be monitored and assessed consistently at the local and central level, as should the availability and competency of staff.

The difficulty in recruiting competent medical staff for existing positions is a recurring theme. Given the duration of existing vacancies in facilities consideration should be given to adjusting pay rates to competitive levels with the private sector and to considering additions to the benefit package.

The current organizational structure does not encourage thinking, the sharing of effective ideas or decision-making that benefit youth. Encouraging the growth of professional staff and providing evidence that creative thought and approaches are valued should also contribute to successful recruitment and retention of competent and committed staff.

Staffing recommendations for medical and related staff follows as Attachment 1. Numbers of existing positions were provided by DYS; recommended numbers are baseline figures and computed on current duties and expectations but not done by location. These numbers are also related to current population levels. Hours of work should be consistent with youth and programmatic need and the availability of family.

Nurse practitioners should be added to the staffing mix to complement the number of physicians and to provide clinical supervision for nursing staff.

Nutrition

DYS provides a 3300-calorie diet, which is consistent with adolescent needs. Those with special dietary requirements appear to be accommodated and educated. Pregnant females are to have meals adjusted to meet the demands of pregnancy in adolescence. These comments are based on the existence of these guidelines. The nutrition program was not adequately assessed to determine the efficacy of the program or individual factors. The girls at Scioto frequently complained that pregnancy diets were not adequate.

Comments

There is a crisis of leadership at the Deputy Director level that is reflected at the facility level. The lack of direction and programming that is evident at the facility level

seems to be generated from Central Office since communication and collaboration are not in evidence. The messages to those in the field are incomplete and inconsistent at best. There does not seem to be an acknowledgement that removing a previously accepted approach requires both a simple explanation of why and a replacement. The same error that is being made with youth on special management plans is being made with employees. The impact of these errors for youth and for staff is not easily measured but it clearly prohibits the accomplishment of providing a safe environment for youth or staff.

Summary

The Medical Team visited Scioto Juvenile Correctional Facility, Marion Juvenile Correction Institution, Indian River Juvenile Correction Institution and Cuyahoga Hills Juvenile Correction Facility in August and September of 2007. Ohio River Valley also had a medical but no dental review and basic nursing services were reviewed at each facility the Core team visited. Youth interviews were conducted at every facility visited.

Findings

- Medical care and the documentation of the care provided require close attention. There must be a program established for the recognition and care of chronic diseases identified in this adolescent population. There must be greater attention paid to developmental norms and to the standards of care for an adolescent population.
- There must be additional attention to the special needs of female adolescents in all aspects of programming and care. Developmental milestones for physical and emotional development should be identified and used in the provision of care and education. Dietary and physical activity behaviors should be monitored and designed to engage youth in healthy lifestyle choices that can transfer to a community setting.
- Acute care is provided consistent with need but is not addressed as part of ongoing care to diminish the requirement for an emergency response and to engage the youth in managing his/her own health care effectively.
- Access to medical staff is adequate and nurses are available 24/7 on site for all but Freedom Center. The night nurse at Scioto reports to Freedom Center if needed during the nighttime hours.

- Education on preventing disease is reported as being provided but, if it is, is inadequately documented. The prevention of disease and normal human development should be a recognized part of both medical and educational programs and particularly important in an adolescent population.
- Plans of care for medical and mental health needs should be individualized and available in the medical file for the multidisciplinary treatment team that must be developed.
- Quality improvement programs and infection control must be developed.
- The dietary and nutritional programs should be assessed to insure compliance with available standards of care for adolescent populations.
- Medical staffing should be adjusted to meet operational demand and to set a standard for care in the absence of nationally recognized staffing ratios,
- An active program of health care that is multidisciplinary in approach and supported by policy and procedure is a current requirement. Engaging youth in understanding their own needs and participating in care should be a focus of all programs.

ATTACHMENT 1

Staffing Recommendations[47]

1. There must be a relief factor established and considered for all nursing positions.
2. Credentials must be consistent with the population served; e.g. family practice physicians.
3. Competency of all staff should be regularly assessed and consistent with program expectations as described in position descriptions.
4. Peer review should be completed for each professional employee on a regular basis.

Physician	Current 22 hours/week	Recommend: 60 hours/week plus specialties
Nurse	Current 48.5 hours/week	Recommend: 60 hours/week (Marion not included)
Medical Records Tech	Current 0	Recommend: 1 for large facilities; 0.5 for small facilities
Health Info Tech	Current 0	Recommend: 1 for large facilities; 0.5 for small facilities to complete scheduling of appointments, etc.
Phlebotomist		Recommend: 6-15 hours/week depending on facility need.

The baseline recommendations considered current duties and expectations but not location or facility security levels. Hours of work should be consistent with program needs and the availability of youth as well as family members. The increase in nurses should include nurse practitioners that would complement the physician numbers and provide clinical supervision for registered nurses. The projections for physicians include establishing chronic care clinics and an effective healthcare education program.

[47] We offer these recommendations at least as starting points for any subsequent negotiations that follow this Report.

DENTAL (ORAL) SERVICES

Juveniles' legal right to dental care is of equal significance to the undoubted right to mental health and medical care. Indeed, NCCHC, Standards, Y-A-01 Access to Care reads, "Juveniles have access to care to meet their serious medical, *dental*, and mental health needs." NCCHC promotes timely access to a licensed dentist and the compliance indictors, Y-E-06 are:

1. All aspects of the standard are addressed by written policy and defined procedures.
2. Oral screening by the dentist or qualified health care professionals trained by the dentist is performed within 7 days of admission to the correctional system.
3. Instruction in oral hygiene and preventive oral education are given within 14 days of admission.
4. An oral examination is performed by a dentist within 60 days of admission.
5. Oral treatment, not limited to extractions, is provided according to a treatment plan based upon a system of established priorities for care.
6. Radiographs are appropriately used in the development of the treatment plan.
7. Consultation through referral to oral health care specialists is available as needed.
8. Each juvenile has access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.
9. Where oral care is provided on site, contemporary infection control procedures are followed.
10. Extractions are performed in a manner consistent with community standards of care and adhering to the American Dental Association's clinical guidelines.

The American Public Health Association, Standards for Health Services in Correctional Institutions, p. 111 (2003), notes:

Dental caries (soft, decayed area in a tooth) and fractured front teeth are the most common physical health problems among incarcerated youth. Moreover, adolescence is the age of greatest incidence of caries in the permanent molar teeth. Filling existing caries and application of pit and fissure sealants to intact molars are highly effective interventions to stop further deterioration and preserve the permanent teeth into adult life.

There is not a great deal of case law in the area of correctional dentistry. What exists is exemplified by *Ramos v. Lamm*, 639 F.2d 555, 576 (10th Cir. 1980), "[D]ental care is one of the most important medical needs of inmates." See also *Hartsfield v. Colburn*, 371 F.3d 454 (8th Cir. 2004), on pre-trial detainee, dental care rights.

I need not repeat here what was previously written about competing constitutional sources for the right and my belief that juvenile status argues for a more expansive test for mandated care than a narrow reading of the Estelle, "seriousness" – "deliberate indifference" test.

Caries are endemic to youth and, interestingly, caries was considered to be a serious condition by the Second Circuit on the theory that it is a degenerative condition likely to produce agony, loss of the afflicted tooth, or even infection. Thus, a dental condition viewed by some as "minor" may legally be characterized as "serious" based on the likelihood of what it may become.

Seriousness alone, however, may not be enough if the requisite mental state is lacking. In *McCarthy v. Place*, 2007 U.S.Dist.LEXIS 41977 (S.D. Ohio, June 8, 2007), the court found that enduring six months of excruciating pain due to an untreated toothache was serious. However, the court found that deliberate indifference was lacking since the dentist had an explanation for his omission and the plaintiff's proof was inadequate. *Place*, of course, is about damages while *S.H.* is about injunctive relief.

What follows is the substance of the Dental Summary Report prepared by team expert Donald Sauter, DDS, MPA. Dr. Sauter concludes, "that the overall Ohio DYS dental program is inadequate." He specifies the areas of greatest deficits and recommends changes needed to achieve acceptability.

Methodology and Techniques

In preparation for the site visits, Dr. Sauter reviewed policies related to dental services, Ohio State Dental Board Law and Rules, November 2006, the Ohio State Dental Board Infection Control Manual, June 2004, Centers for Disease Control Guidelines for Infection Control in Dental Health-Care Settings – 2003, and previous site ODYS site visit reports. He then developed 17 review steps to determine the extent to which the ODYS institutions were in compliance with their P&P and providing dental care consistent with the dental literature and regulatory guidelines and rules. These steps served as standards to provide a focus and consistency for my reviews.

Quality of care and level of care must be distinguished. To determine whether care is of adequate quality Dr. Sauter looked to professional organizations such as the American Academy of Pediatric Dentistry, the American Dental Association, infection control guidelines issued by the Centers for Disease Control and Prevention, as well as the professional literature. While it may be appropriate to vary the level of care (scope of services) provided, dependent on a correctional setting, length of time in custody, and the like, the evidence-based literature describes minimum standards of quality for dental procedures.

This report is structured around five areas: 1) access to timely care, 2) adequacy of physical facilities, 3) quality of the providers, 4) quality of the care, and 5) overall program management.

Recommendations on how to achieve an "adequate" level and quality of care are provided.

In establishing a definition of an adequate level of care I am cognizant that the correctional environment is unique and that:

> *… the focus of correctional dentistry is the control of acute dental pain; patient education of the major factors that influence oral health and general well-being; consistent application of preventive dental modalities; the elimination of dental pathology; and restoration of function … recognizing that … restoring a patient to optimal function is often a difficult and sometimes unattainable goal. Dental therapy in*

the correctional environment should be conservative and meet the professional standards of acceptable care found in other public health settings.[48]

Site Visits

Site visits were conducted at four ODYS facilities. Dr. Sauter accompanied the Medical Investigation Team comprised of Barbara Peterson, RN, and Ron Shansky, MD. Two days were spent at each facility reviewing medical and dental records, interviewing staff, and observing their work. A thorough review of the dental physical plant and its contents also was conducted.

Access to Care

Inmate Orientation to Dental Care Access

Juveniles should have a clear idea of what dental services are afforded to them. They should know that emergent care is readily accessible and that routine care may require waiting to have lower priority dental problems stabilized. Juveniles should have detailed information regarding entitled care.

We recommend that the ODYS develop a policy regarding inmate access to acute and routine dental treatment. HSAs and dentists should work together to develop a system for patient education to include an oral and written presentation describing, in detail, procedures for accessing each level of dental care provided at their institution.

Access to Oral Hygiene Supplies

An inspection of the personal hygiene kits distributed to the juveniles was conducted. Dental floss was not present in any of these kits. Dental floss loops were available for distribution at IRJCF but the system was cumbersome and provides a disincentive for the juvenile to floss.

It is recommended that floss in some form be made available to the juveniles. It is necessary to maintain good oral hygiene. Arguments about "safety" are essentially baseless.

Urgent Care

The current system of making appointments for patients with complaints of pain results in some patients not being assessed and stabilized in a timely manner. Dental and

[48] Makrides NS, Costa JN, Hickey DJ, Woods PD, Bajuscak RE. Correctional Dental Services, in Puisis M. Clinical Practice in Correctional Medicine, 2nd ed. (Mosby, 2006).

medical records were reviewed of patients with chief complaints of pain in DIT -10[49]. Some nursing entries in the medical progress notes documented adequate stabilization of pain while others did not. The stabilization of pain by the nurses is inconsistent. The SOAP format was not used for any of the dentist entries.

The lag between a Nurse Health Call or HSR request for pain and stabilization by a dentist is excessive. The ODYS is not providing timely (within 24 hours) stabilization of dental pain.

Juveniles with urgent dental conditions must be able to obtain stabilization of pain within 24 hours. The nurses should receive training in triaging and stabilizing dental pain. Nurses should consistently document the assessment of patients requesting dental care. Furthermore, the dentist and nurses should document emergency or essential / urgent dental care visits using the SOAP format.

Broken Appointments

Dental patients are typically escorted to and from their appointments by a JCO. At all facilities visited the dentist gives the officer a list to maintain a continuous flow of patients. At CHJCF, MaJCF, and IRJCF patients are delivered to the dental clinic in a manner which minimizes down time. SJCF, however, has problems with patient flow due to lack of escorts and conflicts in programming.

It is recommended that the ODYS administration eliminate delays in dental treatment at SJCF and all facilities where patient flow is a problem. Juveniles should be available for treatment during all the hours the dentists are present in an ODYS facility.

Quality of Care

Screenings and Examinations

SJCF is responsible for the Reception Screening examinations for the ODYS system. Records were reviewed to determine the quality and consistency of the Screening Exam (DIT-1). A Dental Screening Examination as defined by the ODYS Policy 403.13 will: 1) expose dental bite wing x-rays, 2) examine the teeth and tissues 3.) identify oral health condition 4) specify the priorities of treatment by category. These screenings must be documented on the Dental Record (ODYS DMH-0059). Therefore, if

[49] DIT-1 through DIT-17 can be found in each site visit report completed by Dr. Sauter. Those reports are appended at part of Appendix C.

any of the elements of the examination are not present (care prioritized into categories, oral health condition, diagnostic bite wing x rays, ODYS dental form DMH-0059, etc), the examination is incomplete and out of compliance with ODYS policy.

The records reviewed at each facility in DIT-1 showed all inmates had Reception Center Nurse Screening and Assessment and a Dental Screening Examination. However, most of the Dental Screening exams were incomplete. Priorities of care were not specified on all of the charts. The need for an annual follow up exam was not documented in all the records. Timeliness of exams was largely in compliance with ODYS policy 403.13, except at Cuyahoga Hills Juvenile Correctional Facility.

ODYS policy 403.13 requires the development of an individualized treatment plan for juveniles receiving dental care. Most charts reviewed did not have a documented individualized treatment plan. Some charts listed carious lesions, but they were not prioritized. Thus there was no treatment plan, just a list of problems.

Controls must be put in place to ensure that juveniles be provided examinations as outlined in ODYS Policy 403.13.

Primary Prevention

In DIT-1, 10 records were reviewed at each facility to measure the level and quality of dental care provided at intake, and compliance with ODYS policy. While all the juveniles had documentation of an initial dental prophylaxis and oral hygiene instruction, none had received topical fluoride treatments. Some topical fluoride is being applied at follow up dental prophylaxis visits, but the method of delivery (on floss or painted on the teeth) is ineffective. Fluoride varnish would be an effective way of placing topical fluoride.

It is recommended that an effective method of topical fluoride application is utilized as part of primary caries prevention in ODYS.

Dental Sealants

None of the charts reviewed of juveniles who had been at in ODYS for at least 13 months had any documentation of sealant placement. An interview with one dentist revealed he did not feel sealants were an appropriate treatment as he had seen caries associated with some sealant placement. Sealant placement and topical fluoride treatments, however, are recommended as part of primary prevention of dental caries

during the teenage years through early adulthood by the American Academy of Pediatric Dentistry.

It is recommended that the pits and fissures of non-carious permanent teeth be sealed to help prevent future decay.

Oral Hygiene Education

All of the initial dental prophylaxis and oral hygiene education is provided at SJCF. One dentist was observed providing intake dental prophylaxis to three juveniles. No direct oral hygiene education was observed on the three patients being treated. When the dentist was questioned about what oral hygiene education is typically provided, he pointed to the posters on the wall. He said he answers questions if the youth have any.

The oral hygiene education program in the ODYS is inadequate.

It is recommended that the ODYS develop a meaningful oral hygiene education program structured to train juveniles mindful of the disproportionate numbers that have difficulty learning.

<u>Dental Caries Stabilization - Secondary Prevention</u>

Many of the patient charts reviewed in DIT-1, DIT-2, DIT-9, and DIT-10 had documentation of dental caries. Not all the dental records reviewed of juveniles who had been in the ODYS at least 13 months had documentation that caries had been stabilized or was being watched due to their incipient nature unless the patient refused treatment. Dental records reviewed showed a systematic deficiency in the area of the monitoring and stabilization of dental caries. Annual recall exams and dental prophylaxis at CHJCF were not completed on time or at all in many cases. All other facilities reviewed were largely in compliance with the ODYS policy on recall exams and dental prophylaxis.

Juveniles at Marion Juvenile Correctional Facility and Scioto Juvenile Correctional Facility did have documentation of caries stabilization for those individuals with stays over 13 months. Prioritization and treatment of caries that have progressed beyond the demineralization stage is recommended as part of secondary prevention of dental caries during the teenage years through early adulthood by the American Academy of Pediatric Dentistry.

It is recommended that juveniles with dental caries be monitored by the dentists in ODYS. Dental caries should be prioritized by level of severity at the time of the initial

dental exam. Timing of recall appointments for caries stabilization should be based on the level of the severity of the carious lesions. ODYS should track annual dental examinations and dental prophylaxis to insure policy compliance.

Removable Partial Dentures, Crowns, and Fixed Partial Dentures

Dental records were reviewed for documentation of replacement of anterior teeth with fixed and removable partial dentures. The dental literature does show some correlation between oral health, self esteem, and missing front teeth in juveniles.[50] The dentists and HSAs were interviewed at each facility about the process of obtaining authorization for fixed and removable partial dentures and full crowns. Full crowns are needed to prevent molar teeth treated with root canal therapy from fracture. Crowns and bridges are needed in a small number of cases to protect and preserve badly broken down but restorable front teeth. ODYS is providing removable partial dentures, fixed partial dentures and crowns for patients who need them. The dentist determines the need for a partial denture or crown and submits the request verbally to the HSA. There were no reports or documentation of partial denture or crown treatment being denied. There were no dental casts or dentures available, however, to evaluate quality of prosthodontic treatment.

The dentist determines who is to be provided with partial dentures and crowns.

Availability of Specialists

Dental specialists in oral surgery, orthodontics, and endodontics are available and utilized for patients who cannot be treated by the institution dentist.

Treatment by dental specialists is available when needed.

Special Needs Patients

Dr. Traugh, who works at 3 of the 4 facilities visited, was interviewed concerning patients with such special needs as mental retardation and mental health problems that would make them unable to receive dental care without pre-medication. Dr. Traugh has not had a problem managing patient behavioral problems during treatment. No inability to treat patients due to behavioral problems was noted in any of the documents reviewed.

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[50] See, Patel RR, Tootla R, Inglehart MR, Does oral health affect self perceptions, parental rating and video-based assessments of children's smiles?, Community Dent Oral Epidemiology 2007; 35:44-52; Davis DM, Fiske J, Scott B, Radford DR, The emotional effects of tooth loss: a preliminary quantitative study; Br. Dent J 2000 188: 503-506; and Margolis FS, The esthetic space maintainer; Compendium Continuing Dental Education 2001 Nov, 22(11):911-4.

Given the high incidence of mental health problems in juvenile justice facilities, the issue of special needs management of dental patients should be monitored by the ODYS.

Quality Management

Quality Assurance

Marion Juvenile Correctional Facility is the only institution visited where there was documentation of a dental quality assurance program. One quality assurance "screen" was: "Significant dental conditions are recorded on the problem list". The QA report said this in 100% compliance. A review of dental records revealed this was not the case.

Another QA screen measured was: "All dental sick call requests from the previous 90 days were triaged within 24 hours". The QA screen rated compliance as N/A. This dental program component should have been monitored, as it is one of the most important functions of the dental program. Many of the nursing assessments of dental complaints were found to be inadequate. Since nurses are responsible for stabilization of dental pain in the absence of the dentist. As nurses do the intake dental screenings they are also responsible for recognizing and triaging dental disease. Deficiencies in the dental program simply are not being addressed by the current quality assurance program.

The Marion Juvenile Correctional Facility dental quality assurance program was rated as ineffective.

Peer Review

There was no documentation of a dental peer review program in ODYS

A clinically-oriented, dental quality assurance and peer review program must be developed and become part of ODYS policy. This system should have thresholds by which deficiencies in procedure, quality, or appropriateness can be corrected.

Dental Record Documentation

Health History

A copy of the Nurse Intake Screening form was attached to each dental record except at CHJCF where the medical and dental records are combined. This screening form contains a health history which is competed by interviewing the patient and it is

adequate to address conditions that may affect the health of the patient undergoing dental treatment.   The nurse will note dental abnormalities in the dental section of this form.

The health history available to the dentist during treatment is adequate to identify conditions where precautions should be taken or physician consultations are needed.

Treatment Plans

ODYS dental policy 403.13 requires a treatment plan to be created that documents dental priorities by category. Review of records in DIT-1 and DIT 2 revealed dental problems were not prioritized by category. The dental examination is conducted at SJCF. Dental needs are listed but not prioritized at this exam. The dental charts do not list the initial components of a comprehensive treatment plan: examination, prophylaxis and oral hygiene education, and diagnostic radiographs. These initial components are being completed at the reception center, but should be listed and marked complete on the treatment plan. The dental carious lesions should be listed in ascending order of severity so the parent institution can more effectively triage teeth that are a priority for stabilization to prevent tooth loss.

It is recommended that comprehensive dental treatment plans be created that prioritize dental problems by level of severity. ODYS should revise their policy to describing the treatment planning procedure in detail.

SOAP Format

There was a consistent lack of use of the SOAP format in filling out the dental record for non-routine (urgent care) dental visits. This should be a standard procedure when the appointment is non-routine, i.e. generated by a complaint by the juvenile. With juveniles being evaluated and treated by multiple providers, it is important for each provider to record and assess the patient's chief complaint to assure it is being addressed and needed treatment is being provided. The standardized SOAP format creates a consistent data set, which facilitates tracking of the patient's progress. The plan should include follow up to insure the patient is dentally stabile.   According to *ODYS POLICY 403.05.01* the SOAP format shall be used in the progress note. The SOAP format is a concise and widely accepted format for documenting urgent dental care. It focuses the clinician to follow a logical process in diagnosis and treatment.

It is recommended that the ODYS Medical Director ensure policy compliance as the SOAP format is used most institutional settings.

Physical Resources

Equipment Condition

The dental clinics and their contents were examined at each facility. There is a general need at all the facilities visited for more instruments used to perform dental prophylaxis and caries restorative procedures. The dental operatory at IRJCF is in good condition but the clinic needs some small cabinetry changes to accommodate a dental assistant. The CHJCF clinic needs complete remodeling of the cabinetry to allow for the addition of a dental assistant. The MaJCF and SJCF clinics are adequate in space and layout.

A systematic equipment and instrument inventory of all their clinics must be conducted. Adequate hand instruments and other equipment should be obtained to allow for uninterrupted dental care while the dentist is present. Necessary cabinetry changes should be made to allow for addition of a dental assistant.

Human Resources

Dental Clinic Staffing

There are adequate dentist hours allocated to all the facilities visited. However, lack of a dental assistant makes overall dental staffing inadequate because dentists must then perform duties not commensurate with their professional competence. Infection control is compromised without a dental assistant available for surgical retraction, high speed evacuation, instrument delivery, restraint of sudden errant patient movement, and proper pre and post dental operatory preparation.

In the interest of a more dentally stabile population, the ODYS could add dental hygienist hours at the parent (non-reception) facilities. This way the dentists at SJCF could focus more attention to stabilizing large carious lesions on the male juveniles prior to their transfer. The initial and annual dental prophylaxis and oral hygiene education could be done more effectively by a dental hygienist. Dental hygienists could administer effective topical fluoride therapy.

The oral hygiene education program and lack of topical fluoride application in the ODYS is clinically inadequate.

It is recommended a dental assistant be hired to work with the dentist when he/she is at the facility. Consideration should be made to adding dental hygienists at the parent facilities to improve primary prevention and provide for the stabilization of caries early in the juveniles stay.

Hygienists

Ohio Department of Youth Services dental policy 403.13 requires a dental exam, oral hygiene instruction, a dental cleaning and dental ”bite-wing” x-rays for all new juveniles within 14 days of admission to the ODYS. Due to the lack of dental hygienists, ODYS dentists are providing the dental cleanings and oral hygiene instruction at the reception and non-reception facilities. The site visit investigation revealed that the oral hygiene instruction provided by ODYS was inadequate.

Dental cleanings consume a significant portion of the dentist’s time at Scioto Juvenile Correctional Facility (SJCF). One side effect is that male juveniles do not have the access to dental caries stabilization that the current dentist staffing could provide with the addition of dental hygienists and a change in the deadline for performing the dental cleanings and oral hygiene instruction.

It is common knowledge in the dental community that dental hygienists are more competent performing dental cleaning than dentists. They have far more training in removing hard and soft deposits from teeth without damaging the tissues. Dental hygienists are also more competent in providing meaningful oral hygiene education to individuals with varying levels of learning ability. This is especially important given the incidence of learning disabilities and mental health problems in a juvenile detention facility.

Recommendation: Dental hygienists should be added at all facilities in the ODYS to improve the quality of the dental cleanings and oral hygiene instruction/education.

Hygienists: Staffing

Many of the juveniles do not have large quantities of hard deposits on their teeth. This would allow the dental hygienist to perform the cleaning and oral hygiene education in about 30 minutes. Currently fluoride treatments are not being provided at intake. Fluoride treatments provided later in their stay are largely ineffective as noted in the ODYS Dental Summary Report. The dental hygienist could provide effective fluoride

treatments consistent with Academy of Pediatric Dentistry Guidelines. Eight dental hygienist hours per week per facility would be a good *initial* staffing level for each facility. This would be in addition to the current dentist hours.

Recommendation: Eight hours per week of dental hygienist services should be added at each facility. This should be monitored for effectiveness.

Hygienists: Costs

To support an estimate of costs of dental hygienist hours we quote a recently published article in the *Journal of Public Health Dentistry*:

The average dental hygienist in Cincinnati, Ohio, makes $30.00 per hour, with more than half receiving retirement and health insurance benefits.

Since the dental hygienists will be hired as contractors it is unlikely they will receive any benefits. The ODYS should expect to pay contract dental hygienists over $30/hour if they offer only an hourly wage.

Licensure and Required Certificates

According to *Ohio Administrative Code*, all clinics must have a copy of dentists' and hygienists' licensure available for review. No dental hygienist or dental assistant is employed. Documentation of current licensure of the dentists is on file at all the facilities reviewed.

Quality of Providers - Dentists

The dentist at CHJCF is not providing adequate follow up for caries, annual examinations, and annual dental prophylaxis (DIT-2, DIT-3). The dentist at CHJCF is not removing all debris from instruments prior to sterilization (DIT-15). The dentist at CHJCF has fabricated removable partial dentures without restoring dental caries. Thus, the performance of the dentist at CHJCF is believed to be inadequate.

The dentist providing services at IRJCF, SJCF, and MaJCF extracted teeth without adequate dental radiographs. Documentation shows this to be corrected following our August 2007 site visits. This dentist is now considered to be adequate. The documentation of the other dentists reviewed shows their care is adequate.

The quality of three of the four dentists reviewed is adequate. It is recommended that the ODYS medical director monitor all dental and infection control procedures and take steps to insure all the ODYS dentists are of adequate quality.

Quality of Providers - Dental Assistants

No dental assistant was employed.

It is strongly recommended that the ODYS provide dental assistants to work with the dentists.

Infection Control

Some of the barrier techniques being used in the clinic were observed. Spore tests were conducted weekly in three out of four facilities. IRJCF was sending their tests in monthly. There was a lack of biohazard labeling on all the ultrasonic cleaners and day light loaders. The instruments were in sterile packs. CHJCF instruments were contaminated with dental cement in sterilized packs. This debris prevents complete sterilization of the instruments. Other handled and stored instruments properly. Eye protection was not provided to the patient at any of the facilities. *The ODYS dental program will be considered* ***inadequate*** *unless all facilities comply with accepted Center for Disease Control and Prevention infection control guidelines.*[51]

Dental extractions are being performed without a dental assistant. This places the operator and patient of risk from bloodborne pathogens. For example, The Federal Bureau of Prisons dental policy states, "Surgical procedures will not be performed without a dental assistant. Institutions should provide one dental assistant for each clinical dentist." This is a standard in the private and public sector dentistry.

It is recommended that the HSA and dentist review the CDC Bloodborne Pathogens Standard and follow the guidelines provided in that document. Current procedures are inadequate. Dental surgical procedures to include extractions should not be performed without a dental assistant.

Dental Program Management

ODYS Dental Policy and Procedures

The ODYS dental policy 403.13 was discussed with the ODYS Medical Director, Dr. John Bradley, and Dr. Mark Traugh the SJCF dental contractor. Dr. Traugh works at 5 of the ODYS facilities and thus has an excellent working knowledge of the overall ODYS dental program. Dr. Traugh was observed to be a very hard working and

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[51] Centers for Disease Control and Prevention. Guidelines for Infection Control in Dental Health-Care Settings - 2003. *MMWR* 2003; 52(No. RR-17):[inclusive page numbers].

committed professional. He takes real ownership in the overall ODYS dental program. Review of the dental records of patient populations managed by Dr. Traugh show his concerted effort to stabilize dental disease and promote oral health. Dr. Traugh could be much more effective with the addition of dental hygienist and dental assistant hours at the facilities he visits.

The current dental policy needs to be rewritten to include instructions on examination, treatment planning, categories of care, emergent, urgent and routine dental care, prevention, dental prophylaxis, fluoride treatments, sealants, caries control etc. Dr. Traugh's observations and analysis of the problems lead us to believe he is capable of crafting an expanded and practical ODYS dental policy and procedure manual.

It is recommended that the ODYS medical director work with Dr. Traugh to expand the dental policy manual. The current manual is not adequate.

Conclusion

As a result of this investigation we conclude that the overall ODYS dental program is inadequate.

In summary, changes need to be made in the areas of: staffing (dental assistant), diagnostic radiography (pre-extraction radiographs), infection control (labeling of biohazards, sterilization of instruments, spore testing, gowns and patient eye protection) urgent care tracking (complaints of pain assessed, and consistently stabilized and documented by nursing or dental staff within 24 hours), primary prevention (fluoride treatments and sealants, annual prophylaxis and adequate oral health education, access to dental floss), categorizing treatment priorities-secondary prevention (caries stabilization-secondary prevention, annual follow up exams, fabrication of partial dentures without caries stabilization), dental record documentation (treatment plans, SOAP format), and access to care (written and verbal instruction on the specifics of requesting emergency, urgent and routine dental care).

IX. RELEASE AUTHORITY

As the *S.H.* investigative team conducted its various site visits the Release Authority was consistently referred to by the various youth we interviewed. Our experience at Mohican epitomizes the frustration of DYS youth with the Release Authority.[52]

Mohican terms itself a Therapeutic Community (TC); as a one-of-a-kind correctional facility for males with serious substance problems. The TC program begins with orientation, moves on to Phase 1 and Phase 2, which are core treatment, and concludes with Phase 3, relapse prevention.

The entire program takes six months and eligible youth must have at least that much time remaining on their sentence.

The MJCF intake manager stated that she is very conscious of the time issue. Because MJCF requires a minimum six-month stay — the average length of stay is seven months — the intake manager tries to select youths that have six months or more remaining on their sentences. If they do not have enough time to complete the program, she will check with court personnel, the Release Authority and the youth's probation officer;

It appears that by the time youths are being identified as in need of this intensive substance abuse treatment program, many have less than six months remaining on their sentences. Consequently, their placement time is being extended by the Release Authority so that they can complete the program.

For example, one youth interviewed was on 'revocation' status; the judge gave him a 90-day revocation sentence. He was placed in Cuyahoga Hills for 45-60 days with a release date in July. In June, the Release Authority added five months based on the "matrix offense" guidelines, considering the time it would take him to complete the program at MJCF. He was placed in MJCF on June 17.

Four other youths interviewed received five, four, two and one month added time respectively from the Release Authority — using the 'matrix offense' guidelines — in order to give these youths sufficient time to complete the program.

[52] See Section II, for additional discussion focusing on detention credit.

The youths at this facility, and every other institution, believe that the Release Authority's extension of the sentence given by the judge is unfair.

To our knowledge, such extensions are viewed officially as within the legislatively created upper limit of the judicial disposition — age 21 — and they lack any pretense of due process. The youth, however, feel powerless and victimized often by events beyond their control, e.g., an extended stay in reception, which results in a program time add-on.

The Release Authority does not assess "matrix offense" time while the youth are at the Scioto Intake and Reception Center. The time is added well after a youth has entered an institution – not knowing up front how long they can expect to be in an institution contributes to the youth's sense of unfairness.

Many of the youths who are ultimately placed in the Mohican program have been in other institutions for brief periods of time while the selection process is ongoing. For example, one youth interviewed spent two months in Scioto, one month in Indian River and when released, he will have spent nearly 8 months in Mohican. Had the referral process begun as soon as he was committed to DYS, either while he was still in the county detention center or at least while he was going through assessment at Scioto, he would have begun his substance abuse treatment virtually upon commitment to DYS and his bed could have been freed up three months earlier.

The Release Authority Board, effective on July 1, 1998, makes release and discharge decisions for the Department of Youth Services. The same legislation also created an Office of Victim Services, the judicial release process, and the requirement for courts to submit a Disposition Investigation Report (DIR) for each youth committed to DYS.

The Release Authority consists of five board members, one of whom is designated as Chair, three hearing officers, the Office of Victim Services, and support services staff. The Authority serves as the final and sole agency for release and discharge decisions based on the standards of public safety and the best interests of the child.[53]

[53] Team member David Roush was our principal investigator in this area and he interviewed the following: Sharon Haines, Jennifer Fears, Norman Hills, Terry Kennedy Mancini, C. Q. Morrison, Renee Burch, Doneta Riegsecker, Aldine Gaspers, Kristine Bell, Walt Fluellen, and Damita Peery.

Release Authority Functions

The basic functions of the Release Authority include:

1. Setting the Presumptive Release Date (PRD) from institutional care and Presumptive Discharge Date (PDD) from DYS custody,
2. Completing release and discharge reviews,
3. Establishing expectations,
4. Considering input from victims, the courts, and prosecutors,
5. Meeting with youth, and,
6. Providing system quality assurance.

The first two functions are more objective with specified criteria for calculating dates and timelines for accepting or rejecting release and discharge decisions. The criteria appear to be consistent with the Ohio Juvenile Code.

Functions 3 through 6 are less structured and more open to the individual interpretation of board members. Allegations of inconsistency from JCF residents and staff stem from the absence of clear-cut criteria along with the method of distributing caseloads. Each incoming youth to DYS is assigned a board member who is ultimately responsible for his or her case throughout the DYS commitment. Board members did not describe much interaction in the review of difficult cases. Indeed, a frequent criticism of the Release Authority is that the five members appear to function more as individuals than a unified decision-making body.

Setting Dates

The nature of the Ohio Code and the decision-making criteria of the Release Authority predispose youth to longer stays than necessary in institutions or on parole. The courts complete a Disposition Investigation Report (DIR) that includes the arrest record, victim information, and victim impact statements. The DYS reception process includes assessments for mental health, medical, education, substance abuse, leisure/recreation, religious, security threat groups, Prison Rape Elimination Act, and sex offenders.

Fred Cohen interviewed Sharon Haines also and held discussions with Director Stickrath and several attorneys.

The information combines to present a picture of the youth based largely on problems and deficits. This information combines with the Level of Service Inventory (LSI) and with the local juvenile court commitment order specifying the offense to establish the Presumptive Release Date based on the Release Matrix (see Table 1). DYS staff and residents refer to the Release Matrix as "matrix time," giving it a supernatural flavor that it actually may deserve.

Level of Service Inventory (LSI)

There are problems with the use of the LSI. DYS is in the process of addressing these issues through research by the University of Cincinnati. Director Strickrath indicated that he expects the findings from the University of Cincinnati study soon. Nonetheless, the Release Authority was unable to respond to several of the criticisms of the LSI identified by Austin (2006).[54] For example, DYS has not separately normed the LSI for girls. This raises the possibility that DYS misclassifies females based on the LSI since males and females respond differently to the test.

DYS has not done an inter-rater reliability study among those individuals who administer the LSI at reception. Inter-rater reliability is a significant problem with the LSI.

Finally, DYS does not account for the differences between the static and the dynamic factors within the LSI. This may be addressed in the validity studies undertaken at the University of Cincinnati.[55]

Set and Forget

Director Strickrath expects the University of Cincinnati study (a) to provide DYS with a greater ability to identify the low risk youth and (b) to provide evidence to change the criteria for setting the PRD for low risk youth and moving them quickly toward release. The group will be called "Set and Forget" based on the relative lack of problems these youth have presented in the JCFs.

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[54] James Austin, "How much risk can we take? The misuse of risk assessment in corrections." Federal Probation, 70 (2), 2006. Austin argues that inmates are not properly assessed for risk by most agencies. Austin worries that too much emphasis on risk has diminished efforts to provide basic treatment services.

[55] As of the cut-off date for preparing this Report, we have not had the opportunity to study the Univ. of Cincinnati's work on point.

Release and Finances

The local courts, by statute, also play a role in the release process. The court has jurisdiction to authorize an early release up to the Minimum Sentence Expiration Date (MSED). If a court orders release before the mid-point between the commitment (minus local detention time) and the MSED, the court must provide probation services following the youth's release. If the court orders release after the mid-point but before the MSED, the youth is placed on DYS parole. After the MSED — and most PRDs are beyond the MSED — the Release Authority has sole jurisdiction. This arrangement calls attention to the Presumptive Release Date, which is based on statutory requirements that tend to lengthen a youth's time in the institution beyond the MSED.

If the court releases before the mid-point, the court supervises and pays for the services. If the court releases after the mid-point date, DYS pays for and supervises parole. Like many of the decisions surrounding DYS commitments, the financial arrangements are critical to understanding decisions. Much of this stems from the complicated formula for state reimbursements of county expenditures for out-of-home placements through RECLAIM Ohio.

If our description of the relationship between the courts and DYS ended here, I think it would be fair to term it bewildering and needlessly influenced by considerations of finance. As this narrative proceeds we will move beyond bewildering and into the incomprehensible.

Review Hearings

Release Authority officials referred to 90-day cycles for reviews. The Authority notifies all interested parties 45-days in advance of a review hearing. Hearing Officers conduct informal follow-up contacts with institutional social workers to make sure that the appropriate paperwork is filed with the Release Authority. While reluctant to indicate the percentage of hearings that are postponed because of local institutional staff members' failures to complete and submit paperwork in a timely fashion, Authority staff acknowledged the problem and conceded that it occurs more often than is acceptable to them. We suspect this is "code" for "a lot."

When asked to explain the reason for this problem, most indicated that JCF social workers have too many youth on their caseloads and have other duties that distract them

from completing the paperwork. This is yet another example where the number of positions assigned to fulfill various functions within the institution is insufficient to achieve institutional goals.

Release Authority personnel conveyed the impression to Dave Roush and Fred Cohen that they are an embattled group. Several board members emphasized their advocacy for youth, which they believe goes largely unnoticed because of all the constraints placed upon their decision-making by Ohio law.

When challenged on issues about length of treatment, about incentives or good time, or about reducing a youth's exposure to a dangerous institutional setting, the Authority officials acknowledged the concerns but blamed their patterns of decision-making on systems issues that constrain their discretion. While this is likely the case in many instances, these protests should not disguise the institutionalized commitment to public safety. This takes the form of continued incarceration even when it is known (or believed) that the DYS intervention itself may aggravate the youth's perceived risk to public safety. Youth advocacy aside, the Release Authority board members seem clear in their commitment to make a quality decision about who is ready for release, and "public safety" trumps "the best interest of the child" every time.

This is yet another decisional point where childcare rhetoric is trumped by the adultification-law enforcement model. Efforts to treat and rehabilitate are blunted at the back end of the system.

The quality of release decisions depends on the quantity and quality of information coming in from the institutions, and hearing officers repeatedly complained that this is their greatest concern. In the absence of useful information, hearing officers must increase the amount of time taken to review a file because they have to follow-up with youth and staff or locate information from various files.

Prior to PRD

Superintendents and Regional Administrators may submit a request for a special review for an early release of a youth if his or her circumstances change. When asked if anyone was aware of a superintendent submitting a special request, board member Hills indicated he had received two from newly minted Superintendent Oprisch at the Indian

River Juvenile Corrections Facility (Oprisch has been with DYS for about six months). He approved only one.

This is a telling example about the Release Authority. First, no one presented the special review strategy as being advocated by DYS. Second, even though the numbers were small, it seems particularly problematic that the Release Authority would deny any special review request from an institutional superintendent or regional administrator, except on the basis of technicalities or statutory constraints. In an era of site-based management, the centralization of the release function increases the disconnect between institution and release decisions. Denial of a special review and an early release likely undermines the authority of the superintendent in the eyes of JCF residents. Hopefully, the denial was based on a technicality or statutory constraint.

Perceived Needs

When asked what was needed to make things run more efficiently, Release Authority staffers suggested (a) improved internal communications, (b) program development based on effective outcomes as opposed to whatever was the popular strategy of the day, (c) a better fit between placements for youth and safe environments to remedy the inability to separate vulnerable from predatory youth, (d) a shift in facility operations that returns the juvenile correctional officer to the primary correctional intervention (a caregiver model), (e) a return to single occupancy rooms, and (f) programs and services that meet the needs of girls.

The Release Authority board members agreed that it is time for a complete revision of the Juvenile Code. The current code dates from 1984, and many Release Authority staff find it as problematic as we do.

Revocation

Revocations are done by the local juvenile court. There are two general pathways to revocation, one through the Bureau of Parole and the other through juvenile court initiative usually based on commitment of a new felony offense or community outcry. The Release Authority does not play a role in either process.

It is important to understand the financial arrangements associated with the different types of revocation. First, when a juvenile court revokes the probation or parole of a youth that it released from a DYS institution before the mid-point date, the juvenile court usually pays the entire amount of the youth's re-incarceration at a JCF. Second, if the court revokes a youth released by DYS, the court typically pays only the first 30 days of the revocation.

Data on revocations appear similar to the demographics of DYS commitments. It is difficult to determine any increased level of disproportionate minority involvement in revocations beyond that already present in the commitment process.

Bureau of Parole Revocations

DYS Parole supervises the youth's reintegration to the community. In addition to the conditions for parole, the Bureau supplies a range of program and services to assist the youth in adjusting to the community. When youth do not comply with the terms of parole, technical violations occur. The Bureau has a range of administrative sanctions that include verbal house arrest, electronic monitoring, altering parole conditions or extending discharge, last chance agreements (sometimes these occur in the home and serve as official notice to parents), petitioning a youth back to court for an official tongue-lashing. These strategies help the parole officer keep the youth in the community.

When this approach fails, the Bureau can petition the juvenile court for a hearing with an attorney to revoke the DYS parole, based on an accumulation of documented violations. When this occurs, the court typically pays the first 30 days of costs incurred by the revocation. The Bureau of Parole estimates roughly one third or more of the revocations occur in this manner.

Re-Offense Revocations

The Bureau estimates that about two-thirds of revocations occur as the result of a substantial problem in the community, such as committing a new felony offense or in some fashion eliciting "public outcry" about public safety. We understand that this basis for revocation is legally dubious, certainly without further explanation, which we are currently unable to provide at this time. One generalization by the Bureau is that this second strategy normally occurs in larger counties because of the lack of re-entry programs, services, and resources.

Challenges

The primary problem facing the Bureau of Parole is the unpredictability of release dates. The second major problem is the inability of the JCFs to prepare youth for re-entry. Youth do not appear to have sufficient employment skills, employment strategies, or appropriate places to live following release from the JCF. The magnitude of this statement of a problem is belied by its brevity. Readiness for release and an affirmative release environment are critical elements in that continuity of care process.

Summary and Recommendations

The DYS release, discharge, and revocation processes are complicated, involving many factors that impact the discretion of the individuals charged with making decisions in these areas. Even the success of RECLAIM Ohio adds a level of complication to the release, discharge, and revocation equations based on how reimbursement is calculated and when it occurs in the sequence of events. It will take more than the limited time we have had to understand more fully the DYS system of release, discharge, and revocation. However, our time was sufficient to acquire enough information to form impressions, to discover patterns, and to identify recommendations for improvement consistent with the objectives of this investigation.

The Release Authority staff is an interesting combination of individuals with various specialties and experiences. Two hearing officers were former JCF superintendents, as was the chief of the Bureau of Parole. Among this mix of DYS staffers, it is difficult to find anyone who consistently endorses the JCF interventions as effective. Instead, staffers readily admit to safety problems stemming from a lack of program and treatment consistency and from too many youth with too few staff who too often opt for security over reformation.

Several changes warrant consideration:

1. The sense of a system out-of-balance starts with the Ohio Code. Any settlement should include a commitment to further study and revision of the relevant statutory provisions.
2. Statutory constraints on release and discharge decisions are weighted against the youth and add to a youth's time. These constraints need re-

thinking from a procedural, operational, and decision-making basis. That is, the youth should not be penalized with additional time when staff or the system cause reception, transfer and paperwork delays and review postponements.

3. The special review should become a clearly defined and articulated procedure advocated by the Release Authority and Central Office as a means to strengthen (a) site-based management, (b) the creation of incentives for appropriate youth behaviors, and (c) the reduction of the average length of stay (ALOS), thus assisting if only slightly in lessening crowding.
4. There is a troubling overemphasis on the JCFs as the location for services and treatments specified by the Release Authority when setting the individual's release expectations. When staff generally criticize JCF treatment services as ineffective and then postpone release until the completion of such a program, the process appears singularly punitive. There should be an expansion of step-down mechanisms whereby youth can receive certain specified treatment programs in the community.

Table 1. The Release Matrix

LSI RISK LEVEL

OFFENSE

	Low Risk	**Moderate Risk**	**High Risk**	**Very High Risk**
Felony 5	2-6 Months Core = 4	4-6 Months Core = 5	5-7 Months Core = 6	6-8 Months Core = 7
Felony 4	2- 6 Months Core = 4	4-6 Months Core = 5	5-9 Months Core = 7	6-10 Months Core = 8
Felony 3	4-6 Months Core = 5	5-7 Months Core = 6	6-10 Months Core = 8	7-11 Months Core = 9
Felony 2	8-12 Months Core = 10	10-14 Months Core = 12	12-18 Months Core = 15	14-22 Months Core = 18
Felony 1	9-13 Months Core = 11	11-16 Months Core = 13	12-20 Months Core = 16	14-30 Months Core = 22
Category 2	10-15 Months Core = 13	12-16 Months Core = 14	12-24 Months Core = 18	14-34 Months Core = 24
Category 1	Includes Youth 12-15 years of age who have committed attempted Aggravated Murder or Attempted Murder. Will serve a minimum of Six to Seven Years, or until Age 21.			

X. GRIEVANCE PROCEDURE, YOUTH ADVOCATE & DISCIPLINE

Grievances

At a meeting in his office, I asked Mr. Rufus Thomas, then DYS Chief Inspector, if he thought the DYS grievance process was working. His candid response was, "The quality of the response is the weakest part."

A recent internal review of the youth grievance process, culminated in a Report from Andrew Propel, Office of Project Management (OPM), dated September 6, 2007. The Report noted the importance of the process without explicitly stating what it should accomplish. Further, youth were found to have easy access to the process based on a monthly average of 647 grievances filed.

Youth also were found to have a "fair" understanding of the process and while timeliness in response has improved, required timelines are not being met.

The internal Report noted that most DYS responses are "fair" with a "significant percentage" granted. I found no definition or criteria for "fair" or specific numbers supportive of "significant" favorable results for youth.

Access to the process measured primarily by the number of grievances filed is misleading. Indeed, during our site visit investigations we found that numerous grievances could be indicative of JCO's, or even Unit Managers, telling a youth to file a grievance instead of resolving an individual, early fixed problem.

"These shoes don't fit and my feet hurt bad!" "So? Go file a grievance."

One cannot begin to evaluate a grievance system without some agreement on the mission, the essential objectives of the process. I strongly suspect that there is no shared understanding, or clearly articulated statement, of such mission.

This is not unique to DYS and it is a problem endemic to adult and juvenile corrections. One might ask, for example, if the grievance system is viewed as an alternative to litigation? As essentially an informal local mechanism to quickly resolve individual concerns? As essentially concerned with identifying and broadly resolving more systemic issues and, thus, closely related to the Q.A. process? As primarily a "venting" mechanism more important for the filing of a complaint than its resolution.

I'm certain these are other possible objective but the one's just listed are quite representative. What also seems rather certain is that DYS itself has not arrived at a clear decision and what the grievance process should accomplish.

Without pretending to have done a broad, representative sampling, the youth we spoke to about grievances had little or no confidence in the process. Questions about its efficacy were more often greeted with amusement than support.

The recent CIIC Report[56] notes that any youth wishing to file a grievance may receive the assistance of any staff person. An attorney may help the youth prepare a grievance form but may not write on the form, may not request its processing, and may not process the form.

Violation of such rules may result in the suspension of the offending attorney's visiting rights. While I understand the desire to avoid creating an adversary process, it is difficult to understand the hostility directed to lawyers who might help an illiterate youth prepare a grievance. This type of help is a far cry from a spirited defense or prosecution.

There appears to be a functional breakdown in the grievance process at the threshold: large numbers of these youth are operating at an extremely low level of literacy. Without help in preparing a grievance, the youths' cause for concern and desire for relief may simply be unintelligible or not presented in a fashion favorable to the youth. And yet there is no mandated assistance and serious threats of sanction directed at lawyers.

Curiously, the internal "Popel Report" of September 6, 2007 complains about grammatical and spelling errors by staff and the use of "shortcuts" ("ua" instead of Unit Manager). I found no reference there to the difficulty youth likely have in framing a grievance and asking for relief.

At a minimum, if the grievance system is to work, the youth should have a right to assistance on the preparation of a grievance. For youth who are unable to orally pursue their grievance there also should be help available. A simple expedient would be to create a list of employees from which a youth may select an "adjuvant" for help in preparing a grievance.

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[56] Correctional Institution Inspection Committee Report (CIIC): Evaluation of the Department of Youth Services Grievance Procedures, p. 80 (Aug. 16, 2006)(Hereafter CIIC Report).

With criteria to be developed to establish need, that same staff list could be used for the additional aid needed by those youth who lack the capacity or communicative sills to orally present and perhaps speak persuasively on behalf of the grievance.

This same assistance, in turn, could apply to the appeal process.

No staff member should be allowed to participate in such an assistance program without having taken specialized training on just how to provide this assistance.

In my discussion with Mr. Thomas I suggested that grievants obviously seek a remedy consonant with their grievance. However, there are some studies, at least in the adult system, suggesting that "winning" is not the only measure of satisfaction; a belief that one was treated fairly may be equally important.

In the same vein, there are three areas of decision-making that most directly impact youth in the custody of DYS and where there is a feeling of helplessness as to the decision-making: grievances, discipline and classification/placement/release decisions. The perceived unfairness of these areas contribute to the youths' cynicism and very likely may serve as a needless obstacle to achieving positive change.

In the current DYS system, the role of the institutional coordinator needs to be revisited and very likely revised. See Policy No. 304.03, Section D for functions of the grievance coordinator. If an informal resolution is not obtained then the grievance coordinator appears to be the central figure in any resolution. Yet, the coordinator has no special training and no clearly defined role. The coordinator may be a Deputy in one facility and an executive secretary in another.

I was told that "people who are good with data get dumped on" to do this job. This relates to the Activity Management System (AMS) now in place to document incidents and grievances within DYS. The grievance coordinator (or Site Manager's designee) is to document in the AMS and this may be a case where documentation requirements overwhelm substantive and procedure needs.

When I asked Mr. Thomas how he would describe the role of the coordinator he said it was to serve as a conduit and not a problem solver. Who then regularly solves grievances nee problems remains unclear to this writer. What is clear, however, is that if the DYS grievance system is to function efficiently and fairly the process must be easily

accessible, youth should have a right to assistance, and the norm should be to resolve issues at the local level as expeditiously and fairly as possible.

An adversary model is not needed and, indeed, may be a negative element. That is, there need not be a zero-sum-winner and loser game here. The objective should be to achieve some measure of satisfaction and a sense of fairness with the youth.

Data collection and analysis should, inter alia, be aimed at detecting grievance trends suggestive of systemic concerns requiring system-wide action.

The CIIC Report at page 18 recorded a number of problem areas: Only 60% of the grievances were recorded as completed; 60% of grievances at Indian River and 85% at Mohican had no response recorded; Mohican granted no grievances, Indian River granted 5%, and Circleville granted only 4%. Cuyahoga Hills, on the other hand, granted 42%.

It is difficult to interpret these wildly disparate results. It would be a mistake to conclude, for example, that Circleville is an oppressive and unfair facility while Cuyahoga Hills is wonderfully youth-oriented. Our site visits belay that impression.

More likely, these results speak to what is grieved and how the process is conducted and not the climate of the facility.

Over a four-month period only 69 grievances were reported on the use of force; that is, about 3.82%. Our interview and record data studies suggests that staff use of force is among the most common problem experienced and yet of 464 grievances about staff in the period studied only 69 were designated as use of force. [57]

The "no response" problem obviously is a serious one. The CIIC Report notes:

> **GRIEVANCES WITH NO RECORDEDGRIEVANCE COORDINATOR ACTION**
>
> The lack of response to juvenile grievances is a major problem currently faced by the DYS system. Several institutions (Cuyahoga Hills JCF, Circleville JCF, Ohio River Valley JCF) appear to be very good at recording at least some action taken by the Grievance Coordinator in

[57] Complaints about staff amounted to 25.7% of all grievances for the period, twice as many as the next category. CIICR Report, p. 23.

response to the grievance. Other institutions, particularly Indian River JCF and Mohican JCF, report many extremely serious grievances with no recorded response or action taken by the Grievance Coordinator. This causes great concern, as all grievances should be answered, most especially those that are serious.

The following is just a sample of the grievances from January 2006 that recorded no response or action taken by the Grievance Coordinator. A full listing of all grievances from January 2006 that did not record any response/action can be found at the end of this report. (Note: Grievances have been edited for grammar, spelling, and confidentiality. All notes made within the text are of the Grievance Coordinator.)

One serious area to highlight is the high number of medical grievances with no recorded response at Marion JCF. The Grievance Coordinator even notes that he or she cannot understand what the youth is writing, but there is no recorded action or response. Face to face interviews should be imperative in such instances.

Indian River JCF

- The teacher … keeps provoking me to get into trouble. This woman has issues in her household and she bringing it here with her personal problems. She also tried to kick me…
- Medical staff continues to put me on rec restriction and give me Motrin for an ankle injury which needs to be x-rayed because it is not healing right.
- My roommate passed out and I paged up to ... He came down the hall and just told me to let him sleep.
- Youth … keeps punching me every day in SMP Rec.
- Ms. … found out I wrote grievance forms on her and she said every day she works, she gonna write me up. Need Unit change.
- Ms. … switched my room and then after lunch switched me back for no reason. I don't want to be in Room 17 because my roommate plays too much.

- JCO … wrote me up for drawing a nude female. He put on my YBIR that I wanted to suck his dick and that I said he was cute.

Marion JCF

- My medical needs are not being met. I have a very serious problem with my XXX (? Cannot read). It dislocates a lot – Medical will do nothing but give me Motrin (which doesn't work)
- JCO … or JCO … let somebody in my room and they took all of my hygiene I ordered off commissary.
- On 1/14/06 I was taken to the hospital for chest pains – The doctors there told me to discontinue ?? (can't read) a medical DR. she prescribed for me. I stopped the XXX (?) and Dr…
- Youth says that he asked JCO … to call Medical because he hit his head when he fell off his bed-- He said wait, she'll be over around 11:30 pm – He had fallen at 10:10 1/14/06. He w…
- Youth states that he has a serious problem with his left shoulder – Occasionally dislocates from its socket – I have informed medical dept. of his problems a lot of nothing gets do…
- The JCO called medical to see if I could get my inhaler and she said wait until medline.
- On 2 occasions I was given Motrin for pain relief. In my medical records it shows that I am allergic to Ibuprophen, which is in Motrin. The nurse neglected to inform me that there wa…

Mohican JCF

- The units have rats in the ceiling.
- Youth was accused of assaulting another youth and the other youth hit him first and did not get discipline for it. JCO … wrote him up.
- JCO … threatened to strike this youth because they each disrespected the other.
- Another youth came into his class and assaulted him and he doesn't feel safe.
- Ms. … is racially prejudiced toward black youth and doesn't teach.

- Youth's pillow case had racist writing on it.
- JCO … gives LE's without Pull Ups and shares sexual information about women, verbally abuses, threatens and cusses.
- JCO … won't sign off on LE's, uses sexual words to him, and threatens him and cusses him out.
- Staff are bringing in contraband to run the units.
- Black youth go around in rec. calling white youth "Honky" but the white youth would get into trouble calling a black youth "Nigger." They are both racial slurs and should be pe…

<u>Scioto JCF</u>

- I signed up for Health Call and they didn't call me for Health Call. This is the 9th or 10th time they have done this.
- I recently got my Level 2 dropped for receiving 7 YBIRs in a week. I don't think that is fair considering we have Level 3's on Allman who are openly involved in gay relationships.
- Been wearing dirty clothes for a week.
- We have had to wear the same clothes for the past week.
- I don't receive my meds. Mr. … asked Nurse … if going without one dose of my seizure medication (would do anything to me). One dose skipped gives me a migraine and an ups…

Clinical Grievances

DYS should consider using a different process for grievances involving clinical issues: medical, mental health, and dental. There is simply no way that a person without training and education in the clinical area of complaint can satisfactorily resolve a grievance concerning diagnosis, treatment, or prognosis.

Failure to obtain a pass, delayed receipt of medically required shoes, even delay n receiving, for example, Motrin can be resolved without clinical input. However, where the complaint involves receipt of the wrong medication, a challenged diagnosis, or the wrong medical procedure, DYS should consider a process whereby an independent clinician in the appropriate field reviews the grievance, interviews the challenged clinician, studies the records, and resolves the problem with ameliorative action.

There would, of course, have to be further study of this proposal and rule making on point. However, if one objective here is to reduce pain and suffering and limit liability exposure, then something resembling this process should be considered.

***J.P.* Litigation**

I am, of course, aware of the litigation and Stipulation of Settlement in *J.P. v. Taft*. *J.P*. is independent of *S.H*. but the right of access to the courts, which includes a right to legal assistance, is focused on resolving what appears to be the identical issues of conditions of confinement as encompassed by *S.H*.

As I understand *J.P*., the Settlement does not provide counsel for youth to litigate against DYS. Sharon Hicks, the *J.P*. attorney, serves as a conduit to other attorneys. In speaking with her she noted the difficulty in creating a "stable of lawyers" and even in persuading individual lawyers to accept DYS youth cases for litigation.

Ms. Hicks also regularly visits DYS facilities and reportedly finds herself advising youth on grievances, answering questions on sex offender registration, and gang-related issues. In other words, while she is supposed to serve as a conduit to other counsel and to sort out meritorious from non-meritorious cases, she now seems to be less conduit and more problem-solver and information provider.

The parties might well consider seeking to consolidate *J.P.* with *S.H*. particularly if there is to be post-settlement monitoring. Youth who seek damages for harm inflicted on them obviously would retain the right to individual lawsuits and provision could be made in S.H. for a referral process.

Youth Advocate

Don Reyna serves as the Youth Advocate (his professional card adds the title "Ombudsman"). This position has existed for about three years and Mr. Reyna has been in the position since its inception.

In an interview with this writer on October 16, 2007, Mr. Reyna stated that while he was hired by Geno Natalucci-Persichetti, the job description never was clarified for him. Indeed, he believes the former Director hired him in response to some [unnamed] lawsuit but after being hired he was given practically no direction. The current job description reads:

60% — Under administrative direction, relives the Deputy Director 5 (DD) of the most difficult administrative duties plans, coordinates, formulates, and implements the Department of Youth Services' (DYS) Youth Advocate Program & applicable policies and procedures (e.g., ensures complete access by all youth housed by DYS to all applicable grievance forms, personally assists youth with the completion and tracking of paperwork necessary to file grievances; etc.): ensures all facility staff maintain the Grievance Tracking System in order to maintain accurate and complete record of youth grievances (e.g., logs date grievance filed, nature of complaint, parties involved, outcome, etc.); assists DD in defining & developing agency strategies regarding the Youth Advocate Program (e.g., benchmarks other State's juvenile correctional facilities, researches current trends related to the detention of youth, etc.); address inquires from the public regarding the Youth Advocate Program; act on behalf of & for the DD in his/her absence for reasons pertaining to the maintenance, function, or existence of the Youth Advocate Program; requires extensive travel which may involve overnight stays.

30% — Provides training to incarcerated youth and DYS employees for the Youth Advocate Program (e.g., eligibility, time limits and other related laws, policies and procedures, etc.); ensures proper form development and maintenance and accessibility by all DYS sites; utilize a personal computer; researches, creates, maintains, and provides initial and ongoing training for all DYS staff and youth.

10% — Speak on behalf of the Director & for the Chief of Staff at interdepartmental meetings &/or committees addressing the rights of incarcerated youths; act on behalf of Director & give technical advice to the Chief of Staff for special projects/emergency responses.

Mr. Reyna has been a police officer and previously served as a Deputy Warden at two Ohio prisons. I found him to be a warm, genuinely concerned individual but placed in a position that is almost hopeless.

I asked about supportive staff and Mr. Reyna indicated for staff, he has a "car and a cubicle." He does consider the facility grievance coordinators as part of "his staff" but I took that to be, at best, a metaphor.

What then, does the Youth Advocate actually do? He is in the field four days a week, trying to be at each facility twice each month. The week before we spoke, Mr. Reyna indicated that forty youths at ORV wanted to see him.

Mr. Reyna lives in the Columbus area and returns home each night from a site visit. ORV is about a 3-hour drive each way and if he works an 8 or 9 hour day that might give him 2 or 3 minutes with each youth if he went non-stop.

I do not believe I need to complete the thought here.

Mr. Reyna views himself, in some sense as a part of the grievance system. He states that when he is at a facility the youth call him the grievance man. He does listen to youth complaints about not getting their clothing back clean, "we wear rags!," complaints about bed linens, and the like.

He uses his knowledge of the personnel and the system to help resolve these individual complaints. Whether he is simply a parallel track to the grievance system or more like an independent agent attempting to solve youths' problems is unclear to me.

Finally, Mr. Reyna also prepares Conditions of Confinement Reports for the Director who described him to me as "my eyes and ears" in the facilities.

A copy of three of such reports are attached at Appendix F.

The concept of a youth advocate or Ombudsman is one that deserves a good deal of support. However, with no staff and an uncertain mandate, Mr. Reyna is in an untenable position. The first order of business should be to clarify the role and as a barometer of the office's significance, staff it accordingly. On April 23-23, 2006, a conference entitled, "Opening a Closed World" was held at the LBJ School of Public Affairs in Austin, Texas.

Speakers reviewed the various approaches taken by the Council of Europe (Sylvia Casale), the British Prison Inspector (Anne Owers), the Swedish Ombudsman for Penal Matters (Cecilia Nordenflt), and the California Inspector General (Matthew Cate).[58]

[58] Conference materials are in the possession of Fred Cohen.

Several themes emerged: an Ombudsman must be independent, well funded and staffed, and able to bring about change.

The resolution of individual problems of inmates and residents is less important to this type of office than the identification of system problems and their solution. It is the difference between an individual lawsuit seeking damages and a broad-based, class-action, conditions lawsuit.

At the moment, the Youth Advocate's office is largely symbolic, but worthy of expansion along with role clarification. It could well serve as adjunctive to the individual problem-solving of an effective grievance system in pursuit of system problems and change.

The Disciplinary Process

This writer has studied the various Policies and SOPs governing the DYS disciplinary system and observed several disciplinary hearings. In Section II, I described a disciplinary hearing involving a seriously disturbed, 15-year-old accused of creating an "institutional hazard;" that is, cutting his arm.

He had no one to assist him, he entered a guilty plea with no explanation of the potential consequences, and the mental health representative present (I suppose) to help did nothing. The youth hardly was competent to challenge the charge itself based, as it seemed, on a direct manifestation of his illness.

Based on a request from Deputy Director Monique Marrow, I outlined my suggestions for conducting a disciplinary hearing where the youth is on the mental health caseload or otherwise manifests evidence of a mental disorder. That outline follows:

1. No charge should be brought up at a hearing when the hearing officer previously determines it has no basis in law or fact.
2. You do not ask the youth, "You don't want assistance, right?" Just the opposite presumption should apply and with retarded or mentally ill youth, I would always assign a trained representative or a youth advocate.
3. Where a youth is on the mental health caseload then the Mental Health Assessment form used by DRC is a decent model. The initial questions relate to hearing competency; that is, does the youth understand the charges; is he/she able

to assist an advocate; (new here) does the youth know what the potential consequences are if found guilty?

4. You cannot assume these youth know what it means for example, to "create a institutional hazard." The hearing officer must record the proceeding (it is not done now) and make certain there is a record to support going forward and a record as to competency and consequences.
5. Treatment team should carefully consider the negative consequences of any potential disposition and, turning it around, suggest (when possible) a disposition consistent with the treatment plan.
6. Where a youth begins to deteriorate during a hearing, the hearing officer should suspend the hearing, stating "why" for the record and indicate when it might be continued (e.g., when the attending psychiatrist indicates the youth is sufficiently stable to proceed).
7. Finally, the record should reflect the extent to which the youth's illness or condition contributed to the violation that is the subject of the hearing. This is not to create a type of insanity defense but to put the behavior into context. The more therapeutic the environment, the easier it will be to view harmful conduct as "acting out" v. "willfully disobey."

I understand that this is not in policy and procedure or SOP format, but I do suggest it is a reasonable basis for handling discipline involving a mentally disordered youth.

In reviewing SOP, 303.01.03 (revised, Sept. 27, 2006), I found the rules to be a bit more complicated than need be or perhaps it would be more accurate to say, verbose. Section IV, A (7)(c) should be revisited. As with the grievance process, staff assistance is discretionary, mandatory if the youth so requests.

I could find nothing explicit on the representative's role except a suggestion that it is evidence gathering. I think it is worth considering mandatory assignment of staff assistance with the role varying depending on what the youth requires. That would include evidence gathering, interviewing staff or youth, assisting in understanding the charge, challenging a charge, speaking to the disposition, and the like.

Understanding the consequences of a guilty plea, in turn, would be central and I would anticipate "plea deals" with the tribunal.

Finally, the prospect of 180 days disciplinary time added to the length of sentence and extended terms of isolation are highly dubious sanctions.

In my judgment, extending a term of confinement, even though it is, in fact, moving a release date, is a sanction so severe that a facility disciplinary board should not have that authority.

Any term of "penal isolation" for more than, say, five days is constitutionally suspect and in any settlement of this case, that issue must be clearly resolved.

XI. MISCELLANEOUS

Lighthouse Youth Center at Paint Creek

On October 2, 2007, Team Member Barbara Peterson paid a one-day visit to the privately owned and operated residential center at Paint Creek, outside the village of Bainbridge, Ohio. It was originally funded by a grant from the Office of Juvenile Justice and Delinquency Prevention to explore the effectiveness of private sector options for a staff-secure residential treatment of serious juvenile offenders.

Based on Ms. Peterson's brief visit and assessment Report, Paint Creek appears to be a success worthy of further study and evaluation. What follows is Ms. Peterson's brief report:

> The Lighthouse at Paint Creek is a privately owned and managed residential rehabilitation center for males age 15-18. Maximum capacity is 67.
>
> The facility is located on 33 acres in Ross County. The original buildings, it had been a sports camp, were used initially to house youth and programs. Since 2001 two residential halls, one with 30 beds, the other 33, have been built. There are 51 single rooms and 6 that house two youth.
>
> In 1998 an eight-room school was constructed. The original campus had a combination baseball diamond/football field and two tennis courts and those remain today. The tennis courts are used for "vennis" a combination tennis/volleyball game invented by youth. Three volleyball courts and a track have been added. There are plans to replace the current activities building with a full size gymnasium. Due to space limitations in the current building the emphasis is on outdoor recreation activities in all but the coldest weather.
>
> The campus is open; there are no fences and no locks on the doors. Youth, except for those in the final phases of programming, are always within sight of a staff member. Those nearing release may spend time doing chores off the unit but must report in at regular intervals and must

attend programming if scheduled. There has never been a successful escape; attempted escapes average one per year for 19 years.

All staff are trained in positive interventions to de-escalate or manage difficult situations. Over the past three years the average for use of physical restraints is eight times per year. Since 1986 no youth or staff member has sustained a serious injury as a result of youth to youth, youth to staff, or the use of physical restraint.

The philosophy of LYC-PC provides the basis of all programming and interventions. It states: "We provide interventions that promote positive relationships and responsible lifestyles for juvenile male offenders and their families". The core values of programming are listed as: positive change occurs only when there is an atmosphere of mutual respect and personal safety; responsible thinking leads to responsible behavior and a positive community support system enhances positive changes.

Program components include group and individual counseling sessions with the emphasis on group activity. Each resident has a case manager who helps him with all individual issues including family contact, development of an individual treatment plan, and communicating progress to referring courts and DYS.

There is a peer-mentoring program and behavior modification and reality therapy are interwoven into all programs. The center offers chemical dependency and sex offender services and mental health support.

Treatment never ends at LYC-PC. Even at meals staff sit at round tables and have 'mealtime' conversations with youth as they all eat.

Education staff is comprised of 4 academic teachers, one career based program teacher (CBIP) and one computer instructor. Boys are able to earn 5 credits per year. Age and the number of high school credits earned prior to admission make the GED a better option for most of these youth and 74% leave the program with a GED certificate.

CBIP focuses on job finding and retention skills, consumer math and life and social skills. Youth who are within six months of release can be

assigned to a workstation on campus. Each receives a stipend based on his efforts at work and school. Each is eligible for an increase in stipend every eight weeks.

Every resident has computer classes and the level of training is based on individual competency. Certificates are available for every level of achievement and are posted in the classroom.

In 2004 a college class of 12 qualifying students was initiated as a pilot program. Due to the success of this trial the program continues.

There is one nurse for this facility. Medications, from individually labeled prescription bottles, are self-administered under the supervision of a youth worker who notes the medications as taken. Failure to take a medication as ordered is reported to the nurse who follows up with the youth. She sees youth individually and provides education about the medications and the importance of taking it as prescribed. The need for the nurse to intervene is rare. The expectation is that youth will be responsible with medications and they are.

A dentist sees all youth every six months. Services are provided off grounds. Youth are also seen by the dentist immediately prior to release to complete any work and insure dental health at the time of discharge.

A family practitioner is available on grounds one day per month. His family practice partners also provide immediate and emergency care off site as required. Youth with a chronic disease such as asthma are seen regularly and an interval history is provided for the physician' visit.

Laboratory and x-ray services are provided off-site.

Immunizations are documented and completed as necessary. The nurse provided basic health education on a number of topics including normal growth and development and sexual development. She provides disease related information on a 1:1 basis.

There are two youth workers per housing unit on first and second shifts and one on the night shift. Youth participate in and are responsible for many aspects of programming and unit management. During visits to

each housing unit youth were engaged in meaningful activities. Youth earn jobs such as door monitor to remind others of the rules of conduct if necessary. It was difficult to identify staff initially because they also were involved with youth in activities. There was no yelling at any time yet there was always conversation.

Two youth conducted my tour of the campus. They were knowledgeable about all aspects and areas of the program and included all buildings in the tour. One of the former dorms is used for semi-independent living quarters for youth awaiting release and who have earned the privilege. These youth continue in all scheduled programming and unit activities but are permitted to sleep independently in one room of the former dorm. There is also a cabin on grounds that has been renovated and is available for families who are visiting. One of my guides was to be released the following Monday and his father would be staying in the cabin overnight. The Program Director suggested he might be able to stay with his father in the cabin. She encouraged him to follow up by asking his unit.

The size and setting of this facility are unique in DYS as is the relationship although the youth are not precisely the same as those in all other facilities. The attitudes of all staff encountered were positive, youth felt empowered prepared to sustain the changes they had made. Youth interviewed individually and as a group had nothing but positive comments about the experience and each also had a plan for the future. There is much to be learned from this facility.