S.H. v. Stickrath
Stipulation Agreement
Case No. 2: 04-CV-1206

Psychiatry Site Visit Report
Ohio River Valley Juvenile Corrections Facility
Franklin Furnace, Ohio

February 11 – 12, 2009

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Introduction

This report is prepared in accordance with the provisions of the stipulation judgment for injunctive relief in *S.H. v. Stickrath, 2:04-cv-01206.* In this case,

> Plaintiffs allege a system-wide failure regarding conditions of confinement within facilities operated by DYS that endanger Plaintiffs' physical health and safety; threaten Plaintiffs' emotional and psychological well-being; deprive Plaintiffs of adequate programming, education, medical and mental health care, and dental care; and deprive Plaintiffs of due process of law.

The purpose of the site visit to Ohio River Valley Juvenile Correctional Facility, ORVJCF, on February 11 and 12, 2009, was primarily to ascertain data regarding the conditions of confinement for youth on the Special Management Unit, SMU. There are concerns that the level of mental health care available to Caucasian youth with acute mental illness is not available to African American youth, and to youth that allegedly have engaged in gang-related behavior at some point during their DYS commitments. Allegedly, these youths systematically are denied transfers to the MHU when the MHU is the designated setting for youths with acute serious mental illness.

Also, there are concerns that criteria by which youth are admitted to the SMU, which include the results of an "arbitrary" rating tool do not comport with the evidence based level of scrutiny articulated in the Stipulation Agreement.

Additionally, there are concerns that the DYS Release Authority is being excessively punitive, by adding additional commitment time to the DYS commitments of mentally ill youth when their disruptive behavior may be related to DYS' failure to provide minimally acceptable mental health treatment to these youth.

Qualifications of Evaluator

The qualifications of this examiner were submitted for review in the past. A copy of these qualifications will be made available on request.

Scope of Evaluation

The evaluation will be limited to conditions of confinement and the emotional well-being of youth in the SMU. As such, comments and observations will be made regarding the conditions in the SMU and in the MHU, which offers a higher level of mental health care to youth committed to DYS.

Limitations of Evaluation

The evaluation was based on information made available to me during my visit to ORVJCF. If additional information becomes available, I reserve the right to submit an addendum to this report.

Sources of Information

1. Facility tour of ORVJCF on February 11 – 12, 2009.
2. Interviews with staff and youth during the February 11 – 12, 2009 tour.
3. A review of youth records, including master files, psychology files, and medical files.
4. ORVJCF Statistical Summary: Precautionary Status for November 1, 2008 – February 12, 2009, prepared by Joseph M. Carver, Ph.D., Psychology Supervisor.
5. Unit Plan for McKinley Unit, ORV's Mental Health Unit.
6. ODYS Activity Management System Incident Summary Report for ORVJCF from December 1, 2008 until January 31, 2009.
7. ODYS forms, including:
    a. Medical Transfer Summary
    b. Transfer Intake Assessment Form
    c. SMU Admission Tool
    d. SMU Placement referral packet with youth's name redacted.
    e. Suicide Precaution forms:
        i. Notice of Precautionary Status
        ii. Notice of Change of Precautionary Status
        iii. Notice of Revocation of Precautionary Status
8. Behavioral Health Services Level of Care flow sheet
9. ORVJCF Institutional Youth on the Mental Health Caseload.
10. ODYS "Race Count" by Institution for January 19, 2009.
11. ODYS "Count of DXs [Diagnoses] per site."
12. ODYS Healthcare Services Mental Health Medication Report for ORVJCF.
13. "All Youth at this Site and the DX [Diagnosis] and Caseload Status" for ORVJCF, printed January 19, 2009.
14. ORVJCF "Institutional Youth on the MH Caseload" printed February 5, 2009.

15. Sleep hygiene group curriculum.
16. A Mental Health Treatment Plan with names redacted.
17. Blank ODYS Risk Assessment Interview form.

The Facility Tour

ORVJCF has five buildings and ten living units. The Liberations Building contains five living units, including McKinley - the Mental Health Unit or MHU, and Grant, the home of the Special Management Unit, SMU.

On January 19, 2009, the census at ORVJCF was 267. The average youth age is seventeen years, however youth as young as thirteen or fourteen, and as old as twenty also are at the facility.

There were 58(21.7%) Caucasian youth and 209(78.3%) non Caucasian youth. There were thirteen youth assigned to the McKinley Mental Health Unit: one is biracial, two are African American, and ten (76.9%)are Caucasian. There were nineteen youth assigned to the Grant Special Management Unit: three (15.8%) are Caucasian, fourteen are African American, and two are biracial. There were 117 youth assigned to the Mental Health Caseload; 36 (30.8%) are Caucasian. These statistics suggest that Caucasian at ORV youth have disproportionately more mental illness and more serious mental illness than do African American youth. On the other hand, these numbers also could suggest that ORV behavioral health team members and administration are less skilled and/or comfortable with evaluating African American youth for the presence of psychiatric disorders, including engaging them and understanding how culture and history, including a youth’s developmental history, may influence the presentation of mental illness in different racial and ethnic groups. Given the exposure rate of African American youth to community base violence and trauma, a reasonable person in like circumstances may conclude that African American youth are not receiving adequate screening for psychiatric disorders.

Statistical Data

The Mental Health Precautionary Status Statistical Summary contains data for November 1, 2008 through February 12, 2009. During that timeframe:

- Seventeen youth on the Residential Mental Health Unit and 26 youth assigned to general population units were assigned to precautionary status.
- Five youth were placed on Suicide Watch; one remained on watch for five days and all other youth were removed from Suicide Watch after one day.
- Thirteen youth were on Behavior Status on the Residential Mental Health Unit and twenty were assigned to general population units.

Staff and Unions

All ORVJCF behavioral health team members belong to a union except the psychiatrist, the social work supervisor, and the psychology supervisor. When facilities close or layoffs occur, the bumping process may displace well-trained staff that know and work well with youth. This practice alters the quality of mental health services and behavioral interventions available to youth throughout ORVJCF.

New behavioral health and direct care staff must complete required training in 90 days to remain in their new positions. During the orientation period, new staff members do not receive additional monitoring, mentoring or supervision. Youth are subjected to the inexperience of new staff members without much recourse. Staff inexperience is conducive to disruptive youth behavior and may deprive youth of a minimally acceptable level of care, especially when there is frequent staff turnover, as may occur when other juvenile corrections facilities close and established behavioral staff are reassigned or lose their jobs.

At this point, behavioral health and direct care staff assigned to the SMU and MHU do not have special job classifications. Although this process may be complicated, assigning special classification status to these positions would enhance the stability of the SMU and MHU programs and would require candidates that wish to work in those areas to complete special training before they bid for positions. This process would likely deter less interested and less committed staff from seeking these positions. On the other hand, this practice would complicate the process of filling positions when staff shortages exist.

In the past, ORVJCF has relied heavily on relief staff due to staffing deficits. The staff shortage made it difficult to cross train employees for different positions. The staff

shortage situation is improving, and cross training generally does not occur.

Training and Trauma-Informed Care

There are concerns about continuing the "Trauma-Informed Care" program because of its cost. A less costly alternative may be used in the future, if it is deemed to meet youth rehabilitative needs.

Protective Custody

Youth that need protective custody have been housed on the Special Management Unit and on the Mental Health Unit depending on the needs of the youth. Some youth engage in disruptive behavior so they may be removed from threatening situations in the general population. These youth are less likely to buy into and complete the SMU Behavior Management Program and/or the MHU program, because they do not want to return to the general population. The grievance system, which staff and youth have said is ineffective, does not offer a viable venue for youth to address many of their safety concerns.

Behavioral Health

Psychology

The ORVJCF Psychology Department consists of a Psychology Supervisor, a doctoral level Psychologist, three Psychology Assistant II staff, and a Psychology Assistant I. The Psychologist was recently assigned to the SMU full-time to develop the SMU rehabilitation program. The ORVJCF Psychology supervisor said that psychologists presently run sleep hygiene groups for youth in the general population and an anger management group for youth in the SMU. Groups are supposed to meet at least twice weekly.

Psychiatry

ORV contracts for 25 -30 psychiatry hours per week. The ORVJCF psychiatrist is board certified in general psychiatry and has an interest in forensic psychiatry. He provided psychiatric consultation to the Ohio Department of Rehabilitation and Corrections for about ten years before he began to consult to ORVJCF. He spent additional time, during his residency training, treating adolescents; he said he feels comfortable working with the ORVJCF youth population.

Despite these strengths, the ORVJCF psychiatrist does not have access to a DYS administrative child psychiatrist for

consultation regarding developmental issues, community practice standards, peer review, and related matters. Also, the ORVJCF psychiatrist has not taken a vacation since he arrived at ORVJCF more than one year ago. Additionally, he works Mondays, Tuesdays, and Wednesdays; he does not meet or exceed the maximum number of contract hours. Clinic office space limitations make it difficult for the psychiatrist to work on other weekdays. He is available by phone 24 hours per day.

Gang-related concerns and interventions, including facility lockdowns, may extend the workday for the psychiatrist, who evaluates four to six new youth weekly. Medication compliance numbers are tallied weekly, for each prescribed medication, so that the psychiatrist may address adherence concerns with youth that in a timely manner.

There are safeguards in place that increase the likelihood that youth have consistent psychiatric follow-up. The psychiatrist documents when he wishes to follow up with a youth and writes medication orders that last thirty days. Nursing staff alerts the psychiatrist if a medication order is about to expire and has not been renewed. Youth usually are evaluated before medications are renewed.

The psychiatrist makes an effort to contact parents to obtain additional history and to review medication treatment plans with them. Youth rarely meet with the psychiatrist more than once per month even when they are initiating new medication trials.

Social Work

DYS social workers historically were not part of the behavioral health team. They recently were granted access to behavioral health progress notes and they do not document in the "psychology charts." Thus, their interactions with youth are reviewed by behavioral health staff and others during treatment team meetings. According to DYS Central Office administrators, efforts to integrate social workers into the behavioral health team have been slow due to unions, state licensure regulations and other administrative and bureaucratic obstacles.

Education

Briefly, a school psychologist (0.5 FTE) who conducts psychoeducational testing for youth in need of education remedies, such as 504 plans, and related services. School

officials also develop behavior intervention plans for disruptive youth.

Grievance System

Every youth interviewed said the grievance system does not work. Several youth said they have given up on writing grievances because grievance officers "never answer them." Staff said youth that write too many grievances "can end up in the SMU because staff say they [youths] don't fit in," even if their grievances are valid.

Crisis Intervention and Suicidal Youth

Psychology team members said that when a youth is at risk for self harm, the youth is placed in "direct sight" of a juvenile corrections officer until a member of the psychology team arrives to conduct the assessment. Psychologists are expected to respond within four minutes after they are contacted. Psychology assistants must consult with a supervisor before the youth's level of monitoring is adjusted.

Youth placed on suicide precaution plans have their progress reviewed daily by behavioral health team members. The psychiatrist may remove a youth from suicide precautions unless a psychologist is not available and the facility superintendent approves this intervention. This practice marginalizes the role of psychiatry in DYS and falls below the community standard of care.

The Mental Health Unit

On the first day of the survey, the census for McKinley, the mental health unit, was thirteen. The unit can accommodate 20 youth.

According to the Residential Mental Health Unit Plan, criteria for admission to the McKinley MHU are:

1. Increased risk for danger to self.
2. Increased risk for danger to others
3. Presence of acute psychiatric symptoms "that can be more efficiently and effectively treated in a small unit setting with aggressive psychiatric treatment and support."
4. Difficulty maintaining stability in the general population due to a youth's deteriorating adaptive and/or interpersonal skills.

5. Vulnerable youth with cognitive, medical, neurological, and/or psychiatric disorders that impair their capacity to function successfully on general population units. (Note: staff say youth with IQs lower than 50, which is in the moderate mental retardation range, are considered vulnerable).

The MHU team consists of a unit manager, a social worker, a psychologist/psychology assistant, and a general activity therapist. Also, a total of eight juvenile corrections officers, JCOs, are assigned to work on the unit. The unit presently does not have a general activity therapist. The psychiatrist is not mentioned in the Unit Plan, but provides consultation to youth on the Mental Health Unit. The psychiatrist has no defined role or leadership expectations on the Mental Health Unit; he does not attend treatment team meetings and does not direct the care of youth with acute serious mental illness. This DYS practice deviates substantially from the community standard.

MHU interdisciplinary team meetings occur weekly and youth progress is reviewed monthly, or more frequently, if indicated. The treatment team consists of the unit manager, social worker, psychologist/psychology assistant, education representative and general activity therapist. Each youth is expected to participate in his treatment team meetings. Youth receive individual and group therapy as needed; no minimum frequency is specified.

Staff assigned to mental health units must participate in training on diagnosing mental disorders, psychotropic medication, Trauma-Informed Care, evidence based treatment interventions, violence against others, suicidality and violence against self, precautionary status interventions, Emergency Response, cognitive behavioral treatment theory, the “Thinking for Change” program, and Advanced Verbal Strategies.

MHU team members are supposed to meet monthly to exchange “experiences, insights, and new knowledge.” These problem solving meetings should help staff enhance their skills and improve interdisciplinary communication. Team members must also attend annual in-service training. Additionally, staff may propose additional training opportunities to the Unit Manager at any time.

Central Office

Central Office Administrators have been working to develop a comprehensive behavior modification program for the SMU on a piecemeal budget. The Director of Behavioral Health Services has been accessing and modifying public access materials from juvenile corrections programs in other states that have more established programs. She also has been purchasing books and other materials for the unit. The transition of this program from concept to reality has been turbulent, at best, in view of budgetary, administrative, and staffing limitations. Yet, the process is moving forward.

The Special Management Unit

By all accounts, the SMU is designed for youths that endanger the general population by engaging in violent behavior. Staff said the youths assigned to the SMU "exhibit more criminal thinking" than youth on the MHU. Many youth that are on the SMU have engaged in gang activity during their DYS commitments.

Documents suggest that any youth that has engaged in aggressive or disruptive behavior may be admitted to the SMU. A youth may be transferred to the SMU for up to three days before a mandatory administrative review must occur.

MHU, SMU, and general population staff unanimously reported that mentally ill youth and youth with physical, cognitive, or medical vulnerabilities are not eligible for SMU placement. They also stated that youth that have engaged in STG activity, at any point during their DYS commitment, are not eligible to be transferred to the MHU. Also, MHU staff are not in a position to override decisions about transferring youth from the MHU to the SMU even when the proposed intervention is deemed to be therapeutic, is in the interest of the MHU for safety purposes, and is in the youth's best therapeutic interests.

Staff reported that in recent weeks, the SMU has become more therapeutic; an incentive-based program has been put into place. The current SMU Unit Manager is viewed favorably by SMU and MHU staff. He is easy to work with and wants youth to succeed. Time restrictions and scheduling conflicts precluded a face to face interview with the SMU Unit Manager.

Each youth considered for transfer to the SMU is evaluated for the appropriateness of this placement using an "SMU Admission Tool" that contains the following areas of inquiry:

- Initial Offense Level
- Serious Youthful Offender
- Escape Attempts in Past 30 Days
- Assaultive Behavior in Past 30 Days
- Significant Injury to Peers or Staff Requiring Medical Treatment
- Pending Ohio State Patrol Charges
- Frequency of Youth Behavior Incident Reports in past 30 days with primary rule violations
- Frequency of In-School Suspensions in Past 30 days or 30 days prior to Intersession
- Security Threat Group, STG, involvement
- Program Participation

Responses to each inquiry are encoded with scores between zero and fifteen. The SMU Admission Tool Guidelines form indicates:

Scores on the Admission Screening Tool have been statistically evaluated. The following results were present:

Average Score	45
Score Range	28 -71
Standard Deviation	12
68% Average Score Range	33-57

Youth that score 46 or greater on the SMU Admission Tool are eligible to remain on the SMU for rehabilitative programming; youth with scores below 46 remain in the general population. A treatment team may craft an individualized or STG Special Management Program for any youth in the general population.

Although some areas of inquiry included in the SMU Admission Tool have been associated with increases in youth violence, the SMU Admission Screening Tool does not specify the characteristics of the population that was used for the statistical evaluation or how the scoring numbers were derived. It is unlikely that the SMU Admission Tool scores were standardized on a population of incarcerated mentally

ill youth. Yet, this is a population on which the SMU Admission Screening tool is frequently used.

The average score on the SMU Admission Screening tool is 45 with a standard deviation of 12. The minimum score for admission to the SMU is 46. This means that any youth that scores in the higher half, 51st percentile or greater, of the scoring range, or one out of two youth is eligible to be admitted to the SMU. Thus, most youth that are eligible for SMU admission are functioning within the average range of behavior for the normed population. This suggests that admissions criteria for the SMU are excessively punitive and therapeutic alternatives for disruptive youth are not being considered by DYS and ORVJCF administrators.

Additionally, inadequately treated mental illness, such as psychosis, increases the likelihood that a person will engage in violent behavior. Behavioral health team members that are not properly trained to evaluate and treat mentally ill youth are indirectly contributing to violence in the ORVJCF and DYS communities. Despite this concern, youth that engage in repeated acts of aggression have had their DYS commitments extended by months, if not years. Punishing youth for inadequate staff training and competence comports with cruel and unusual punishment of mentally ill juvenile offenders.

In sum, the SMU Admission Tool does not comport with the evidence based requirements articulated in the SH.V. Stickrath Stipulation Agreement.

There are special management plans for youth that have engaged in STG, activity, including gang fights, gang initiations, singing gang-related songs, acknowledging membership in a gang, making gang-related statements, using gang signals or using gang-related graffiti. These actions take precedent when juvenile corrections officers classify disruptive behavior for incident reporting. For example, a youth that was locked in his room "began kicking his door repeatedly and threatened to break off a sprinkler head. He also sang gang related songs and admitted to being" a gang member. His behavior was classified as "Gang Related Issues" and "Disruptive Behavior," in that order. The youth was placed on a STG behavior modification plan.

ORVJCF staff unanimously reported that youth with STG affiliation are not eligible to be transferred to the MHU

for care. Thus, mentally ill youth that have a history of STG related activity are denied the same level of care afforded to youth without this classification. A DYS Central Office administrator said this is not the case; youth are assigned to the MHU based on the presence of vulnerability due to acute mental illness, medical, physical, and/or cognitive disability.

Youth with acute mental illness that are physically aggressive and may place youth on the MHU at risk for harm are assigned to the SMU or for care in the interest of community safety. The mental health programs on the MHU and SMU differ substantially. Consequently, aggressive youth with acute mental illness do not receive the same level of care as youth assigned to the MHU.

The DYS practice of depriving violent youth with acute mental illness will precipitously increase in significance after Marion Juvenile Corrections Facility, MJCF, closes. ORVJCF and DYS Central Office administrators unanimously stated that the MJCF youth, as a group, are more aggressive than are youth currently housed at ORVJCF. Also, MJCF has a unit that serves youth with serious mental illness. Thus, MJCF youth with serious mental health concerns that are transferred to ORVJCV may not be eligible to receive services on the MHU because of past violent and/or gang-related behavior, even if the illness exacerbated the concerning behaviors. Additionally, the closure of MJCF may result in staff changes at ORVJCF due to union seniority and bumping practices. Thus, the SMU and MHU may, in the future, be less stable; they may have less experienced staff that lack training and are unfamiliar with protocols, practices, and the target populations.

SMU Special Management Plan

The SMU Special Management Plan was introduced as a six week individualized behavior modification program, although youth are permitted to work through the plan sooner and many youth take longer than six weeks to work through the plan. See Figure 1 for Details.

***Figure 1.* The SMU Three Level System**

Red Phase – orientation phase
Youth receive orientation to the SMU program from a social worker. Youth are permitted to leave their rooms for showers. They complete school work, dine, engage in recreational activities, and receive medication in their rooms.

Youth must participate in process groups including Strategies for Success.

Youth must receive no disciplinary "write-ups," must complete their school and therapeutic assignments, and must participate in weekly treatment teams before they are advanced from Red Phase to Yellow Phase.

Yellow Phase – Intermediate Phase
Youth have one hour of recreational activity out of their rooms each day. Also, they are eligible to attending school on the SMU with other youth. The youth does therapeutic book work or bibliotherapy.

Blue Phase – Highest Phase
After one week of satisfactory behavior on blue phase, youths are permitted to attend school in the academic building. The youth does bibliotherapy.

The SMU Bibliotherapy Curriculum:
"Criminal and Addictive Thinking"
"Gangs: The Choice is Yours"
"My Change Plan"

Staffing

Prior to January 20 2009, the SMU program was run by a single social worker, who was responsible for documentation, groups, orientation, and team review. Presently, there are two FTE social workers and one FTE doctoral level Psychologist assigned to the unit.

When I arrived on the SMU on February 11, 2009, a social worker was conducting a group session with youth in her office. There is no dedicated group room on the SMU; staff must remove items from their desks and offices so youth will not have access to contraband during group, individual, and family therapy sessions.

The newer social worker conducts orientation sessions and assigns each youth to a "red phase" of the Special Management Plan. Weekly individual treatment team meetings are attended by the youth, social worker, psychologist, and JCOs. When a youth has met his goals, he is advanced to the "yellow phase" of the program and begins to work with the more experienced SMU social worker. The youth will advance from "yellow phase" to "blue phase" after he meets the requirements for advancement.

There is no orientation manual for the SMU. The orientation process is verbal. There was no documentation in the psychology chart, or elsewhere, regarding the SMU orientation, treatment team meetings, individual sessions, or group sessions conducted by social workers. This may, in part, be due to roles and expectations for social workers that are being redefined at the DYS Central Office level. That is, social workers are not permitted to write in psychology charts. On the other hand, SMU social work staff may be overwhelmed by the volume of work they do; they have not had time to document their interactions with youth in any systematic fashion.

Although the role of the SMU Psychologist has not been clearly defined, he has begun to document anger management group sessions for each youth in his respective psychology chart. The social worker that sat in on the first anger management group said the group is "promising."

Social workers have had to train themselves to run the SMU. There is no curriculum, manual or training program. The

recent addition of therapeutic workbooks to the program has added structure to the SMU program.

SMU Social workers are pleased with the recent installation of speaker phones in their offices. They use the phones to conduct family sessions with youth. At times, involving family members has helped resistant youth modify their behavior sooner. For example, youth that have exposed their genitals to others often do not want their families to know about their behavior.

There are concerns that with the closing of DYS facilities, the existing staff on the SMU, MHU and elsewhere may be "bumped" from their positions in favor of staff with less interest and experience and more seniority. Yet, there are no training manuals, training modules, or other resources to distribute to new SMU staff.

<u>Constructive Suggestions from SMU Staff</u>
The following suggestions were made by SMU staff that are interested in introducing and maintaining a higher quality of care for youth.

1. A consistent budget is needed so that staff will have access to necessary administrative, rehabilitative educational, training, supervisory, and clerical resources for the SMU.

2. Staff need consistent access to therapeutic materials.

3. Clerical support dedicated to the SMU is needed to facilitate record keeping, parent contacts, messages, etc.

4. Staff could benefit from having access to a copy machine with scanner. The current process of obtaining copies and scanning in records is time consuming and wastes valuable time that could be used for therapeutic interventions with youth.

5. SMU Staff need access to timely notes from the psychiatrist. Nothing appears in the psychology chart until the Monday following the psychiatry visit. The typed notes from the psychiatrist are, however, "extremely helpful."

When asked, staff agreed that regularly scheduled meetings with the psychiatrist could benefit youth, and the program, by enhancing continuity of care, facilitating referrals, and promoting interdisciplinary exchange of ideas and information.

Medication
ORVJCF medical staff reported that morning medications are distributed at 6:30 AM.(Nursing shift change is at 7AM.) Staff on the BMU consistently reported that (contract) nurses distribute medication at 5AM. This creates problems for youth that oversleep or do not want to awaken at 5AM to receive medication. This practice also alters the effectiveness timeframe of stimulant and other medication designed to contain youth behavior throughout the school day.

If a medication for Attention Deficit/Hyperactivity Disorder, AD/HD, such as Adderall XR (long acting dexedrine) or Concerta (long acting methylphenidate/ Ritalin) is given 90 minutes earlier than anticipated, the medication effect will stop 90 minutes earlier during the school day. Consequently, youth will be subjected to unnecessarily higher and more frequent medication dosages to contain their behavior.

Clearly, the nursing practice of dosing medication at 5AM is not the least restrictive medication alternative for SMU youth and is not cost effective. On the other hand, a 6:30 AM medication distribution time may not allow third shift nurses sufficient time to distribute medication *and* to complete required documentation before the 7:00 AM shift change. Before I left the ORVJCF campus, DYS administrators assured me that the DYS Medical Director had been informed of this problem and "it has been addressed."

Youth records indicate that several youth have had their oral stimulant medication discontinued after they have been found with a stockpile of stimulant capsules in their rooms. This suggests that medication checks are not being given due diligence by nurses. Several interventions may diminish the practice of youth hoarding and "cheeking" medication, including:

1. Increased Staff Training and accountability
    a. Frequent nurse in-service training should occur to review medication distribution practices,

including proper mouth checks. This is particularly important because contract nurses, who may be subject to higher turnover, distribute medication to the youth.

b. Nurses that do not correctly conduct mouth checks should be held accountable after they have completed the requisite training.

2. Greater use of dissolvable medication
   a. The antidepressant mirtazapine (Remeron) is generic and has a dissolvable SolTab formulation that makes it difficult for youth to regurgitate it. Mirtazapine's sedating effects may also be beneficial to youth struggling with insomnia and may improve the appetites of youth receiving stimulants for AD/HD. Mirtazapine is FDA approved for treatment of adults, so appropriate disclosures must be documented when it is used with youth.

      The antipsychotic medication risperidone (Risperdal) also has a dissolvable M-Tab formulation.

   b. lisdexamfetamine dimesylate (Vyvanse) may be dissolved in water before it is issued to youth with AD/HD. The medication is formulated to prevent recreational drug users from deriving a "high" from it.

   c. Dissolvable medications tend to taste better than crushed medications because most dissolvable medication manufacturers factor taste into the product development and manufacturing processes.

3. Improved monitoring of youth
   a. Monitoring youth closely for 30 minutes to one hour after they ingest medication to reduce the likelihood that they may spit out the medication. (This practice is more easily accomplished on a mental health unit.)

   b. Prohibiting youth from using the bathroom for the first 30 minutes to one hour after they ingest medication; youth may regurgitate medication when they are not being watched

closely by direct care staff. (This practice is more easily accomplished on a mental health unit.)

4. Crushing medication
   a. This practice should be limited to medications that are not enteric coated. Crushing enteric coated medication affects how the medication is processed by the body. Pharmaceutical manufacturers have not studied, and the FDA have not approved, the use of enteric coated medications that are crushed.

5. Greater use of liquid medication, including concentrates and suspensions
   a. Some youth will resist liquid medications because they do not like the taste. This matter should be addressed therapeutically.

Diagnoses

I reviewed 184 pages of diagnoses (and removed diagnoses) and make the following observations:

- Although diagnoses listed were made by masters and doctoral level psychologists, not one diagnosis listed was made by a psychiatrist who treats the most debilitating mental health disorders with medication and other interventions. This suggests the role of psychiatry is marginalized in the DYS System. The practice also provides an inaccurate clinical picture of each youth's mental disorder(s).

- Conduct Disorder diagnoses were listed in excess. Conduct Disorder is the only psychiatric diagnosis that may be made by any lay person. The practice of labeling mentally ill delinquent youth with conduct disorder as their primary mental health disorder allows behavioral staff, including psychiatrists, to justify depriving challenging youth of necessary behavioral health treatment and interventions. This practice must stop. Youth need to be engaged by behavioral health practitioners, to have their diagnoses clarified and to receive evidence based interventions for their disorders. Accurate

diagnoses and optimization of treatment stabilizes youth and renders the residential environment more conducive to productive rehabilitative activities.

Charts:
There is a master file, a medical chart, a "psychology chart," and an education chart for each youth in the DYS system. At ORVJCF, the psychiatrist places a handwritten note in the youth's medical chart after each contact. The psychiatrist also dictates a DYS note into a his personal digital tape recorder. The psychiatrist brings the digital tape recorder to his home, where he transcribes each note using his personal voice recognition software. He prints the notes and brings them to ORVJCF the following Monday. DYS compensates the psychiatrist for transcription time. There is no notation in each youth's psychology chart regarding psychiatry contact until the Monday following the clinical contact. Thus, in an emergency situation, the behavioral health crisis evaluator may not have access to information derived during the youth's most recent psychiatry session.

The psychiatry notes contained information regarding family contacts, therapeutic interventions, clinical decision making, bloodwork and each youth's response to clinical interventions. Notations regarding treatment team meetings were noticably absent; the psychiatrist, by design, is not an active participant in SMU and MHU treatment team meetings.

The following notes were absent from the MHU and SMU charts I reviewed:

- Social work notes
    - Individual therapy
    - Group therapy
    - Unit orientation
    - Family contact
    - Changes of priviliege level
    - Treatment team meeting

- Psychology notes*
    - Group therapy**
    - Unit orientation
    - Family contact
    - Changes of priviliege level

- o Individual therapeutic interventions and clinical response.
- o Treatment team meeting

* Most mental health charts contained typed psychology notes. Some were monthly, others were less frequent; the quality of most therapeutic interventions were below the minimally acceptable community standard.

** The SMU psychologist had documented one group therapy note for each youth.

Medication:
The twenty-page Mental Health Medication Report lists psychotropic medications that are prescribed to youth. Most medications listed comport with the community standard for psychiatric care in adolescents. There are a couple of concerns:

1. Three youth are prescribed doxepin (Sinequan), which is the most dangerous of all tricyclic antidepressants because it can change heart rhythms and can be fatal. Doxepin is often used in corrections patients because it is inexpensive and is easily crushed. A baseline EKG is required before initiating treatment with doxepin. Also, EKGs should be ordered at three month intervals. However, this medication is not commonly used to treat adolescents; safer alternatives are available.

2. The antiseizure medication levetiracetam (Keppra) also is not commonly used to treat psychiatric disorders in adolescents. If this medication is being used to treat a psychiatric disorder, instead of a epilepsy/a seizure disorder, the practice should cease.

Chart Reviews

<u>TMC</u>
Youth TMC is remanded to DYS for Breaking and Entering. Although his original commitment was seven months, he has been in the DYS system for three years due to extensions of his commitment by the Release Authority. TMC is assigned the MHU because he is physically vulnerable due to his small stature. He has set off the fire sprinkler system at ORVDYS and is monitored closely by staff. A one point

during his commitment, he averaged twenty disruptive incidents per month. He has made toy guns, and has accessed other contraband. He is one of the most disruptive youth at ORVJMS. Yet, he is sufficiently intelligent to stop short of generating an incident report and has rarely generated incident reports in recent months.

TMC has a history of mood disorder, substance dependence, self injurious behavior, and disruptive behavior. In November 2008, letters containing STG content were found in his room. These letters contained riot plans, including plans that described injuring staff and youth. MHU staff concluded that because TMC has a leadership role on the MHU, a serious consequence must occur for his behavior. He was transferred to the SMU for five days to address these problems and the "placement was effective" according to DYS administrators.

I was unable to ascertain how staff determined that five days was the appropriate amount of time for TMC to spend on the SMU, especially since other youth would have to spend six weeks there for similar actions. MHU staff say they wanted TMC to remain on the SMU so he could complete the entire SMU rehabilitative program. This request was denied "because of his mental health issues." DYS Central Office administrators approved the five-day SMU transfer for TMC.

<u>ASC</u>

Youth ASC had an extensive history of treatment at community mental health facilities before he was remanded to DYS. He is impulsive, depressed, and has a working diagnosis of bipolar or manic depressive disorder. He had 100 days added to his DYS commitment because he participated in an STG fight.

In the past, ASC has flipped furniture, destroyed holiday decorations, kicked doors, and threatened staff and youth. The youth has engaged in self injurious behavior, including cutting his forearm with a piece of plastic. On August 19, 2008, ten stimulant capsules were found in his room. He had been cheeking medication for AD/HD, possibly in an effort to use them recreationally.

Despite his emotional difficulties, ABC did not have frequent psychological follow-up. He has been prescribed various medications, including stimulants, antidepressants, and antipsychotics, in low to moderate dosages. He has

refused medication on numerous occasions and he has unrealistic expectations of medication.

ASC is unable to think abstractly and he does not plan well. Thus, he has difficulty factoring possible consequences into his decision-making processes. He lacks problem-solving and coping skills. He has significant mental illness that affects his ability to make rational well-reasoned decisions.

CSQ

Youth CSQ arrived at a DYS facility in early 2007 for felonious assault. He had at least three fights per month when he initially arrived at DYS; he is well known to SMU staff.

CSQ presently is assigned to the SMU because he fought in school. He had had six months added to his DYS commitment because staff found a shank in his belongings. Records indicate that CYS is curious about "satanic worship." CSQ has received intermittent treatment for Attention Deficit/Hyperactivity Disorder, AD/HD, and he recently has refused medications. Despite the presence of a chronic psychiatric disorder, he intermittently has been on the mental health caseload during his stay.

On August 25, 2008, psychology staff removed CSQ from the psychology caseload. On September 4, 2008, psychology staff(different person) says the youth has "legitimate fears." More specifically, "He believes some of his anxiety is resulting from a trauma he experienced in the community." The youth is not evaluated by psychology staff again until December 17, 2008, when he tells psychology staff he does not want medication for AD/HD. During that session, CSQ also reveals that when he was nine-years-old, he was present when his friend was fatally shot. The youth complained of nightmares related to this trauma. (*Note: These symptoms are suggestive of posttraumatic stress disorder or a mood disorder and warranted further examination and follow-up.)*

On December 17, 2008, the psychologist responds to CSQ's concerns by reviewing appropriate sleep hygiene with him (details were not specified in the note) and by removing CSQ from the psychology caseload. No referral was made to the psychiatrist.

EMS

Youth EMS, who is detained for a sexual offense, has been in the DYS system for about three years. Before he was remanded to the DYS, he had experienced severe physical abuse, was sexually abused and developed an addiction to recreational substances. EMS' mother and sister also have had addiction and legal problems.

According to several staff members, EMS was assigned to ORV's MHU because he "failed to meet progam expectations" in a DYS sexual offender rehabilitation program. At some point in the past, he was diagnosed with a psychotic disorder. He has not had symptoms of psychosis at ORV and he has suggested that he may have misrepresented the truth by saying he heard voices soon after he was detained by police for his offense as a way to make sense of his behavior and to avoid consequences.

EMS was transferred to the ORV MHU from another DYS facility in Summer 2008. During his first week, he assaulted a MHU resident. He has not engaged in disruptive behavior since then.

ORV staff told me that EMS seemed relieved when they suggested that he may not be psychotic. He "functions as a leader" on the MHU and has cooperated with treatment, including twice weekly sexual offender programming. When he was at the referring facility, he received daily sexual offender programming and the expectations were higher. Now he is in a MHU setting where his functioning is higher than most if not all other residents. He has coasted through the rehabilitation program and has video game privileges, and other rewards that he might not earn in a more restrictive or more challenging program. Thus, EMS, who is Caucasian, has not really been rehabilitated.

EMS is prescribed a low dosage of an antipsychotic medication and therapeutic dosages of a mood stabilizer medication and an antidepressant medication. MHU staff said they have been unsuccessful with their efforts to transfer this Caucasian youth to the SMU or a residential setting.

My interview of EMS, in the presence of staff, compelled me to support the MHU staff's conclusion that the EMS should not be assigned to the MHU. ORV had no signs or symptoms of acute mental illness, dangerousness to self or others, or

grave disability that would warrant his continued assignment to such a restrictive level of care.

ESL

Youth ESL, who was adjudicated delinquent for Felonious Assault has been at ORV since mid 2008, when he was transferred from another DYS facility due to failure to adjust. Prior to being committed to DYS, ESL apparently fathered one to three children. Also, ESL engaged in disruptive behavior in school, including fighting and walking out of classes. He had several previous delinquency adjudications for Assault, and Illegal Conveyance of a Deadly Weapon.

In late 1999 ESL attempted to hang himself after he was removed from his mother's custody. He also engaged in fire-setting and physically abused a cat during his latency years. He has never been hospitalized at a psychiatric facility and he began to experiment with recreational drugs when he was seven; by age thirteen years, he regularly used alcohol, cannabis, and ecstasy. His primary psychiatric diagnosis is attention deficit/hyperactivity disorder and records suggest he also has "one or more mood disorders," including bipolar or manic depressive disorder. He has received mental health care at various institutions.

ESL had many past traumas, including the loss of his brother who was killed by their mother's former partner. Records also suggest ESL's brother's death was related to gang activity; ESL was previously affiliated with gangs. Also, his mother moved out of state in the past year. His local supports are limited to nonexistent.

The youth has spent significant time on the SMU. In a recent two month period, ESL: engaged in a "group cafeteria fight," had "gang-related" conflict youth from a different region of Ohio, encouraged other youth to "bust out their [room] windows," jumped on tables, threw chairs, and engaged repeated physical aggression towards another youth. Also, he fractured another youth's nose.

As a result of his behavior, ESL was placed on a Special Management Plan and was transferred to the SMU. In early 2008, the youth threatened to harm himself. A few weeks later, he said his medication was not working. He was pessimistic about his future and had thoughts of escaping from the facility and harming himself. About that time, 150

days were added to his commitment due to disruptive behavior, including fighting and tossing furniture. In late 2008, the Release Authority 100 additional disciplinary days to ESL's commitment after he participated in a "STG fight."

On December 12, 2008, a psychology staff-person says "It seems that it is difficult for [this] youth to disrupt his cycle of behavior." However, I could find no interventions, in ESL's psychology chart that were designed to assist the youth with this task by addressing his concerns, including the traumatic death of his brother, in therapeutic digestible components.

<u>KSJ</u>
Youth KSJ has a history of Assault and Harassment by an Inmate complaints, In the past this African American boy sent a death threat to his assigned juvenile court judge and other courtroom personnel. KSJ's brother is serving a 45 year prison sentence.

The youth, who has a history of aggression in school and the community, also has a history of serious mental illness. While hospitalized at a psychiatric facility in the past, KSJ ate dirt when he was "trying to kill myself." He also made several suicide threats while there.

KSJ's is a greater danger to himself when he uses drugs, such as ecstasy. On one occasion, when he was intoxicated, he tried to shoot himself in the head with a hand gun. Also, he received 62 sutures in a finger after he slammed it in a car door; he was intoxicated when this occurred, too. Additionally, he tried to jump off of a bridge when he was under the influence of recreational drugs. To his credit, KSJ has wisely selected his friends in the community; they intervened whenever he engaged in dangerous life-threatening behaviors. During a previous evaluation, KSJ said he would be dead if his friends did not help him.

Records indicate that whenever KSJ has been psychotic, he has been under the influence of illicit drugs; when he abstains from drug use, he has not been psychotic.

The youth has experienced many traumas including abandonment by mom and the deaths of his newborn sister, grandfather, uncle, and aunt. He described the time frames surrounding these events as "angry times." He was ten-

years-old when his grandfather died in his arms. His Full Scale intelligence quotient, IQ, is 66, which places him in the mild mental retardation range of intelligence (55 – 70), however a 17 point difference between his verbal and performance scale scores, 77 and 66, are suggestive of a learning disability and borderline IQ. Also, he is intolerant of being teased. Yet, this youth, who continues to have disruptive behavior and poor impulse control, is not classified as vulnerable and has spent substantial time on the SMU. As a matter of fact, on October 15, 2008, an administrative override was granted to place the youth on the SMU because he refused to accept a skin test for tuberculosis.

His recent offenses include:

- Removing a cast from his leg on October 8, 2008
- removing parts from a school computer with alleged intent to make a bomb on November 4, 2008
- telling staff he wanted to kill himself on November 11, 2008
- writing a letter threatening to kill Acting Superintendent Sutherland on November 17, 2008.

There was no documented evidence of mental health interventions used to explore or address to the youth's impulsivity, aggression, grief, loss, or hyperactivity.

SSB

Youth SSB was detained after he stole his mother's car. He has in the DYS system since mid 2008 and apparently suffers from posttraumatic stress disorder due to chronic life-threatening physical victimization, by his father during his early childhood. SSB has physical limitations as a result of this trauma. Records also suggest SSB has severe behavior problems, and AD/HD. Additionally SSB, who is Caucasian, lost a sibling in the past.

In the year preceding his commitment to DYS, SSB was hospitalized after he attempted to hang himself. Within DYS, he was physically aggressive at an outlying facility and was transferred to the ORV MHU for stabilization. On October 2008, SSB endorsed depression and he "wouldn't commit to safety." He struggled with being away from his family and "feeling threatened by other youth."

He is now assigned to the SMU and has not received programming because his records have not been transferred to ORV from the referring facility.

MSS

Youth MSS, who is Caucasian, was remanded to DYS in late 2008 due to a sexual offense. He has been assigned to both the SMU and the MHU during his commitment.

Youth 1:1 Interviews

ASB

Youth ASB was remanded to DYS three-and-one-half years ago for an arson-related charge. This is not his first DYS commitment. He has been cruel to animals, has engaged in sexual activity on DYS property, and has urinated and defecated in his room, which does not have plumbing facilities.

ASB, who experienced "extreme physical abuse" before his fourth birthday, was adopted when he was four-years-old. About five years ago, ASB was hospitalized after he complied with command hallucinations and cut a cat's throat with a chainsaw. His adoptive parents have severed their relationship with him.

ASB, who has working diagnoses of bipolar disorder, and AD/HD disorder was previously diagnosed with reactive attachment disorder of early childhood. He has engaged in bizarre and disruptive behavior at DYS. He isolates himself and he struggles to fit in with others. *(Note: ASB pushes people away by engaging in bizarre behavior; by doing this, he successfully avoids being abused by others, but fails to make the healthy relationships he craves.)*

In mid 2008, the youth, who was assigned to the MHU, exposed his genitals to others and placed his feces in a desk drawer. He confessed to the latter incident after staff was unable to determine who had done it. *(Note: A healthier well-defended adolescent may never had made this disclosure in an effort to avoid adverse consequences.)*

ASB, who is now assigned to the SMU, has refused to cooperate with testing at ORV. Previous testing results include an IQ of 70 (55-70 is suggestive of mild mental retardation).

During my interview with ASB, he stated it is extremely important for him to “prove myself. I get my respect.” He also insisted he has “been on top” in every fight he has had at DYS. Clearly, this youth, who was severely traumatized at an early age, will do and say whatever is necessary to convince others not to challenge him. His intellectual limitations make it challenging for staff to refocus his behavior because staff does not have the skill set to manage youths with ASB’s cognitive challenges.

There were no therapeutic interventions documented in ASB’s psychology chart that describe therapeutic efforts to engage ASB or to help him feel safe.

TMZ

Youth TMZ is remanded to DYS for Domestic Violence. He has a history of AD/HD. Psychiatry staff says in a December 9, 2008 note, that TMZ “tells me that he has not been compliant with Strattera [atomoxetine, a medication for AD/HD] because. . . it is distributed at such an early hour in the morning here on the SMU.” Although morning medications are supposed to be distributed at 6:30 AM, nursing staff have been issuing morning medications to youth at 5:00 AM on the SMU.

On January 6, 2009, psychology staff says “psychology follow up is likely to be minimal as youth TMZ does not display any motivation for individual counseling.” He had two years added to his commitment apparently due to STG behavior (fighting and threatening to kill someone) and having a toothbrush shank.

Youth TMZ told me that this is his eighth visit to the SMU. He has been there since October 2008, after he wrote a letter to his sister that contained gang language. “Security opened it.” Although TMZ knows using gang language is against the rules, he said, “That’s how we [TMZ and his sister] talk all the time.” He acknowledged engaging in frequent gang-related activity at ORV “because that’s how you survive.”

On one occasion, he stole a phone and made a 135 minute call to his sister. “They [security] recorded it.” He said the action and consequences were “worth it” because he was able to connect with his sister for the first time since he came to DYS. TMZ said he receives more consistent phone privileges on the SMU than when he was in the general

population, GP, because "in GP, it depends on who the social worker is." The GP social workers "expect you to make calls using collect phones." His sister does not have resources to make collect calls and TMZ receives one phone call per month on the SMU.

When asked about his future, he said he plans to "chill and retire" from the ORV gang. "They let you retire after you've been in the gang for two years so you can do your time and go home. I plan to do my time so I can get out of here."

TMZ said he finds the ORV psychiatrist accessible. The youth said he did not believe that SMU assignments were racially biased and he would "never go" to the MHU because "I'm not crazy. I mean I got (sic) problems, but not like that." TMZ prefers to continue to receive mental health care on the BMU.

XSC

Youth XSC, who is on the SMU Blue Phase of treatment, was admitted to DYS in late 2006 for a sexual offense. He said that in April 2008 he had "a death in the family." After this loss, he struggled with containing his anger; his behavior became increasingly violent. He said he had "nineteen acts of aggression, including one serious staff assault, eight staff/peer assaults and one weapons violation." He acknowledged engaging in all the offenses except the serious staff assault, which he intends to appeal.

As with many sexual perpetrators, XSC was a victim of sexual abuse prior to committing his offense. He suffers from depression and posttraumatic stress disorder and is prescribed an antidepressant medication and a sleep medication. He also has a medical condition that may render him prone to psychosocial difficulties.

XSC, who is Caucasian, said that he does not feel safe in the presence of other youth, "especially in school" because of the aggression and gang-related activity that occurs there. XSC does not want to join a gang. He wants to complete his commitment and to return to the community. He would prefer to be on the MHU, because youth assigned to the general population "think the mental health kids are weird – they don't get messed with."

The youth believes his mental health concerns are being managed adequately by mental health providers that visit the SMU. He found it easy to advance through the SMU red-yellow-blue level system. He suggested that the SMU could be more successful if staff were consistent. For example, at times, staff may avoid confrontation with a disruptive youth and chose not to reduce a youth's level because the staff member does not want the youth to retaliate.

XSC said, "Some kids learn they can get away with things and they keep doing it." Examples provided included refusing to return to a cell and attempting to attack a peer. XSC said that juvenile corrections officers should consistently "slap a red level" marker on the door of any disruptive youth as soon as he goes into his room. "That would send a clear message. They'd stop messing around so much."

Also, youth that are not emotionally ready for school should not be encouraged to attend classes; they should receive education services on the SMU. The teachers complain about disruptive youth and "we don't learn," said XSC. Note that on February 11, 2009, the school day ended early due to a fight involving several youths.

TSQ

Youth TSQ is a seventeen-year-old boy who has been remanded to DYS, since late 2007, for assaulting a police officer. He has a history of being neglected, with subsequent group home placement, during which he tried to hang himself using a belt and a doorknob. Prior to being detained, he made homicidal threats and brought weapons to school.

TSQ described himself as "quick to anger" and he tends to "flip out" if his anger persists. In the past year, he has written a suicide note, ingested a small amount of cleaning fluid, and made verbal suicide threats. He is prescribed two medications for attention deficit/hyperactivity disorder and his records suggest he is "not motivated for treatment." Yet, there are no notes in the youth's record which suggest that a trauma history has been taken or that his emotional concerns have been therapeutically addressed by psychology.

SSS

Nineteen-year-old SSS was remanded to DYS in late 2006 for Aggravated Robbery. He was the respondent to an arson

complaint when he was eleven-years-old, and has a longstanding history of disruptive behavior. SSS transferred to ORV's SMU from another DYS facility after he attacked two juvenile corrections officers. He has lived on the SMU for less than one month and is on Red Phase. He said he prefers the SMU because he has more phone contact with his family. "In GP [general population]" you only get phone calls as time permits. They think you can use the pay phones over here. My family can't afford that. Here [on the SMU] you get a five minute phone call every month."

He described his "goals on red. I have to identify the victims I created; identify thoughts I had when creating the victims; identify five victims; [and] put myself in they (sic) shoes."

The youth has regrets about not completing the program at his previous facility. "They had greater expectations; victim awareness was important." His rehabilitative time was "more productive. We had daily groups." Since arriving on the SMU, SSS has attended five or six group sessions. He volunteered that, at this point, many of his peers assigned to the SMU, "don't want to do nothing (sic) with their" lives.

SSS made the following suggestions for improving the SMU program:

1. Design and assign "groups based on [each youth's] motivation level."
2. Have life skills groups "so we will have some skills when we get out of here."
3. Develop peer support programs.
4. "Offer people different alternatives."
5. Require youths to maintain "daily journals."
6. Train and require youth to engage in "reflective thinking." For example, ask "us to think about 'How do I get to the point where I know my anger is out of control?'"

Conclusions

Psychiatry

1. Psychiatry is marginalized in the DYS system. This makes it difficult for youth with serious mental illness to be evaluated and stabilized using a behavioral health team approach. This needs to change.

2. There is no child psychiatric leadership within DYS. In view of the severity of the mental disorders in the DYS population, and the fact that general psychiatrists work within the system, a full-time child psychiatrist is needed to oversee the DYS Behavioral health system, to provide consultation, to conduct peer review, to facilitate training interventions, and to reinforce a medical model of caring for youth with serious mental illness that comports with the community standard.

3. The ORVJCF dictation system for psychiatric care needs to change so that the comprehensive dictation record of a youth's most recent psychiatric care does not leave the facility with the psychiatrist. The current practice puts confidentiality at risk, and is not cost effective although a better quality note is produced for the record. There are cost-effective in-house alternatives that may meet the dictation needs.

4. Doxepin and other unsafe medications should not be used in juvenile corrections populations when they are not FDA approved for use in children and when safer alternatives are available.

5. The nursing practice of crushing enteric coated medications must stop.

Psychology

6. As a group, the skill set of DYS psychologists at ORVJCF is grossly deficient. Training is desperately needed. Staff inexperience has

resulted in youth receiving additional DYS commitment time, because the youth have not received evidence based treatment interventions for their mental disorders.

7. Several psychology staff tend to "blame the victims" for their diagnosable psychiatric disorders. This is due to clinical inexperience and inadequate supervision. Not all psychologists receive training on evaluating and treating challenging youth, especially youth from inner-city environments and youths of different cultures and backgrounds.

8. Many ORVJCF psychologists do not know how to treat youth with externalizing (disruptive behavior) disorders. Disruptive youth may suffer from treatable psychiatric disorders that must be diagnosed and treated in an effort to contain their behavior. Youth with improved behavior do not receive additional commitment time from the Release Authority. Thus, youth are receiving additional DYS commitment time because of poor staff training and supervision.

9. In several cases, when youth have been open with psychology staff about past trauma and current symptoms suggestive of treatable mental illness, such as posttraumatic stress disorder, staff has responded by intentionally removing youth from the psychology caseload. Youths have been deprived of access to competent mental health care and have been blamed for their symptoms. Youth accountability, for purposes of the Release Authority, should begin after treatable mental disorders have been stabilized.

10. Although many SMU youth are challenging, disruptive, and have violated DYS rules, I could find no documentation of consistent efforts by psychology or social work staff to address these behaviors using constructive evidence based interventions.

11. With the exception of one session of the new SMU Anger Management Group, there is no documentation of group therapy activities at ORVJCF. This leads one to question the quality

of programming, supervision and monitoring psychologists at ORVJCF.

12. Psychologists at DYS do not contact families; psychiatrists and social workers do. This pattern needs to change.

13. There was no evidence to suggest that psychologists have been trained in or use Trauma-Informed Care or Cognitive Therapy principals when they interact with youth. I hesitate to comment about techniques used with youth on the MHU, because I did not explore those records thoroughly.

Social Work

14. Social Workers on the SMU are not integrated into the behavioral health team. This results in fragmented care and communication.

15. Social Workers do not document their contacts with youth and with families.

Youth Quality of Life

16. Youth do not receive sufficient affordable phone calls in the general population. Thus, regular family contact is not an incentive for youth that remain in the general population.

17. The grievance system doesn't work; this was a unanimous conclusion.

18. Although youth have been deprived of competent mental health care to address their emotional and behavioral concerns, they have received punitive consequences, including an extension of their DYS commitments. Thus, the youth have been punished because of staff's clinical indifference to youth mental health rehabilitative needs. This practice is unacceptable.

Vulnerable Youth

19. Vulnerable youth, including those of small stature and those with cognitive limitations (including IQ <50 = moderate mental retardation range) have been denied an opportunity to be placed in the least restrictive setting for their rehabilitative needs; they are required to remain on the mental health unit.

20. The presence of vulnerable youth on the mental health unit has stigmatized the environment and made it unattractive to youth that need more intensive mental health care. Thus, these youth, who choose “badness” over “madness,” are not forthcoming regarding the severity of their mental health symptoms, suffer unnecessarily, and are disruptive members of the ORVJCF community.

Treatment Refusals

21. Medication over parental objection, in the interest of community safety, is not sufficiently used in the DYS setting. This process needs to be examined further, especially since parental refusal of treatment may not be in a youth’s best interests.

The Mental Health Unit

22. Mental Health Unit Staff are not given sufficient authority regarding who is admitted to the Mental Health Unit and who may leave it to go to the SMU or the general population

23. Psychiatrists are not given sufficient authority regarding who is admitted to the Mental Health Unit and when they may leave the unit.

SMU Program

24. The SMU Admission Tool wholly inadequate.
    1. The documentation that describes how the Tool was standardized is not available. Therefore, one must make an adverse inference about the design,

motivations, and intent of the Tool's developers.
2. The Tool does not take severe acute mental illness into account as a mitigating factor related to disruptive behavior.
3. The Tool is not normed on the population it is used to evaluate.
4. The tool has an arbitrary cutoff that punishes 50% of the youth that are evaluated.
5. The Tool doesn't take staff competence, and quality of treatment programs into account.
6. The Tool punishes youth for inadequate staff training and competence.
7. The Tool punishes youth for the absence of evidence based programming at ORVJCF.

25. The communication between psychiatrists and SMU staff is inadequate in view of the mental disorders and the severity of youth behavior on that the SMU.

26. The frequency of psychiatric follow up for SMU youth is also deficient in view of the severity of the behaviors of these youth.

27. Existing SMU psychiatric and behavioral health practice protocols are not cost effective in view of the level of disruption and distress these youth contribute to the ORV community.

Administration

28. The absence of support staff and supplies on or near the SMU is not cost-effective and is not conducive to smooth Unit operation. Skilled behavioral health staff, including social workers, are spending too much time on clerical functions. This practice deprives youth of desperately needed care.

29. The SMU is running out of booklets for bibliotherapy. Adequate supplies are needed for a program to be successful.

Recommendations

Psychiatry

1. A full-time board certified child psychiatrist, preferably with juvenile corrections experience, to oversee the team of psychiatrists and the mental health units throughout the system and to oversee the MHU, in an effort to move towards a medical model of behavioral health care for the most psychiatrically unstable youth. The child psychiatry administrator will facilitate internal review of clinically challenging youth, will accelerate the stabilization of these youth, and will introduce the scaffolding of a professional support and consultation network for psychiatrists, including those that lack child psychiatry training.

2. Psychiatric follow up should occur as frequently as weekly, especially on the SMU, when a youth does not adhere to medication therapy.

3. Each youth on the SMU that receives psychiatric services should be evaluated by the psychiatrist *at least* twice monthly until he has demonstrated satisfactory treatment response and sustained stability on his medication program. At that point, the youth should be more receptive to other therapeutic interventions.

4. The ORVJCF psychiatrist should increase usage of dissolvable medications for youth that are not responding consistently to previously effective medication and for youth that are suspected of cheeking medications.

5. The ORVJCF psychiatrist should attend treatment team meetings on the SMU in a leadership and educational capacity; this practice should enhance the quality of mental health care on the SMU.

6. The psychiatrist should not expect nursing staff to crush enteric coated medications as the practice does not meet the community standard.

7. The psychiatrist should cease from using dangerous medications, such as doxepin, when safer alternatives are available.

Psychology

8. All staff conducting risk assessments for dangerousness of youth, including suicide and aggression, should receive in-service training with increased frequency, at least twice per year, in the interest of community safety.

9. A video or slide show training program for risk assessment evaluations should be designed so that staff may review risk assessment issues with greater frequency.

10. Training on mental disorder diagnosis, taking a trauma history, Trauma-Informed Care (or a similar evidence based program), and crisis intervention are desperately needed for behavioral health staff, who frequently miss posttraumatic stress disorder, depression and other treatable diagnoses.

11. The SMU Psychologist should receive additional training in risk assessment, diagnostic assessment, therapeutic interventions and Trauma-Informed Care (or a similar evidence based program) with all due expedience.

12. The SMU Psychologist and should visit a more established SMU in a different juvenile corrections system so he may develop a better appreciation for how fully functional SMUs are supposed to run. This excursion should be arranged with all due expedience.

13. ORVDYS psychologists should make reasonable efforts to involve families in the treatment process. This will facilitate gathering additional history; also, invested families may motivate youth to exercise increased behavioral control. SMU social workers already have had success with this practice.

14. Behavioral health staff, including psychiatry, should immediately cease from listing conduct disorder as the primary diagnosis for youth that suffer from other psychiatric illnesses. This is a pejorative practice that suggests these youth cannot be treated.

15. Behavioral health staff, including psychiatry, should refrain from listing Conduct Disorder as a diagnosis for youth until staff is adequately trained and have documented exhausting reasonable evidence based assessment and treatment interventions, including full medication trials, designed to alleviate the effects of more treatable psychiatric disorders in youth.

16. The SMU Psychologist should invite the psychiatrist to attend SMU treatment team meetings.

Social Work

17. Social work documentation needs to improve so that there is a consistent record of interventions and clinical responses to those interventions.

18. Social workers should not hesitate to request psychiatric intervention for youth assigned to the SMU.

19. Social Workers could benefit from SMU and behavior management intervention, and documentation training.

20. SMU social workers should invite the psychiatrist to attend treatment team meetings.

Youth Quality of Life

21. The Quality of the grievance system needs to be reviewed in view of staff and youth complaints.

22. The phone privilege system should be reviewed; increased phone calls in general population may

motivate some youth to do what is necessary to avoid going to the SMU.

Vulnerable Youth

23. Vulnerable youth that do not suffer from acute serious mental illness should be assigned to a unit dedicated to meeting their needs. Accommodating these youth on the MHU is not a cost effective operation from a service delivery standpoint. Also, the presence of vulnerable youth on the MHU makes it a less attractive option for youth with acute mental illness who may engage in disruptive behavior so they will be considered “bad” instead of “mad.”

The Mental Health Unit

24. The Mental Health Unit should be used to provide services for youth that are acutely impaired by their mental disorders.
25. A history of STG activity should not preclude youth from being admitted to the MHU. If there is an immediate STG concern, then the SMU may be used as a temporary alternative. However, if the STG issue is sufficient to continue denying MHU level services to youth with acute serious mental illness, then an alternate option, such as a second MHU or inpatient hospitalization should be considered.

26. Vulnerable or fragile youth that are chronically impaired by physical and/or intellectual limitations and that are not acutely impaired by their mental disorders should be assigned to a unit designed to accommodate their needs.

    a. Assigning these youths to the mental health unit for residential care does not comport with the requirement for assigning youths to the least restrictive environment and is not cost effective, given the concentration of staffing, expertise, and

resources that are invested in mental health units.

b. Also, removing these youth from the MHU may reduce the stigma associated with mentally ill youth receiving services at the mental health unit. The unit may become a more attractive alternative to disruptive youth with serious mental illness, who tend to conceal the severity of their mental disorders, because they do not want to be on a unit with vulnerable youth or "weird kids."

27. Mentally ill youth that no longer require the level of care offered on the mental health unit should be transferred to a different residential unit; if a youth could benefit from behavior management unit placement, then the placement should be considered. Youth should not be permitted to coast on the MHU because they have a remote history of acute mental illness.

28. The psychiatrist should have input into whether or not a youth is admitted to or released from the MHU, in accordance with community standards.

1. Youth should not be transferred from the MHU without the psychiatrist's knowledge and approval unless the psychiatrist has already determined, in writing, that the youth is sufficiently stable on medication to move to a less restrictive setting.

2. Except in emergent situations, the files of youth being considered for admission to the mental health unit should be presented to the psychiatrist so that medical necessity may be integrated into the decision-making process.

3. If the psychiatrist does not believe a youth requires MHU placement he should

become an active participant in developing a therapeutic treatment plan for that youth.

29. When deemed appropriate by the mental health team, including the psychiatrist, youth on the mental health team may be transferred to the special management unit or to general population so that they may benefit from the programming available there.

The SMU

30. Youth assigned to the SMU that require a higher level of mental health services should receive services from the MHU team until they are able to transfer the youth to the mental health unit.

31. Youth with mental illness that are assigned to the SMU should be evaluated by the psychiatrist *at least* twice monthly until the youth is deemed stable from a psychiatric standpoint.

32. Youth that will likely be transferred to the mental health unit from the special management unit should be evaluated by the psychiatrist *at least* weekly until the transfer occurs.

33. Treatment team meetings for mentally ill youth on the special management unit should involve the psychiatrist *at least* twice monthly to ensure that behavior and related concerns are appropriately integrated into the medical decision-making process; this intervention should also help direct care and behavioral health staff develop a better appreciation for how medications may influence behavior.

34. In the interest of community safety, youth belonging to rival gangs should not be released for activities on the Special Management Unit at the same time.

35. Documentation of individual, group, and family therapy sessions as well as treatment team meetings on the Special Management Unit needs to improve.

36. Documentation of therapeutic interventions and how youths respond to them needs to improve on the Mental Health Unit and Behavior Management Unit.

37. Increase structure on the SMU to reduce idle time during which youth are more likely engage in disruptive behavior.

38. Mental health education for youth (and staff) should be initiated on the SMU. Phenomenology, treatment and relapse prevention education should begin for youth (and staff) so that youth may become better informed consumers of mental health services and staff develop a rudimentary understanding of how mental healthcare may be used as a resource to maintain safety and rehabilitate youth assigned to the SMU.

39. Standardized diagnostic tools should be used on the SMU and MHU to screen youth for mental disorders, including depression and AD/HD, and to measure treatment response. Such documentation will enhance communication among direct care staff, teachers, social workers, psychologists, and the psychiatrist. Systematic measuring of psychiatric symptoms also will improve the quality of care provided to youth.

Administration

40. The Release Authority should cease from extending commitments of mentally ill use until the SMU and MHU programs are more functional, including:
    a. A more balanced evidence based SMU admission process.
    b. Improved staff training.
    c. Increased flexibility in moving youth between the SMU and MHU.
    d. Increased psychiatric leadership in the SMU and MHU.
    e. Improved standardized diagnostic and treatment protocols
    f. Increased family involvement in rehabilitative care.

g. Improved mental health diagnostic and treatment competence for psychology staff.
h. Improved psychiatric consultation, supervision, and administrative oversight of challenging psychiatric cases and general psychiatric care for youth.
i. An improved SMU morning medication distribution protocol to enhance treatment adherence.

41. Adequate clerical staff needs to be hired to facilitate staff access to data, parents, and educational materials.

42. The psychiatry dictation protocol should not permit the psychiatrist to take clinical data off grounds. Staff should be hired to transcribe dictations and to manage the files. Several cost-effective options exist. The psychiatrist's time will be better spent meeting with patients.

43. Special Management Unit manuals for youth and staff need to be developed to facilitate training and consistency on the unit.

44. Consider seeking input from hospital administrators and clinicians regarding the interventions they use to deescalate youths and to help them cope and solve problems.

45. Clerical staff should place a copy of the psychiatrist's written progress note from the medical chart into the psychology chart.

46. The term "psychology chart" should be changed to "mental health chart," "behavioral health chart" or similar nomenclature to convey the (accurate) impression that at DYS, behavioral health is a multidisciplinary venture.

47. Social work should be integrated into the multidisciplinary behavioral health team, especially on the Special Management Unit and Mental Health Unit.

48. A copy of the Dispositional Investigation Report should be placed in the psychology chart so that critical information regarding trauma and other salient matters will be accessible by mental health providers.

49. Zero tolerance for gangs and gang-related activity should continue in the interest of community safety.

50. Medications over objection should be used more often with violent youth in the interest of community safety.

51. Social work documentation needs to be filed with the rest of the behavioral health paperwork.

52. The psychiatrist's diagnoses should be entered into the behavioral health database, as this is the diagnosis that guides medication therapy and related interventions.

53. Efforts should be made to obtain records from previous mental health treatment providers. These documents will be an invaluable resource when evaluating youth that present diagnostic and treatment dilemmas.

54. Psychiatrists should be permitted to remove youth from suicide precautions without permission from the superintendent. Of course, the psychiatrist should alert behavioral health team members in the interest of comprehensive care. Psychiatrists should not, however be required to conduct routine suicide precaution assessments, unless a salient medication matter is present, due to cost concerns.