

**BEHAVIORAL HEALTH SERVICES
AT THE NEW BEGINNINGS YOUTH DEVELOPMENT CENTER**

Report 2025-2

OCTOBER 27, 2025



OFFICE OF INDEPENDENT JUVENILE JUSTICE FACILITIES OVERSIGHT

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I. INTRODUCTION

The Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) was created by Mayor's Order upon the termination of the Jerry M. litigation in 2021 to "regularly monitor and publicly report on ...[t]he durability of the reforms the Department of Youth Rehabilitation Services ("DYRS") previously achieved under the Jerry M. Work Plan and Consent Decree; and DYRS's progress in achieving Jerry M. Work Plan Goals, including critical Work Plan indicators, that DYRS did not achieve prior to the Superior Court's termination of the Jerry M. lawsuit."¹ The Office was subsequently established legislatively within the Office of the District of Columbia Auditor (ODCA) for fiscal year 2025.² In December 2024, the Council of the District of Columbia passed the Recidivism Reduction at DYRS Amendment Act of 2024, assigning the functions of the Office permanently to ODCA, with certain additional functions, subject to appropriations which had not been approved as of September 30, 2025.³

This report focuses on aspects of behavioral health services at the New Beginnings Youth Development Center (New Beginnings). The OIJJFO relied on an assessment conducted by its behavioral health expert, Dr. Terry Lee,⁴ which is attached to and described in this report.⁵ A

¹ Mayor's Order 2020-115, November 13, 2020, §§I.A.1.-2.

² This was effected in the 2025 Budget Support Act.

³ The legislation states that ODCA shall: "(1) Regularly monitor and publicly report on the durability of the reforms implemented by the Department achieved under the Work Plan and Consent Decree negotiated to resolve Jerry M., and the Department's progress in achieving work plan goals, including critical work plan indicators, that the Department did not achieve prior to January 6, 2021, which may include providing housing for discrete populations, meeting standards to ensure all facilities are safe and humane, and providing free and appropriate education; and (2) Monitor and publicly report on the completeness and timeliness, based on a prima facie review, of individualized rehabilitation plans developed by the Department pursuant to D.C. Official Code § 16-2319." ODCA is continuing to support the work of OIJJFO temporarily to complete certain objectives, including publication of this report.

⁴ Dr. Lee is a psychiatrist board certified in general psychiatry and neurology, child and adolescent psychiatry, and addiction medicine. He has extensive experience in matters related to juvenile justice including providing and directing psychiatric service in both inpatient and community-based juvenile rehabilitation programs, providing expert consultation in the provision of innovative treatment modalities such as multi-systemic therapy and integration of families in juvenile rehabilitation settings, and leading quality improvement initiatives in the juvenile justice setting. See Attachment 1 for Dr. Lee's curriculum vitae.

⁵ Attachment 2, Behavioral Health Consultant Report to the Office of Independent Juvenile Justice Facilities oversight, Terry Lee, MD, August 19, 2025. Additionally, Janet Maher assisted in non-clinical related analysis of

draft version of this report was transmitted to DYRS on September 23, 2025 for agency review and comment. DYRS provided comments to OIJFO on October 17, 2025, which are included as an attachment to this report.⁶

Individual, clinical behavioral health services are an essential and core element of the rehabilitative model. The proper identification of behavioral problems by trained professionals is foundational to developing individualized, evidence-based treatment strategies; however, effective rehabilitation – changing behavioral patterns that resulted in youth incarceration – requires much more than behavioral health services. As Dr. Lee notes in his assessment:

Rehabilitation cannot be compartmentalized into a few hours of individual and group therapy each week. Any and all interactions between youth and staff should be viewed as opportunities for teaching and skills training. In order to support and provide consistent rehabilitation to youth, all staff, including those who are not therapists in the conventional sense, such as administrators, teachers, custody staff, and others, must be trained to be therapeutic in their interactions with youth. Youth spend more time with custody, direct care, and education staff than behavioral health clinicians. As a result, non-clinical direct care staff have great potential to influence youth behavior and rehabilitation.

At the same time, DYRS licensed clinicians play critical roles in rehabilitation, including identifying treatment needs, providing individual and family therapy, educating staff, and managing treatment plans. Licensed clinical staff should help train non-clinical staff to be therapeutic in their interactions with youth and families, and clinical and non-clinical staff should collaborate on the development of treatment and release plans. All staff must work together to teach and reinforce youth and parent/caregiver skillful behavior and ensure a consistent and supportive environment for rehabilitation.

By reinvesting in comprehensive treatment resources, staff training, therapeutic programming that can be more targeted and individualized to specific youth needs, and integrating family-based services, DYRS can fulfill its mission of

youth health records and production of this report. Ms. Maher is an attorney with extensive experience in institutional and health-care settings. She led the Office of Corporation Counsel's Mental Health Division from 1992 to 2000, operated as Deputy General Counsel and Chief of Staff for the District's Child and Family Services Agency from 2000 to 2007, served as a DOJ Compliance Officer at Saint Elizabeths Hospital from 2007 to 2014, as well as overseeing the Hospital's Performance Improvement Department from 2013 to 2016.

⁶ Attachment 3, Memorandum from DC Department of Youth Rehabilitation Services, Office of the Director, "Behavioral Health Services Oversight Report Response," transmitted on October 17, 2025.

juvenile rehabilitation. The future of the youth adjudicated to DYRS custody, and the safety and well-being of the community depend on it.⁷

Given Dr. Lee's comments concerning the key roles every staff member interacting with youth at New Beginnings must play in effective rehabilitation of youth, OIJFO is including in this report descriptions of New Beginnings' staffing model, programs and services offered, and treatment planning documents to provide context for the findings and recommendations relating to behavioral health services emanating from his assessment.

II. BACKGROUND

New Beginnings is a six unit, 60-bed secure residential facility operated by DYRS, which has not exceeded its operating capacity since OIJFO began its oversight. Most youth committed to DYRS are not placed at New Beginnings, but rather are placed in other settings, including community placements and privately operated residential treatment facilities. Often youth who are the most difficult to place and/or who have the most serious delinquency charges are placed at New Beginnings.

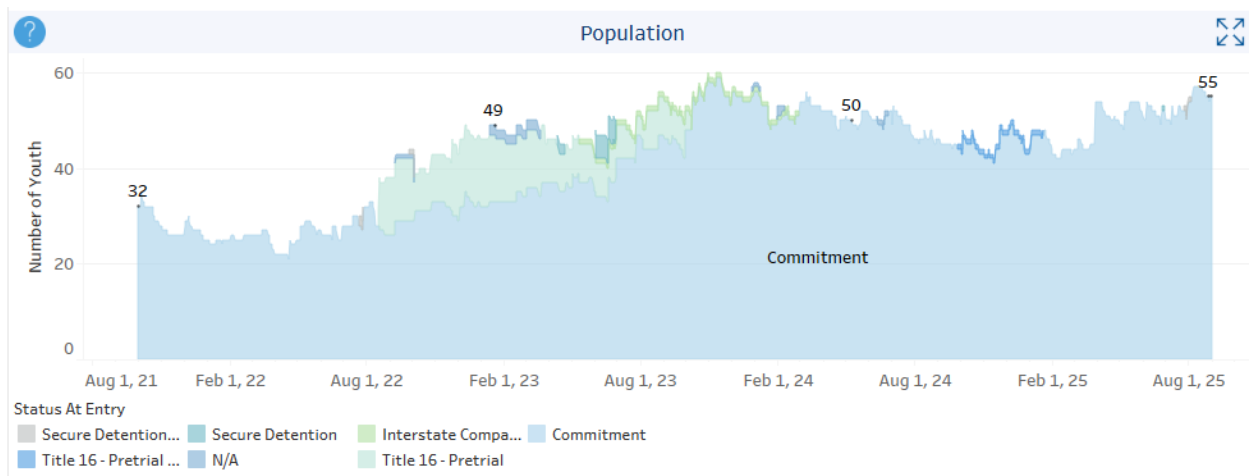
Over time, DYRS periodically has changed who is housed at the facility to meet agency operational needs and programming goals. For example, while DYRS historically operated the facility with one housing unit for girls and five housing units for boys, there was a period between mid-August 2022 and mid-April 2024 when no girls were housed at New Beginnings. The start of this period corresponded to when DYRS began to house a population of male, Title 16 youth at the facility.⁸ Then, in April 2024, DYRS reopened one housing unit for girls at New Beginnings and has continued to operate one housing unit for committed girls and five housing

⁷ Attachment 2 at pages 13-14.

⁸ Title 16 youth are youth under age 18 who are charged as adults. As depicted by the green shaded area in Chart 1, DYRS housed a population of Title 16 youth at the facility between August 16, 2022 and October 9, 2023.

unit for committed boys since that time. Furthermore, at times, DYRS has used New Beginnings to hold committed youth temporarily while they find an alternative placement for youth. These youth, referred to as “awaiting placement” youth, do not participate in the full range of programs at the facility, stay for far shorter periods than those youth who are placed at New Beginnings and generally have been housed in a separate housing unit.⁹

**Chart 1: New Beginnings Population Over Time
October 1, 2021 – August 31, 2025**



By its establishment legislation, DYRS is charged with the following:

- (1) Improving the security, supervision, and rehabilitation services provided to committed and detained juvenile offenders and Persons in Need of Supervision (“PINS”);
- (2) Developing and maintaining a holistic, family-oriented approach to the provision of youth services that emphasizes youth and parental responsibility so as to reduce juvenile crime, delinquency, and recidivism; and

⁹ In its comments on the draft version of this report, DYRS states that awaiting placement youth “receive psychiatric care, individual therapy, and trauma-focused [cognitive behavioral therapy] groups, consistent with their length of stay and stability status. Access to education and enrichment programming is maintained per DYRS policy.” Attachment 3 at page 3.

- (3) Developing and maintaining state-of-the-art service programs, delivery systems, and facilities that will transform the District’s juvenile justice system into a national model.¹⁰

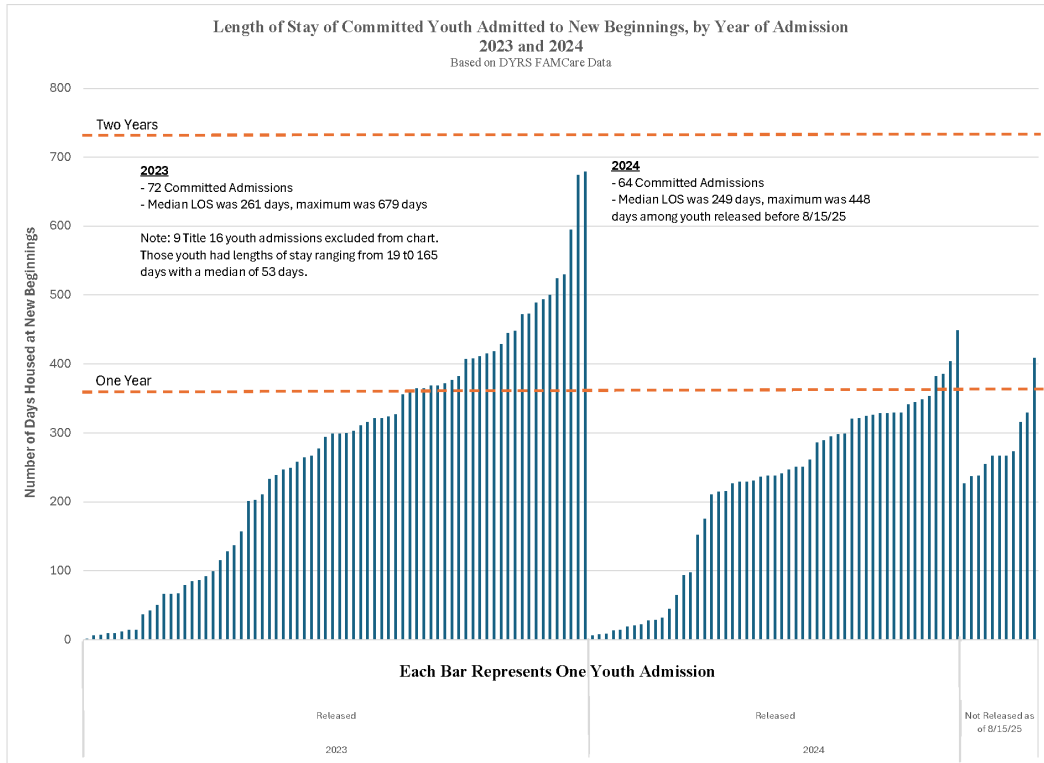
While DYRS has an array of options to place and provide services to youth committed to its care, New Beginnings is the only secure facility DYRS operates to achieve these goals, and the agency relies on it to provide rehabilitative services to many of the highest needs youth ordered to its custody. The agency has the authority to confine youth at New Beginnings for as long as the agency deems appropriate, not to exceed the date of the youth’s commitment expiration.

New Beginnings’ small size limits the number of youth that can be housed at any one time and thus impacts the number of youth who can be admitted. The longer youth are housed at the facility, the fewer the number of youth who can be admitted, and, conversely, the shorter durations at the facility translate into a larger the number of youth who can be admitted. In 2023, 81¹¹ youth were admitted to New Beginnings and in 2024, 64 youth were admitted. The chart below illustrates the total number of *committed* youth admitted during both years and how long each youth remained at the facility.

¹⁰ D.C. Code §2–1515.02.

¹¹ Nine of these youth were detained Title 16 youth.

Chart 2: Committed Youth Admitted to New Beginnings, by Length of Stay 2023 - 2024



As the chart shows, most youth admitted to New Beginnings in 2023 and 2024 were placed there for less than one year. None stayed for two years. Thus, all youth admitted to New Beginnings eventually are released, and many are released directly back to a community setting. Among the 72 committed youth admitted to New Beginnings in 2023, 48 were released directly to a community setting,¹² 18 were released to the YSC,¹³ and six were released to a residential treatment facility. Of these 72 committed youth who were released, 56 (78 percent) had further involvement with the juvenile or adult criminal justice system.¹⁴ Forty-three of the 56 returned

¹² Community settings include release directly home, to a group home, or a foster home.

¹³ Five of those 18 remained at the YSC for periods between 11 and 175 days before returning to New Beginnings and a sixth youth was at the YSC for one day before returning to New Beginnings for eight days, returning to the YSC for 11 days and once again returning to New Beginnings. Five of the youth were released from the YSC to a jail in a surrounding jurisdiction. Six youth were released from the YSC to a residential facility and one youth was released from the YSC directly to a parent.

¹⁴ OIJFO cannot determine how many of these new arrests involved crimes of violence or resulted in convictions based upon the information available to it at the time of the writing of this report.

to the secure custody of DYRS or a Maryland juvenile facility, or were detained in a jail in the District of Columbia or Maryland. An additional 13 were charged with adult offenses in the District of Columbia.¹⁵

Among the specific cohort of 48 committed youth admitted in 2023 and released to the community directly from New Beginnings, 30 were recorded in FAMCare as having “completed the program.” Of those 30 youth, 21 youth (70 percent) were involved with the juvenile or adult criminal justice system after release. Sixteen returned to secure custody of DYRS or were detained in jail in the District of Columbia or Maryland; five additional were charged with adult offenses in the District of Columbia.¹⁶

It is DYRS’s mandate to provide supervision and services to youth at the facility to improve the likelihood that they will successfully and productively reintegrate into the community after they are released. Most youth admitted to New Beginnings have profound behavioral health needs, which makes DYRS’s services not only critically important, but also significantly challenging. As Dr. Lee notes in his assessment:

[I]t is noteworthy that while all the youth in the NB sample presented with complex behavioral health needs, there were several characteristics common to many of the youth. Seventeen of the 17 youth in the sample were identified as Black or African/American and one also identified as Hispanic/Latino. Problem substance use was identified as a concern for 15 of the 17 youth; and 11 of the youth were diagnosed with a substance use disorder either prior to admission through independent evaluations or while at NB. Similarly, 14 of the youth in the sample experienced some type of trauma that was noted in either the independent assessments, DYRS’ assessments, or both. Among the 15 youth for whom cognitive testing was available, 14 of 15 showed a Full Scale IQ in the borderline intellectual functioning range (one standard deviation below the mean) or lower. (The validity of Full Scale IQ scores have been scrutinized when there is marked variability among subscale scores. [footnote omitted] This observation is presented to underscore the extent of cognitive challenges identified within in the

¹⁵ These figures are based only on DYRS and DC Superior Court records and not a review of broader adult criminal justice systems around the District of Columbia and thus may undercount the number of individuals who had additional contact with the juvenile or criminal justice system.

¹⁶ OIJFO could not determine where these five individuals were housed at the time this report was written.

reviewed NB youth cohort.) Of particular note was the seriousness of the offenses for which many youth in the sample were committed; many offenses involved assaults, carjacking, use of firearms (16 of 16 youth for whom charges were listed), and in some cases murder and attempted murder. A significant number of youth in the sample also engaged in risk-behavior while at DYRS, and all were placed on psychiatric medication for some period during the stay at NB.¹⁷

As one facility executive stated, for many youth placed at New Beginnings, DYRS could not find another placement option that would accept the youth: “The last stop is New Beginnings.”

III. METHODOLOGY

To assess the behavioral health services program at New Beginnings, OIJFO selected a sample of 17 committed youth who were housed at the facility for a minimum of 14 days between September 1 and December 31, 2023¹⁸ and who had significant behavioral health needs. This timeframe corresponded to when DYRS transferred the population of detained, Title 16 youth out of the facility. Using this period also allowed the OIJFO’s behavioral health expert to review records over the full duration of many youths’ incarceration at New Beginnings to assess services and youths’ progress over time.

To select the sample, using data from FAMCare, DYRS’s management information system, all 89 youth who were housed at New Beginnings from September through December 2023 were identified.¹⁹ Multiple sources of records were cross referenced for that time period,

¹⁷ Attachment 2 at page 2. In a July 2024 report, OIJFO documented that 72 percent of youth housed at New Beginnings between September 1 and December 31, 2023 were prescribed one or more psychotropic medications. Follow-Up Assessment of Psychotropic Medication Management at the Youth Services Center and New Beginnings Youth Development Center, July 15, 2024 (July 2024 Report), at page 3.

¹⁸ Some youth in the sample were admitted to New Beginnings before September 1, 2023, and/or remained housed there after December 31, 2023, but all were at New Beginnings during this four-month period.

¹⁹ An atypically high volume of youth, 42, were transferred to New Beginnings in the three-month period from August to October 2023. During this period, Title 16 youth were being transferred to the YSC and DYRS moved some committed, awaiting placement youth to New Beginnings.

including: prescribed medications;²⁰ the number of assaults that youth participated in as an assailant;²¹ the number of incidents in which youth reported to have injured himself;²² and data related to youth placed on suicide precaution status (SPS).²³ OIJJFO staff attempted to review data regarding Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2) flags for each youth, but because of data limitations could not do so.²⁴ Similarly, it was not possible to cross reference data regarding substance abuse histories for the universe of youth. OIJJFO staff also reviewed DYRS records related to non-court ordered emergency psychiatric hospitalizations, but there were no youth to whom this was applicable during the sample period.

Of the 89 youth housed at New Beginnings between September 1 and December 31, 2023, 84 youth had a length of stay of 14 days or more at the point of release. Fifty-two of the 89 youth (58 percent) were prescribed psychotropic medications. Additionally, 61 youth (69 percent) were involved in assaultive incidents and identified as the assailant and one youth (one percent) put himself at serious risk of harm and was placed on SPS.

Based on the collected data, OIJJFO selected a sample of 17 committed youth, constituting 20 percent of the universe of youth with lengths of stay of 14 days or more during the four-month period.²⁵ The sample was designed to include youth with a cross-section of diagnosed behavioral health issues, demonstrated high-risk behaviors such as assaultive and/or

²⁰ OIJJFO obtained data regarding all medications prescribed to youth housed at New Beginnings between September and December 2023. Every prescription for psychotropic medications was identified and each medication was categorized according to its drug class, as defined in the 2018 Psychotropic Medication Monitoring Parameter (PMMP) applicable during this sample period.

²¹ To identify if a youth was an assailant, OIJJFO staff reviewed all New Beginnings incident reports that occurred between September and December 2023 that were categorized as youth-on-youth and/or youth-on-staff assaults.

²² OIJJFO staff reviewed all incident reports between September and December 2023 that were categorized as self-injurious.

²³ OIJJFO staff reviewed records maintained by DYRS staff to identify all youth at New Beginnings who were placed on any level of suicide precaution status between September and December 31, 2023.

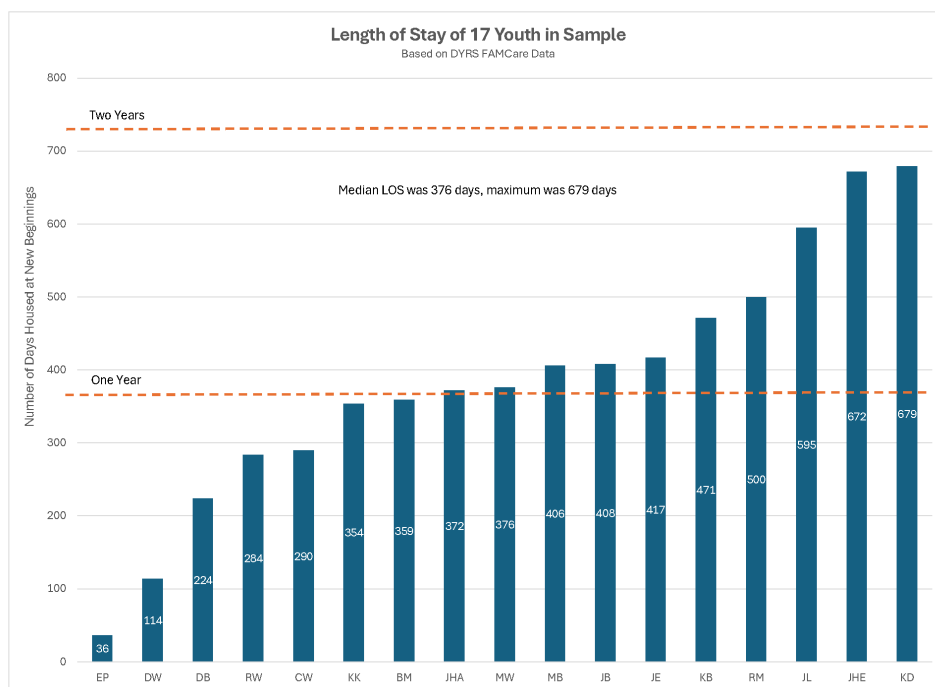
²⁴ See pages 31-32.

²⁵ This sample size was consistent with the size of samples conducted in prior assessments conducted by the Special Arbiter in Jerry M.

self-injurious behavior, and youth who were prescribed psychotropic medications. No outcomes after release data were considered in the sample selection process.²⁶

The 17 youth in the sample were all committed males; there were no females housed at New Beginnings during the period under review. As presented in the chart below, the lengths of stay at release from New Beginnings for the youth in the sample ranged from 36 days to 697 days, with a median of 376 days.

Chart 3: Length of Stay of 17 Sampled Youth



Of the 17 youth in the sample, nine were recorded as having completed the New Beginnings program and released from the facility.²⁷ Of those nine, four subsequently returned to the secure custody of DYRS and three additional youth face new, adult charges in the District of Columbia.²⁸ Of the remaining eight youth who were not identified as having completed the

²⁶ Indeed, only eight of the 17 youth had been released at the time the sample was selected.

²⁷ Seven were placed in their home, one in a group home, and one in a supported independent living program.

²⁸ The three youth have been charged but the cases were pending as of August 13, 2025. One of these three youth suffered a gunshot wound during an incident in the community.

program, all were eventually released from DYRS secure custody.²⁹ Seven of those eight youth subsequently returned to DYRS secure custody or were charged with crimes as adults.³⁰

To conduct his assessment, Dr. Lee reviewed available psychiatric and psychological reports, most of which were completed by independent evaluators at the Child Guidance Clinic of the Family Court Social Services Division of the District of Columbia Courts. Dr. Lee also reviewed each youth's electronic health record (EHR), which included behavioral health records. Dr. Lee recorded a summary of his findings on a standardized instrument that was informed by the standard of care, DYRS policies, and Work Plan requirements in Jerry M., and which is attached to his assessment as an appendix.³¹

In addition to Dr. Lee's review, OIJFO staff reviewed various documents for this report, including:

- individual youths' EHRs;
- individual youths' FAMCare records;
- success plans;
- Youth Level of Service (YLS) documentation;
- Unusual Incident Reports;
- DYRS Schedule A data;
- SPS logs maintained by DYRS staff;
- SPS Observation Forms;
- psychological and psychiatric reports;³²
- completed MAYSI-2s;
- prescription data for youth housed at New Beginnings between September and December 2023; and,
- relevant DYRS policies.³³

²⁹ Four were released directly to their home from New Beginnings. Two were transferred initially to the YSC, then to a detention facility in Maryland, and eventually to the community. Two were transferred to the YSC for two and ten days respectively, were returned to New Beginnings and were then transferred to residential treatment facilities.

³⁰ These figures are based only on DYRS and DC Superior Court records and not a review of broader adult criminal justice systems around the District of Columbia.

³¹ Attachment 2 at appendix.

³² These reports were conducted by independent psychiatrists and/or psychologists pursuant to orders or judges presiding over the youths' juvenile cases.

³³ Behavioral Health Services, Policy No. V.e.9, effective October 11, 2016 (Behavioral Health Services Policy); Medication Management Policy, Policy No. V.d.2, effective January 17, 2018, and DYRS' Psychotropic Medication Monitoring Parameter (PMMP), July 2018; and Suicide Prevention, Policy No. V.b.3, effective June 28, 2016 (Suicide Prevention Policy).

Accompanied by OIJFO staff, Dr. Lee conducted site visits in September 2023 to both the YSC and New Beginnings to familiarize himself with the facilities. During these site visits, he interviewed the DYRS deputy director of health services, who oversees the behavioral health program at both the YSC and New Beginnings; the health services program managers for both facilities, who oversee the behavioral health program at their respective facility; behavioral health staff, the DYRS chief of secure programs, a psychiatrist who provides services to youth at both facilities, and numerous youth and youth development representatives (YDRs) at both facilities. OIJFO staff also interviewed additional behavioral health staff who were assigned to New Beginnings, housing unit-based team leaders assigned to New Beginnings, the New Beginnings superintendent and deputy superintendent who oversees treatment at the facility, juvenile justice institutional counselors (JJICs) assigned to New Beginnings, medical staff assigned to New Beginnings; and numerous youth, supervisory youth development representatives (SYDRs), and YDRs at New Beginnings.

IV. PROGRAM DESCRIPTION

A. Overview

DYRS has developed a structured program at New Beginnings that includes a variety of screenings, assessments, clinical services, group therapy, and psychiatric services with medication management – all within an overarching level-based behavioral modification program that youth progress through in order to graduate from the New Beginnings program.

Youth at New Beginnings routinely interact with an array of staff within the facility, who play a variety of roles. Most frequently youth interact with YDRs who directly supervise them at all times throughout the day. But youth rehabilitation is also supported by unit-based teams of

staff including team leaders, behavioral health specialists, and JJICs.³⁴ Youth also interact with other, non-unit-based staff including restorative justice counselors, credible messengers,³⁵ education staff, and care coordinators.

Each youth is assigned a “core support team,” which consists of the team leader on the youth’s housing unit, the youth’s assigned behavioral health clinician, the JJIC assigned to the unit, an educational staff member, and the youth’s credible messenger.³⁶ The core support team is responsible for developing a youth’s success plan with goals, discussed in more detail below,³⁷ and the plan informs decisions about a youth’s readiness for release from the facility.

While there is a single superintendent of New Beginnings in charge of the facility, the aforementioned facility staff involved in the rehabilitation of youth report through several different chains of command, some of which flow outside of the superintendent’s scope of management. For example, team leaders and unit-based YDR staff report to the superintendent through one deputy superintendent. Non-unit based YDR staff report to the superintendent through a different deputy superintendent. JJIC staff, during the review period and until recently, reported directly to a manager outside of New Beginnings who oversaw both New

³⁴ Team leaders are housing unit managers who supervise the YDRs assigned to their respective housing units. Behavioral health specialists provide clinical services and conduct therapeutic group sessions at the facility. JJICs provide certain case management services, and according to the DYRS Care Planning and Coordination Handbook, “serves as the liaison between the Care Coordinator and the facility, supports the youth with family engagement and ensures the youth receives appropriate support while in the facility.” See Department of Youth Rehabilitation Services, Care Planning and Coordination Handbook, effective April 2017 (DYRS Care Coordination Handbook), at page A-7.

³⁵ Credible messengers provide mentorship to and advocacy for youth at New Beginnings.

³⁶ Some staff members stated that care coordinators were invited to attend core support team meetings, but generally did not. Additionally, many core support team members stated that each youth are assigned a non-supervisory YDR from their housing unit (a “youth advocate”) who can attend meeting, but that they are not always present. Some staff members stated that restorative justice staff members based at New Beginnings were part of the core service team, but other staff members who organize the meetings of the core support team indicated they were not regular members of the team.

³⁷ See pages 19-20.

Beginnings and the YSC.³⁸ Behavioral health providers report to the New Beginnings behavioral health services program manager, who does not report to the superintendent, but rather to the deputy director of health services. Education staff are all contract staff who report to a facility principal, and the contract is managed by a contract administrator outside the New Beginnings reporting structure. Credible messengers are also contract staff, and report to a separate contract administrator who is not a part of the New Beginnings reporting structure.

In short, while the superintendent of New Beginnings is responsible for the operation of the facility, neither that position nor any other position at the facility includes both the authority and responsibility to manage all staff who are responsible for the various rehabilitative elements of the New Beginnings program.

B. Behavioral Health Staff

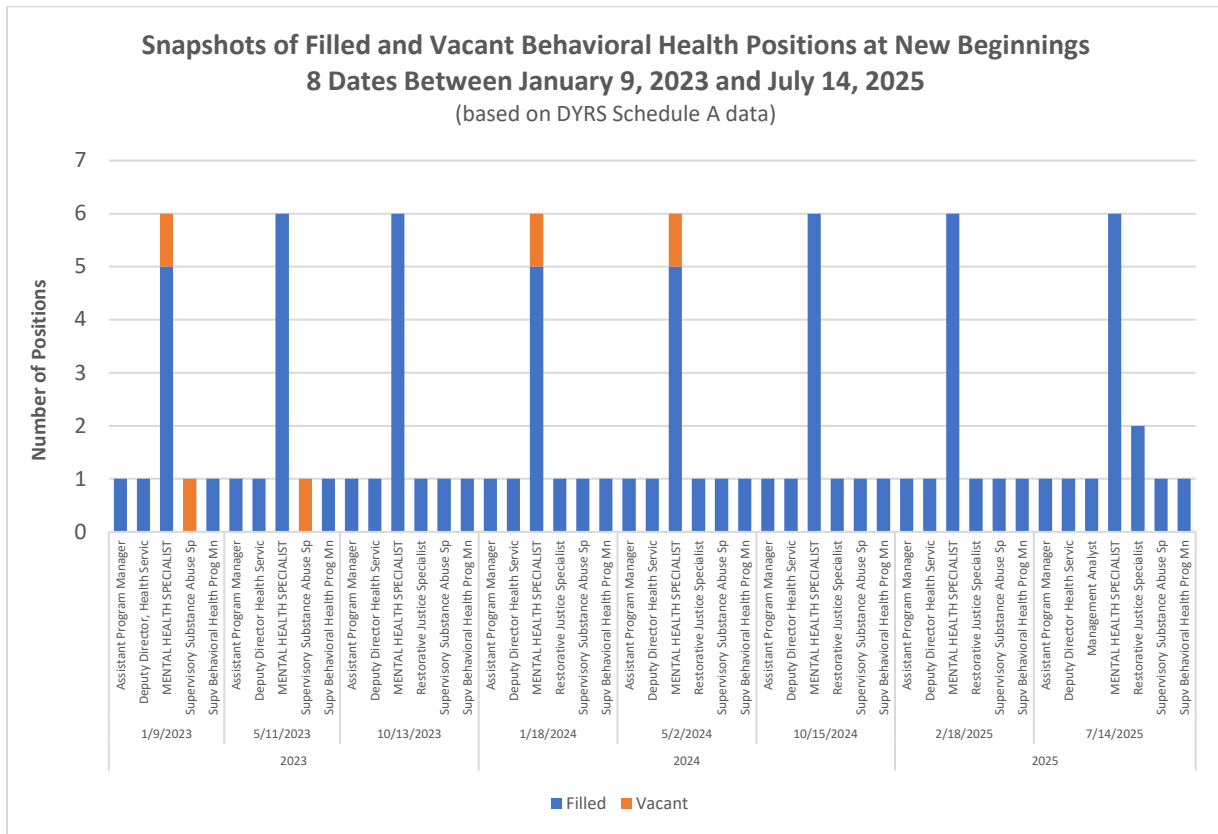
Behavioral health staff play a central role in the rehabilitative program. As behavioral health providers, they are responsible for assessing, diagnosing, and developing treatment plans for youth, ideally informed by any work by other licensed providers. These assessments and treatment plans should be at the core of any program to change youth behavior prior to release to the community.

DYRS employs a deputy director of health services, who oversees the behavioral health programs at both the YSC and New Beginnings, and behavioral health services program managers who administer the behavioral health programs at each facility. New Beginnings has six dedicated behavioral health positions, one assigned to each of the facility's six housing units. Each unit contains 10 cells, which keeps the clinician to youth ratio low, a maximum of 1:10 if a unit is filled to capacity and frequently they are not.

³⁸ The relevant managerial position now reports to the superintendent of New Beginnings and the JJICs now report through that manager to the superintendent.

Snapshots showing filled and vacant behavioral health positions at New Beginnings over a two-and-a-half-year period illustrate that while at times there have been behavioral health positions vacancies, all of the positions are frequently filled.

Chart 4: Filled and Vacant Behavioral Health Positions at New Beginnings



In fact, five of the six behavioral health specialists who are currently at New Beginnings have been there for at least two and a half years, three of whom have worked there for more than five years; the most recent hire was in mid-2024. This level of staff consistency is important to the establishment of clinical relationships and building trust between youth and behavioral health staff. In their comments on the draft version of this report, DYRS notes that “filled positions do

not equate to full-time availability. During the review period, coverage was impacted by extended staff absences, requiring temporary reassignments across facilities.”³⁹

C. Screenings and Assessments

1. Psychiatric and Psychological Evaluations

Prior to their admission to New Beginnings, many youth have court-ordered psychiatric, psychological, or other evaluations conducted by independent evaluators as part of their court case. Dr. Lee found that “[t]hese reports reflected thorough and extensive assessments and, in many cases, formal psychological testing, and included specific diagnoses and useful recommendations for treatment and/or follow up.”⁴⁰ These evaluations are conducted prior to a youth’s admission to New Beginnings, and there is evidence that they are frequently made available to DYRS staff and to behavioral health and other program staff involved in supporting the treatment goals of the youth.⁴¹ As detailed in the table below, 16 of the 17 youth in the sample selected for Dr. Lee’s assessment had one or more evaluations, which were included in FAMCare.

Evaluation(s)	Number of Youth in Sample
Psychiatric Evaluation & Psychoeducational Evaluation	9
Psychiatric Evaluation & Psychological Evaluation	4
Psychiatric Evaluation Only	1
Psychological Evaluation Only	1
Psychoeducational Evaluation Only	1
No Evaluations	1

These evaluations contain a wealth of information regarding behavioral health needs and diagnoses. The reports include significant information regarding a youth’s social, legal,

³⁹ Attachment 3 at page 1. This phenomenon of positions filled by staff who are not available for duty is not limited to behavioral health staff. OIJFO has emphasized the adverse impact of staff who are not available for duty among YDR and SYDR staff at both the YSC and New Beginnings for years.

⁴⁰ Attachment 2 at pages 5-6.

⁴¹ OIJFO staff found these evaluations in youth FAMCare records, which are available to facility staff.

substance use, trauma and medical histories, their then-current clinical presentation, and often include specific recommendations for placement and treatment, which should facilitate DYRS' development of behavioral health treatment plans and inform staff interactions with youth.⁴² Behavioral health staff should be expected to review these evaluations as part of their routine intake process and certainly consider them when developing a youth's behavioral health treatment plan. As discussed in more detail below, however, Dr. Lee found that "there is no evidence in the behavioral records that the New Beginnings behavioral health staff utilized the diagnostic or treatment information in the independent evaluations in formulating treatment for the youth."⁴³ In their comments on the draft version of this report, DYRS stated that the success plans completed for youth at New Beginnings refer to and incorporate the diagnostic and treatment recommendations included in the independent evaluations.⁴⁴ However, a review of the success plans completed for youth in the sample suggest that this is in fact not the case. This is discussed in more detail below.

2. Youth Level of Service (YLS)

The YLS is a tool used to evaluate a youth's risk and needs related to reoffending and is intended to inform placement decisions once youth are committed to DYRS. The tool does not need to be completed by a behavioral health provider; rather, it is an empirically-validated instrument that can be administered by trained, non-behavioral health professionals to gather and consider risk-related data in a uniform way.

⁴² See page 36-37 below for a fuller discussion of these evaluations. These independent evaluations also often included detailed information concerning the youth's cognitive functioning, which is an important consideration in creating the myriad plans developed for a youth during his stay at New Beginnings.

⁴³ Attachment 2 at page 6, footnote 14.

⁴⁴ Attachment 3 at page 2. DYRS states that "[i]ndependent evaluations are consistently referenced in each youth's NB Success Plan, which integrates diagnostic and treatment recommendations into individualized programming."

The screening is organized into eight domains⁴⁵ and each is categorized as high risk/need, moderate risk/need, or low risk/need. Based on the domains, the YLS is used to calculate a total risk score.⁴⁶ In addition to informing placement decisions, relevant information gathered in the YLS should ultimately be incorporated into a youth's behavioral health treatment plan. At the same time, a YLS is not a substitute for behavioral health assessments performed by licensed providers.

The YLS is designed to incorporate various sources of information, including interviews with the youth, the youth's family, and the youth's probation officer; any psychiatric or psychological evaluations; educational records such as report cards and/or individual education programs (IEP); police reports; court social services (CSS) reports or summaries; interviews with other relevant stakeholders such as credible messengers; and, incident reports.⁴⁷

Prior to a decision to place a youth at New Beginnings, a YLS should be completed by a care coordinator and a copy of the assessment should be maintained in the youth's FAMCare record. New Beginnings staff report that the YLS is a helpful reference document, as it provides detailed background information on the youth. For example, one staff member provided an example of a youth who was grieving the loss of their father; the YLS detailed other losses that the youth had experienced and provided context to understanding the youth's behavior and informing appropriate care. For youth with a completed YLS, staff report that the completed instrument is used by the youth's "core support team," to inform the youth's

⁴⁵ The eight domains include: family circumstances/parenting, peer relations, leisure/recreation, attitudes/orientations, prior and current offenses/dispositions, education/employment, personality/behavior, and substance abuse.

⁴⁶ The total score will place a youth in one of four categories of risk: low, moderate, high, or very high.

⁴⁷ See Attachment 4 for an example of an YLS.

“success plan,” to guide the youth’s behavioral goals during his period of incarceration at New Beginnings.

Multiple staff at New Beginnings, including managers, JJICs, and behavioral health specialists, report that while some youth have a YLS completed before the youth arrives at the facility, many do not. One New Beginnings manager described the YLS completion as “a work in progress.” This is consistent with OIJFO’s review of youth records. Of the 17-youth sample in Dr. Lee’s assessment, OIJFO staff found a completed YLS in just six youths’ records. A YLS was not found in the FAMCare records of 10 of the sample youth.⁴⁸

D. Plans

1. Success Plans

Success plans are individualized plans based on a template that contain goals developed for and with youth based on their strengths and needs. According to the DYRS Care Coordination Handbook, success plans should be “highly personalized and designed to help each youth experience long term success consistent with the six domains within the [positive youth justice] framework and elevate their sense of self-worth and self-efficacy. SMART Goals are the framework that guides the development of the Success Plan.”⁴⁹ The plans should include specific, measurable goals with associated action steps and timelines.⁵⁰ Unlike behavioral health treatment plans which focus on diagnosed behavioral health problems, success plans are broader and include non-behavioral health related goals such as “advance to the next school grade.”⁵¹

⁴⁸ The FAMCare record of the remaining youth in the sample was locked for administrative purposes after the assessment began and a determination could not be made regarding whether this youth had a completed YLS.

⁴⁹ See DYRS Care Coordination Handbook at page F-17. The six domains of the PYJ model are work, education, relationships, community, health, and creativity.

⁵⁰ See Attachment 5 for examples of success plans.

⁵¹ In addition, success plans generally specify actions to be taken by the youth, while behavioral health treatment plans specify interventions of the staff to support the youth in meeting their behavioral health goals and objectives.

According to staff, success plans should be informed by the YLS, where available and developed within 30 days of a youth's admission to New Beginnings, led by the youth's assigned behavioral health staff team member and in consultation with the core support team. The DYRS Care Coordination Handbook provides that success plans should be updated at least every 90 days.⁵² Success plans should be uploaded and maintained in FAMCare. Of the 17 youth in Dr. Lee's assessment sample, OIJFO staff found at least one success plan in FAMCare for 15 youth for the admission in the period of review; four youth had only one success plan in FAMCare, two youth had two success plans in FAMCare, three youth had three success plans in FAMCare, and six youth had four or more success plans in FAMCare. One youth did not have a success plan in his record for the relevant admission, and for one additional youth OIJFO staff could not access FAMCare to review his record. For those youth with multiple plans, when updates were completed, the intervals ranged from two months to just under six months.

Success plans are particularly important to the New Beginnings rehabilitative model. Once developed, the goals are used as a framework for youth to advance through six program levels and ultimately petition to be released from the facility. Youth are required to "petition" to their assigned team of staff each month to demonstrate that they have made sufficient progress to advance to the next program level.⁵³ In light of the centrality of the goals of the success plans to the decision-making regarding each youth's preparedness for release to the community, there should be a close relationship and congruence between success plans and a youth's behavioral health treatment plan goals, described below.

⁵² See DYRS Care Coordination Handbook at pages A-2 and A-9.

⁵³ See pages 22-24 for further discussion of the level system at New Beginnings.

2. Behavioral Health Treatment Plans

According to DYRS policy,⁵⁴ all youth admitted to New Beginnings receive a behavioral assessment completed by a behavioral health staff member. During the assessment, a range of information is collected from the youth, including: history with DYRS; legal history; education history; social relationships; treatment history, to include diagnoses or hospitalizations; current medications; substance abuse history; suicide assessment; and trauma history and related symptoms. Additionally, behavioral health staff are expected to review any past EHR entries, assessment results, including the MAYSI-2, and psychiatric or psychological evaluations that were conducted prior to the youth's admission.

Based on the assessment, a list of diagnosed problems is created⁵⁵ and a treatment plan is then established to address the targeted diagnoses or problem and/or complaints, along with long-term goals and short-term objectives to address the issues. Additionally, each targeted diagnosis or problem is connected to interventions to be provided by staff to support the youth in reaching the goals, sometimes with suggested follow-up intervals.⁵⁶ The intervention is assigned to a staff member and each diagnosis or problem includes a date initiated and end date, as well as a progress score. Problem lists and treatment plans are stored in youths' EHRs. Core support team members and other staff at the facility do not have direct access to youth behavioral health treatment plans but are advised on the content by behavioral health staff for the development of success plans.

⁵⁴ Behavioral Health Services Policy at §VI.A.

⁵⁵ In contrast, success plans may contain some clinical goals, such as improving anger management skills, but also may include goals not incorporated in the youth's behavioral health treatment plan, such as improving school attendance.

⁵⁶ These include interventions such as medication management, psychiatric follow-up, psycho-education groups, or individual therapy.

All 17 youth in the sample from Dr. Lee’s assessment had behavioral health treatment plans related to the relevant admission in their EHR. Twelve youth had one or more updated plans, in addition to their initial plan.

The behavioral health plan should guide the youth’s treatment for the duration of their stay at New Beginnings. As noted in the prior section, success plans and the associated level system, discussed below, are also intended to be behavioral modification systems. Thus, success plans and behavioral health plans should be closely related to and complement one another. The goals and actions in each plan should be consistent, so that staff and youth are working on meeting congruent goals advancing the youth’s rehabilitation.

E. Processes

1. Level System

The New Beginnings program is based on an incentive-based, graduated system in which youth progress through an initial orientation phase and then six levels. At the completion of level six, youth are eligible for “home petition.” Staff report that if youth are determined, they can complete the program within six to nine months (approximately 180 to 275 days). Among committed youth admitted in 2023 and who were recorded as having completed the program, the median length of stay was 264 days and the maximum was 679 days.

Youth begin in an orientation phase, which lasts two weeks, and then proceed to Level 1 where they begin a process to advance through six levels. On Level 1 and Level 2, youth petition to advance to the next level every 45 days. Once youth reach Level 3, youth petition to advance every 30 days. When youth have completed Level 6, they move to home petition; most discharge planning occurs on the home petition level and youth remain on this level until they are released from New Beginnings.

To guide youths' work, DYRS developed a standardized "wellness calendar"⁵⁷ for youth. The calendar is organized into the program's six levels and each level has numerous tasks or activities organized around four "core values:" accountability, empathy, temperance, and resilience. Activities vary by level and by type and may include a range of options from behavioral health and self-care to practical life skills.

To advance through the program levels, youth must complete and submit a "petition packet"⁵⁸ to their core support team, demonstrating they are ready to progress. Illustrating completion of activities from the wellness calendar is part of the petition packet. In addition, youth must also demonstrate how they have made progress against goals set forth in their success plans, how they have demonstrated behavior consistent with the four core program values, attend individual and group therapy sessions, reflect on any incidents they were involved in, and answer a series of questions related to their efforts, skills development, and behavioral outcomes.

During the level petition process, a petitioning youth's core support team uses a "staff petition scoring" sheet,⁵⁹ which incorporates the information the youth presented in their petition packet (55 percent), the youth's presentation at the meeting (15 percent), and daily progress sheets completed by staff based on youth behavior throughout each day (30 percent). Each member of the core support team scores the youth, an average score is calculated, and if the youth achieved an establish point threshold, they advance to the next level.⁶⁰

One facility manager observed that the petitioning process is not appropriate for all youth placed at New Beginnings. The manager noted that some youth have significant cognitive

⁵⁷ See Attachment 6.

⁵⁸ See Attachment 7. Note that the attached packet includes pages 1 of 6 through 4 of 6. Unit staff who provided the packet stated that those pages represent the complete petition packet.

⁵⁹ See Attachment 8.

⁶⁰ According to the scoring sheet, 70 points are required to reach level 1, 75 points for level 2, 80 for level 3, 85 for level 4, and 90 for levels 5, 6, and home petition.

limitations and have difficulty understanding how to complete petition packets or, in some cases, have limited reading and writing skills. The manager stated that in these cases, staff assist youth in preparing the packet but also questioned whether the program would achieve intended behavioral changes if the youth could not comprehend the program. Multiple staff involved in the petitioning process stated their belief that youth are able to advance through the levels without demonstrating real progress addressing identified behavioral health problems as long as they complete activities on the wellness calendar and avoid documented incidents while at the facility.

2. Youth Progress Meetings

Core support teams on each unit meet weekly in youth progress meetings (YPMs), not attended by youth. Staff reported that they discuss two to three youth at each meeting, assessing each individual's progress every two to three weeks. The YPM meetings are a forum for staff to discuss how youths' treatment and behavior is progressing, set goals for the next 30 days, and discuss any areas where the youth might be struggling. Team leaders are responsible for documenting a summary of the YPM in the youth's FAMCare notes.

3. Team Decision Making Meetings

The DYRS Care Coordination Handbook provides that team decision making (TDM) meetings “draw[] upon the youth's and family's strengths, experiences, knowledge, and resources to create a plan for the youth while committed to DYRS. Participants include the youth, TDM Team member, Care Coordinator, family members as well as community and agency stakeholders.”⁶¹ According to the handbook, the first meeting should be held within 30

⁶¹ DYRS Care Coordination Handbook at page A-9.

days of a youth's admission to New Beginnings to develop the success plan and should occur every 90 days thereafter.⁶²

In practice, however, core support team members at New Beginnings consistently stated that the core support team and principally the behavioral health specialist, developed the success plans. Some core support team members stated that they did not know what the difference was between YPMs and TDM meetings. Multiple New Beginnings core support staff members stated that TDM meetings occur infrequently. One staff member stated that the "TDM meetings are few and far between" while another flatly stated that "TDM meetings are not happening."

The handbook states that when a youth reaches level 6, a discharge TDM should be conducted to determine the youth's community re-entry plan and a discharge success plan.⁶³ Numerous core support team staff stated that these meetings, coordinated by the youth's assigned care coordinator, are scheduled as youth reach level 6.⁶⁴ These same staff reported that while youths' parents or guardians are invited to attend the meetings, often they do not attend.

4. Memberships

New Beginnings' behavioral program also includes a four-level, incentive-based "membership" program. Other than minimum number of days youth must be at the facility before they can begin to progress through the levels, memberships are independent of the six program levels.

Youth begin on a "think" level for a minimum stay of 14 days and can then move to "learn" level (minimum of 30 days), "contribute" level (minimum of 60 days), and eventually to

⁶² *Id.* at page F-11.

⁶³ *Id.*

⁶⁴ In their comments on the draft version of this report, DYRS states that as they pertain to release and transition procedures, TDM meetings "are convened at least 30 days prior to release, ensuring continuity of behavioral health care in the community." Attachment 3 at page 3.

the highest level, “contribute alum.” The progression through the stages is based on a youth’s behavior. The higher the membership, the more incentives a youth can earn, such as later bedtime, access to longer telephone calls, or the ability to listen to music on an MP3 player. If a youth does not sustain positive behavior, their membership level can be stepped back.

F. Services

As a part of the program, youth must participate in a variety of therapeutic groups. The groups are intended to develop and bolster emotional, behavioral, social, and vocational skills based on the needs identified and goals established by their core support team. As noted above, youth are expected to track their participation and reflect on their insights during their level petition process.⁶⁵

There are a series of “core groups” that are offered to all youth, which are run by the behavioral health staff, some with assistance from the credible messengers. These occur in the afternoons, from 4-5 PM, in the school building. Most groups have a curriculum that runs from eight to 16 weeks. Once a youth has completed the program, they receive a certificate indicating their completion and they can then be enrolled into one or more new groups. Each youth should be enrolled in at least one core program at a time. The core programs include restorative justice ready,⁶⁶ TGTCA,⁶⁷ WAIT,⁶⁸ SPARCS,⁶⁹ Power Source,⁷⁰ and victim impact. A substance abuse group is also conducted for identified youth, led by a DYRS employee who is a substance abuse specialist. DYRS’s program description also indicates that horticulture, animal assisted therapy,

⁶⁵ See pages 23-24.

⁶⁶ This group is run by DYRS restorative justice staff members who are a part of the behavioral health program. It focuses on restorative justice principles and practices, including conflict resolution.

⁶⁷ Trauma and Grief Component Therapy for Adolescents (TGTCA) addresses trauma and bereavement.

⁶⁸ Behavioral health staff must have a special certification to run this program. Washington Aggression Interrupting Training (WAIT) focuses on anger management, social skills, and moral reasoning.

⁶⁹ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) focuses on developing resilience and practicing coping skills for youth who have a history of stress and difficult experiences.

⁷⁰ Power Source focuses on the social-emotional development of youth.

supportive trauma services (pathways), and creative expression sessions are offered based on individual needs (*i.e.*, rather than to all youth). These programs are held once or twice per week and JJICs are responsible for documenting in the case notes in FAMCare when a youth participates in a group.

In addition to the core groups and programming, unit-based YDR staff conduct morning and evening group discussions on the housing units. According to team leaders and YDRs who conduct the groups, these sessions are a chance for all youth on the unit to establish expectations for the day, reflect on the day, and evaluate the “daily enactment of program values.” Staff also reported that YDRs run “real talk sessions” on the unit, which include discussions regarding current events, life skills, or other topics as chosen by the YDRs. YDRs are expected to produce their own curriculum for these groups.

There are also a limited number of vocational programs that are conducted in the afternoons including barbering, culinary arts, and music production. On afternoons when youth do not have a scheduled group, they remain on their housing unit and have free time.

In addition to therapeutic groups, youth are expected to participate in weekly individual therapy with their assigned behavioral health staff member, who has an office on the housing unit. These sessions should focus on the youths’ needs as outlined in their behavioral health treatment plans, and which should also be reflected in the youths’ success plans. The behavioral health staff record notes related to the individual therapy in the youth’s EHR.

Behavioral health staff also report that youth should participate in family therapy, if appropriate for their plan. But both behavioral health staff and other core service team staff reported that there are often barriers to family therapy. In some cases, a youth’s relationship with their family members is unstable, there could be safety issues, and/or the youth express that

they do not want to participate. Staff report that in other cases it is difficult to schedule meetings with family members. If a youth receives family therapy, behavioral health staff is expected to record relevant notes in the EHR. To foster more family engagement, New Beginning staff periodically organize “family fun days” around holidays or other events and invite families to New Beginnings. Staff report that these events often encourage higher levels of family turnout and are an important positive event for both youth and their families.

V. FINDINGS

Youth incarcerated at New Beginnings are there because they have been found to have engaged in some delinquent behavior and, for most, very significant delinquent behavior, often including violence against others. Behavioral health models focus on identifying underlying problematic thoughts, emotions, and learned behaviors and applying evidence-based models to change those problem areas. This is a basic distinction between a rehabilitative program and a strictly punitive or retributive program, the latter of which does not necessarily focus on changing individual thoughts, emotions, or behaviors. For this reason, the diagnostic and treatment services provided by behavioral health providers at New Beginnings are a bedrock component of the rehabilitative model and must be integrated with the overarching level-based behavioral modification system at the facility. The success of the program depends on successful problem identification and the integration of the treatment of identified problems into the larger design of the facility’s program.

Dr. Lee conducted a case-record review of a sample of 17 youth. The goal of the assessment was to assess performance against certain standards that had been adopted in the Jerry M. litigation, including initial screening; initial and ongoing assessments; psychiatric treatment; responses to repeated behaviors that put individuals in risk of danger; self-harming

behavior; responses to behavioral health emergencies; and the development and implementation of behavioral health treatment plans that meet the individual needs of each youth. These standards are intended not only to ensure the safety of youth while they are housed at New Beginnings, but also to identify and address behavioral health problems for youth to return to the community as productive individuals.

A. Screenings

In order to ensure youth with behavioral health or substance abuse issues are promptly identified and provided any needed emergency service, both the standard of care and DYRS policy require that all youth admitted to a secure facility be screened for behavioral and substance abuse disorders.⁷¹ Specifically, DYRS policy provides that “[a]ll overnighters and new admissions shall receive comprehensive behavioral health screening upon admission to a DYRS secure facility. This screening includes completion of both the Initial Medical Screening and Risk Assessment ...and the MAYSI-2.”⁷² Additionally, the Policy requires that if the youth flags in the substance abuse scale of the MAYSI-2, a secondary screening, a GAIN-Q screening or other empirically equivalent substance abuse screening tool, shall be administered within five days of the youth’s commitment to DYRS.⁷³ As is explained in more detail below, DYRS did not meet either of the performance standards related to screenings as required by policy and the standard of care.

1. MAYSI-2 Administration

Performance Standard #1: For any youth at New Beginnings who flags a caution or warning on suicidality and /or thought disorder of the MAYSI-2, a QMHP should complete a telephone consultation and a face-to-face assessment within 18 hours of administration of the MAYSI-2 or within a shorter specified time period if clinically appropriate.

⁷¹ Attachment 2 at page 3. See also Behavioral Health Services Policy at §§VI.A.1. and VI.A.4.

⁷² Behavioral Health Services Policy at §VI.A.1.

⁷³ *Id.* at §V.A.4.iii.

DYRS policy requires the MAYSI-2 to be administered after the admission of each youth, including for youth “transfers between secure facilities.”⁷⁴ The policy further provides that the MAYSI-2 should be administered within four hours of admission and if a youth scores in the suicide or thought disturbance domains of the MAYSI-2, a referral shall be made to a qualified mental health professional.⁷⁵ For these youth, DYRS requires that a telephone consultation including a Qualified Mental Health Professional (QMHP), the youth, and admission staff should be completed promptly and a face-to-face consultation completed within 18 hours (or sooner if clinically appropriate) in order to assess the youth’s risk to self or others and need for and immediate behavioral health intervention.⁷⁶

Historically, the MAYSI-2 was administered to youth by medical staff at the time of admission on a computer terminal and youth could answer questions at their own pace. Because MAYSI-2 results could be adversely impacted if youth rushed through the MAYSI-2 administration,⁷⁷ the Special Arbiter at that time completed an analysis of the duration of the

⁷⁴ *Id.* at §VI.A.4.i. The MAYSI-2 is a well-accepted screening tool using a 52-item yes/no questionnaire for the express purpose of providing youth corrections institutions with an empirically valid tool for screening youth concerning the presence of specific mental health problems and needs. It is simple to take and administer. The 52 individual items contribute to seven scales, reflecting Alcohol/Drug Use (AD), Anger/Irritability (AI), Depressed or Anxious states (DA), Somatic Complaints (SC), Suicide Ideation (SI), Thought Disturbance (TD), and Traumatic Experiences (TE). *See* The Special Arbiter’s Abbreviated Report to the Court Regarding Defendants’ Progress Toward Meeting Work Plan Requirements Related to Behavioral Health Services at the Youth Services Center and the New Beginnings Youth Development Center, filed June 15, 2020 (Special Arbiter’s June 2020 Report) at page 11 and Ex. 1 thereto at page 2. By policy, transferred youth who have taken the MAYSI-2 within the prior two weeks do not need to take the MAYSI-2 upon admission to New Beginnings.

⁷⁵ *Id.* at §VI.A.4.ii., incorporating Suicide Prevention, Policy No. V.e.9, effective October 11, 2016 (Suicide Prevention Policy).

⁷⁶ Suicide Prevention Policy at §§VI.A.4. and 5. and B.1-4. This standard also reflects Goal V.A.1.b. of the Jerry M. Work Plan, one of the requirements that DYRS had not yet met when the lawsuit was dismissed and for which the OIJFO was charged with monitoring implementation. Dr. Lee considered this standard in his assessment of the care provided at New Beginnings. Attachment 2 at pages 3-4.

⁷⁷ Special Arbiter’s June 2020 Report at page 14 (“Dr. Barnum notes that in a significant portion of cases, youth may be rushing through taking the test, and the results may therefore not provide valid information about their mental health concerns.”).

self-administered MAYSI-2 screens and found that 67 percent of youth were completing it in 2.5 minutes or less, casting doubt on the validity of the screening results in many cases.⁷⁸

Following the 2020 report, at some point in 2023, the computer-terminal based MAYSI-2 was deprecated, and the company migrated to an online platform. Until DYRS adopted the online platform at New Beginnings in 2024, youth completed the MAYSI-2 in hard copy rather than on computer.⁷⁹ Medical staff report that when youth are admitted to New Beginnings now, medical staff can choose to have youth take the MAYSI-2 online or to complete it in hard copy. Either way, the results must be scanned and included in the youth's EHR.

At the YSC, which experiences thousands of youth admissions per year, self-administration of the MAYSI-2 on a computer terminal helps staff manage their limited time. At New Beginnings, which has a low volume of admissions, there is an opportunity for staff to sit with and administer the screening tool to youth. While more labor-intensive for staff, it could help prevent youth from rushing through the screening and provide staff an opportunity to observe the youth, ensure that all questions are asked, and allows staff to assess the validity of the youth's responses, which may result in a more accurate assessment of the youth's need for immediate behavioral health services or further evaluation by professional mental health staff.

To determine if DYRS met the standard of care and its policy requirements, the OIJFO reviewed the EHR to locate MAYSI-2 instruments for each of the 17 youth in the sample. Results of a MAYSI-2 relating to the reviewed admission could not be located in the EHR for

⁷⁸ *Id.* at page 14.

⁷⁹ In its comments on the draft version of this report, DYRS reported that the agency transitioned to an online MAYSI-2 platform in May 2024. Attachment 3 at page 2. The comments note that “[a]ll youth now receive screening upon intake;” however, according to staff who administer the MAYSI-2 at New Beginnings, youth who have taken the MAYSI-2 within the prior two weeks do not receive the full MAYSI-2 upon admission, consistent with practices established during the Jerry M. litigation. Even with the new online platform, DYRS health staff must print and upload the results of the screening to the EHR as they did in the past, so it is not obvious how the platform itself will resolve delays in access to the MAYSI-2 through the EHR.

five of the 17 youth, nor was there any explanation as to why the MAYSI-2 was missing.⁸⁰ Of the 12 available MAYSI-2 screens, the time between admission and the MAYSI-2 administration could not be determined for three of the 12 youth, as the time of MAYSI-2 administration was not indicated in the EHR. For the remaining nine youth, the MAYSI-2 screen was completed within between 48 minutes to six hours and 52 minutes; MAYSI-2s for seven of the nine youth were completed within three hours of admission.

Of the 12 youth for whom a MAYSI-2 was available, two youth scored positive in the Thought Disorder domain, and thus should have received a telephone consultation and a face-to-face consultation within 18 hours of the MAYSI-2 administration. No youth flagged a caution or warning for suicidality. For one youth who flagged a caution in the Thought Disorder domain, both a telephone consultation and face-to-face consultation were completed within the required timeframes.⁸¹ However, in the second case,⁸² a face-to-face consultation was completed within 18 hours of the MAYSI-2 administration but there was no evidence in the record that an earlier telephone consultation occurred. In both cases, the face-to-face consultation included a review of the MAYSI-2 results and a behavioral health assessment of the youth. The QMHP completing the face-to-face consultations found no evidence of thought disorder in either youth.⁸³

2. Substance Abuse Screening and Assessment

Performance Standard #2: Youth who score a caution or warning on the substance abuse scale of the MAYSI-2 shall promptly be screened using the GAIN-Q screening and assessment.

⁸⁰ In all five records where the MAYSI-2 is missing, notes in the record reference that the MAYSI-2 was completed, but the MAYSI-2 documents were not located in the record. In its comments on the draft version of this report, DYRS states that the agency “recognizes that certain documentation – particularly historical MAYSI-2 results and early behavioral health plans – were not readily retrievable due to legacy software and backlog in electronic health record (EHR) uploads. Corrective actions are in place to resolve these gaps, including EHR integration and workflow modernization.” Attachment 3 at page 1. The specific corrective actions that are in place were not described, other than the MAYSI-2 is now completed online.

⁸¹ Attachment 2 at page 3 and footnote 4.

⁸² *Id.* at footnote 5.

⁸³ *Id.* at page 4.

As noted above, DYRS policy requires that youth who flag on the substance abuse scale of the MAYSI-2 be further assessed using the GAIN-Q (or other empirically validated substance abuse screening tool) within five days of admission. Of the 12 youth in the sample for whom a MAYSI-2 was available, one youth flagged a caution for alcohol/drugs.⁸⁴ No GAIN-Q or equivalent assessment was evident in the record for this youth.⁸⁵ In their comments on the draft version of this report, DYRS states that the agency “has embedded the GAIN-SS into the behavioral health intake process and added the CRAFFT tool in the medial assessments, ensuring universal substance use screening.”⁸⁶ Historically, the GAIN-Q was intended to be included in DYRS’s intake screening process, but frequently was not. It will be important to assess administration practices with respect to the two more recently adopted screening instruments.

While none of the other 11 youth for whom a MAYSI-2 was available flagged on the Alcohol/Drug portion of the assessment, independent evaluations completed by psychiatrists or psychologists for seven of these 11 youth cited evidence of the youths’ alcohol or drug use, and thus the independent evaluators recommended GAIN-Q or similar targeted substance abuse assessments for each of these seven youth.⁸⁷ Despite these recommendations, there was no

⁸⁴ *Id.* (EP).

⁸⁵ *Id.*

⁸⁶ Attachment 3 at page 2. According to the GAIN Coordinating Center, the GAIN- SS is “a screener to be used in general populations to quickly and accurately identify clients who would be flagged as having one or more behavioral health disorders on the GAIN-I.” The GAIN-SS is a more abbreviated screening tool than the GAIN-Q. See <https://gaincc.org/instruments/>. According to the Center for Adolescent Behavioral Health Research, which now manages the instrument, the CRAFFT “is an efficient and effective health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21.” See <https://craftt.org/about-the-craftt/>.

⁸⁷ Attachment 2 at page 4 and footnote 8. Independent psychiatric and/or psychological evaluations for 16 of the 17 youth in the sample had been completed prior to their admission to DYRS facilities and were available to DYRS staff at the time of their admissions to DYRS. See pages 16-17 for additional information regarding the independent evaluations.

evidence that any formal substance abuse assessment occurred for any of these seven youth.⁸⁸ In addition, independent evaluators recommended targeted substance abuse assessments for two additional youth for whom a MAYSI-2 could not be located in the EHR, but neither of these youth received the recommended assessments.⁸⁹ Thus of the 17 youth in the sample, 15 had identified substance use histories prior to admission to New Beginnings, 10 of these youth were recommended for substance use assessments, and none received them.

B. Assessments, Problem Lists, Treatment Plan Development, and Treatment Services

In general, the standard of care requires completion of initial and ongoing behavioral health assessments to identify a youth's behavioral health needs. The assessments should result in the development of problem lists for the youth, which in turn drive the development of treatment plans and treatment services. Assessments should include "[an] interview [of] the youth, contact [with] family to obtain additional information and corroborate information provided by the youth during the interview, ... review [of] available prior assessments, independent evaluations, and treatment records"⁹⁰ and lead to the creation of an all-inclusive problem list. The purpose of the problem list is to organize treatment and ensure all relevant issues are being treated; "[t]hey provide a summary of the results of the clinical assessments and support the development of a clinical formulation and treatment plan."⁹¹

⁸⁸ The recommendations by the independent evaluators specified that a substance abuse assessment, not simply a screening be conducted. The GAIN-SS is a short screening tool that is used to identify an individual who made need further assessment and is not a full assessment. For these seven youth, substance abuse *assessments* were specifically recommended by the independent evaluators due to the youth substance use diagnoses.

⁸⁹ Attachment 2 at page 4 and footnote 9. Finally, substance use was noted in independent evaluations for five youth in the sample, but further substance abuse assessments were not recommended for these five youth by the independent evaluators. *Id.*

⁹⁰ Attachment 2 at page 4. "A behavioral health assessment should include an assessment of symptoms, biopsychosocial history, history of treatment, level of impairment, substance use, medication usage, and suicidal risk." *Id.*

⁹¹ *Id.*

Written treatment plans should be developed for all youth. As noted by Dr. Lee in his report, the “treatment plan should reflect a comprehensive, individualized plan that addresses those needs identified during the assessment process and take into consideration the youth’s strengths, intellectual functioning, and legal circumstances.”⁹² The plan should include specific goals, objectives, and interventions, and include specific details on the frequency of treatment, the name of the treatment provider, and timeframes for meeting the goals and objectives.⁹³

1. Assessments, Problem Lists, and Treatment Plans

*Performance Standard #3: Youth at New Beginnings with behavioral health needs revealed by the assessments shall have a problem list entry that is updated as indicated for each behavioral health need that is addressed in the youth’s treatment plan.*⁹⁴

In evaluating whether DYRS was meeting the standard of care relating to completion of assessments and development of problem lists and treatment plans, Dr. Lee considered the following criteria:

- Whether all behavioral health needs revealed through the MAYSI-2, clinical assessments preceding and during the youth’s admission to New Beginnings, and reported behavior at New Beginnings were identified and addressed in the behavioral health assessments at New Beginnings;
- Whether the problem lists in the EHR included a problem list entry for every behavioral health need revealed by the assessments (including those that should have been identified but were not);
- Whether the problem list was updated as clinically appropriate; and
- Whether every problem was addressed in the youth’s treatment plan and included interventions appropriate to the problem, objectives and goals.⁹⁵

⁹² *Id.* at pages 4-5.

⁹³ *Id.*

⁹⁴ This performance standard reflects the standard of care and Goal V.A.1.c.i. from the Jerry M Work Plan, another requirement which was not met at the time of the dismissal of the Jerry M. case and thus monitored by OIJFO.

⁹⁵ Attachment 2 at page 5.

As explained below, DYRS did not meet these standards in completion of assessments or in the development of problem lists and treatment plans.

Dr. Lee's review of the behavioral health records for the 17 youth in the sample found that for 16 of the 17 youth, some behavioral health problems revealed through screenings and assessments were not identified at New Beginnings, or, if identified, were not added to the problem list. He also found that problem lists were not always updated as new problems developed or were resolved. His review identified several issues that arose on a somewhat consistent basis in the sampled cases.

First, Dr. Lee noted that assessments, problem lists, and treatment plans completed at New Beginnings often failed to include diagnoses, problems, and treatment recommendations made by independent evaluators, or if considered and rejected by DYRS behavioral health staff, why staff concluded that those diagnoses, problems, and treatment recommendations were no longer applicable to the youth. Specifically, for 16 of the 17 youth in the sample, independent evaluations had been ordered by the courts prior to the youth's DYRS admission and "reflected thorough and extensive assessments"⁹⁶ which included psychological and psychiatric evaluations, psycho-educational testing, interviews with the youth and collateral sources such as family and probation officers, and review of prior assessments, court records, social histories, and educational records. The evaluations provided both diagnostic and treatment recommendations and were a valuable resource available to DYRS staff at the time of the youth's admission.⁹⁷

However, Dr. Lee found that in 15 of 16 of the sampled cases for which independent evaluations were completed, at least one diagnoses identified by an independent evaluator was

⁹⁶ *Id.* at page 5.

⁹⁷ The independent evaluations for the 16 youth were maintained in DYRS' FAMCare system.

either not identified at New Beginnings or not included on the problem list.⁹⁸ Trauma was not included on problem lists (or only added well after trauma symptoms presented) in seven cases despite information in the independent evaluations noting an extensive trauma history and symptoms of trauma.⁹⁹ Conduct Disorder or Depressive Disorders were diagnosed by independent evaluators for eight youth in the sample, but were not added to the problem list.¹⁰⁰ In addition, Dr. Lee noted that delinquent behaviors and repeated high-risk behaviors occurring at New Beginnings were not added to problem lists in ten cases.¹⁰¹ He also noted parent-child relational issues were identified by independent evaluators in ten cases, but never added to problem lists.¹⁰² Finally, substance use disorders were missing from the problem lists of four youth, and the problem lists relating to 14 youth should have included low cognitive functioning or learning disorders but did not.¹⁰³

In six cases, problem lists were updated during the youths' admission to New Beginnings to add new problems although updates in these cases were not always timely or comprehensive. Specifically, in two cases,¹⁰⁴ Disruptive Mood Dysregulation Disorder (DMDD) was added to the problem lists although in one of these two case, the problem list was updated just days prior to the youth's discharge from New Beginnings.¹⁰⁵ In two others, Post-Traumatic Stress Disorder (PTSD) was added to the problem lists during the youths' admissions; in one of these cases

⁹⁸ *Id.* at pages 5-6 and footnote 14.

⁹⁹ *Id.* at page 6 and footnote 15.

¹⁰⁰ *Id.* at page 6 and footnote 16.

¹⁰¹ *Id.* at page 6 and footnote 17.

¹⁰² *Id.* at page 6 and footnote 18.

¹⁰³ *Id.* at page 6 and footnotes 19-20.

¹⁰⁴ KB and CW. In KB's case the diagnosis was included in the independent psychiatric evaluation completed prior to admission but was not formally added to the problem list until seven months after his admission. In CW's case, the new problem (added diagnosis) was added just before the youth's discharge.

¹⁰⁵ CW. There were no independent evaluations completed for this youth prior to the reviewed admission.

PTSD was only added approximately 10 months after admission.¹⁰⁶ In a fifth case, while Depressive Disorder and Trauma were not added to the problem list despite these problems having been identified in the independent evaluations, although the problem list was updated to reflect that a previously identified problem – noncompliance with medication – was resolved.¹⁰⁷ Finally, in a sixth case, the problem list was updated following an incident of self-injurious behavior.¹⁰⁸

These deficits in creating and maintaining a comprehensive problem list translated into gaps in the treatment plans for youths in the sample. One youth had no treatment plan developed by New Beginnings until six months after admission,¹⁰⁹ another had only one treatment plan in a 13-month span,¹¹⁰ and some plans lacked any interventions to address problems that were on the problem list.¹¹¹ Dr. Lee found that treatment plans for 13 of 17 youth in the sample failed to adequately address disruptive behaviors, trauma-related symptoms, cognitive and learning concerns, or substance use disorders.¹¹² Family involvement in treatment planning and treatment services was minimal and treatment plans often lacked detail as to the specific interventions to be provided, the staff who was to provide the treatment, or the frequency of treatment.¹¹³ For 11 youth, treatment recommendations or recommended follow up assessments made by independent

¹⁰⁶ DB and DW. In DB's case, PTSD was added in July 2023, one month after admission and in DW's case, it was added 10 months after admission. In addition, for DW, DMMD and Conduct Disorder were identified by both the independent psychiatric and psychological evaluators but were never added to the problem list.

¹⁰⁷ MW.

¹⁰⁸ JHE.

¹⁰⁹ CW. Attachment 2 at page 6 and footnote 21.

¹¹⁰ JHA.

¹¹¹ See, e.g., EP, JHA, and DW (four treatment plans located in EHR, only the last had interventions specified for each problem on the problem list).

¹¹² *Id.* at page 6 and footnote 22.

¹¹³ *Id.* Dr. Lee notes “[m]ost treatment plans included generic statements such as ‘referral to psychiatry,’ ‘psychiatric follow up,’ ‘substance abuse education,’ ‘individual therapy,’ and ‘psycho-educational groups’ but specific groups or treatment interventions were not detailed in the treatment plans.” *Id.* at pages 6-7. The names of the specific psycho-educational groups or substance use groups were not specified in the treatment plans nor were the days and times of the groups or providers included in the plans.

evaluators were not included in treatment plans;¹¹⁴ this was prevalent with respect to family therapy.¹¹⁵ Indeed, in two cases, individual therapy was included in a treatment plan despite the fact independent evaluators recommended against it due to the youth's low verbal functioning.¹¹⁶ Notably, in none of the sampled cases did the youths' record reflect that New Beginnings staff considered the recommendations by the independent evaluator but decided against the implementation for an articulated reason. Finally, Dr. Lee found that in some cases, without any explanation or apparent rationale, updated treatment plans no longer addressed a problem which had been addressed in a previous treatment plan and remained on the problem list or that treatment services were being provided but were not linked to a problem on the treatment plan.¹¹⁷

The written treatment plans in most cases also lacked specificity as to the specific treatment to be provided, the provider who was to provide the treatment, and the frequency of services. In general, a treatment plan should be individualized and consider the youth's strengths, intellectual functioning, and legal circumstances.¹¹⁸ It should reflect input from the entire treatment team, the youth, and family.¹¹⁹ It should inform the staff and the youth of the specific treatment goals, objectives, and interventions for the youth, and identify staff responsible for the intervention and specific frequency for the intervention and should be updated regularly.¹²⁰ In other words, it should serve as a calendar for the team and the youth.

¹¹⁴ *Id.* at page 7 and footnote 26.

¹¹⁵ *Id.* at page 7. Family therapy was specifically recommended in 11 cases (KB, DB, JB, MB, KD, JHA, KK, RM, DW, RW, and MW) but not included in the youths' treatment plans.

¹¹⁶ *Id.* In KB's case, the independent evaluator noted that the youth's difficulty with verbal expression warranted against use of individual therapy, yet it was included in the youth's treatment plan; in KD's case, the independent evaluator recommended art or recreational therapy, therapies that are active and goal-oriented rather than traditional talk therapy.

¹¹⁷ *Id.* at page 8 and footnote 28.

¹¹⁸ *Id.* at pages 4-5.

¹¹⁹ *Id.* at page 5.

¹²⁰ *Id.*

These standards were not met for most treatment plans reviewed. For example, in a number of cases there were no specific interventions for identified problems.¹²¹ In others, substance abuse treatment listed in the treatment plan was generically described as “substance abuse education,” but the specific groups, name of provider, or substance abuse education model to be used was not identified.¹²² In virtually all cases involving the provision of group therapies, the treatment plans include a generic reference to psycho-education groups, but the name of the particular group for the youth, the day and time of the group, and the provider were not specified.¹²³ Frequency of group therapies was usually only vaguely referenced in treatments plans; for example, in some plans the frequency of psycho-educational groups was indicated as “1-4 times weekly,” and thus how often and when a particular group was to be provided was unable to be determined.¹²⁴ In several cases, the treatment plan provided for group therapies “as permitted,” suggesting that the youth’s attendance at group therapies required specific approval.¹²⁵ Several treatment plans also were altogether missing,¹²⁶ not updated regularly¹²⁷ or had the same interventions for every problem addressed in the plan.¹²⁸ Finally, plans often did not change despite the youth’s minimal documented progress.¹²⁹

As previously noted, in comments on the draft version of this report DYRS stated that the success plans completed for youth at New Beginnings consistently refer to and incorporate the

¹²¹ *Id.* at page 7 and footnote 25. *See, e.g.*, KB, MB, JL, RM, EP, CW, and DW.

¹²² *See, e.g.*, KB, JE, JHE, KK, JL, RM, CW, RW, and MW.

¹²³ *See, e.g.*, KB, MB, JB, KD, JE, JHA, JHE, KK, JL, CW, RW, and MW.

¹²⁴ *See, e.g.*, KB (psycho-ed groups 1-5x weekly), KD (psycho-ed groups 1-4x weekly), and JHA (psych-ed groups at least weekly).

¹²⁵ *See, e.g.*, JL, RM, and DW. In another case, the frequency of the treatment intervention (for substance abuse) was described in the treatment plan “as needed” or “as recommended.” KK, JL, and RM.

¹²⁶ *See, e.g.*, JHA and DW.

¹²⁷ *See, e.g.*, DB, JB, JHA, and CW.

¹²⁸ *See, e.g.*, DB, JB, BM, CW, RW, MW, KD, and KK.

¹²⁹ *See, e.g.*, KD, JE, JHA, JB, JE, and KK. In none of the sampled cases were treatment plan documents updated because of high-risk behavior despite multiple referrals to behavioral health. *See* pages 54-55.

diagnostic and treatment recommendations included in the independent evaluations.¹³⁰

However, a review of the success plans completed for youth in the sample indicates that this is not the case. First, success plans could not be located in FAMCare for the reviewed admissions for two of the youth in the sample,¹³¹ and in none of the success plans for the remaining 13 youth was a specific reference to an independent evaluation found.¹³² While some of the success plans for a few youth identify “goals” reflecting an issue that was identified in an independent evaluation,¹³³ success plans did not include “goals” for *all* of problems identified in the independent evaluations, and the “action plans” in the success plans did not consistently incorporate the specific *treatment* recommendations made by the independent evaluators.¹³⁴

2. Treatment Services

Performance Standard #4: Youth shall receive behavioral health services consistent with the service needs identified in their initial and updated behavioral health screenings and assessments and treatment plans.¹³⁵

The standard of care requires the delivery of individualized treatment services that are tailored to a youth’s needs and intellectual functioning. Further, treatment should be adapted based upon the youth’s response to treatment, or lack thereof, and support the treatment goals of transitioning the youth to the next setting, whether it be a group home, family, or some other

¹³⁰ Attachment 3 at page 2. In its comments on the draft report, DYRS states that “[i]ndependent evaluations are consistently referenced in each youth’s NB Success Plan, which integrates diagnostic and treatment recommendations into individualized programming.”

¹³¹ EP and MB.

¹³² BM (one success plan), DB (four success plans), DW (one success plan), JB (three success plans), JE (three success plans), JHA (two success plans), JHE (five success plans), JL (three success plans), KB (five success plans), KK (three success plans), MW (one success plan), RW (three success plans), and RM (one success plan). One youth (CW) was not evaluated by an independent evaluator for the reviewed admission. The FAMCare record of the remaining youth (KD) in the sample was locked for administrative purposes after the assessment began and a determination could not be made regarding whether this youth had a completed success plan.

¹³³ See, e.g., KK and JHE.

¹³⁴ See footnotes 99-118 and footnotes 145-153.

¹³⁵ This performance measure is consistent with Jerry M. Work Plan Goal V.A.5.b.i., which was not met prior to the dismissal of the Jerry M. lawsuit and thus was subject to review and reporting by the OIJFO.

setting.¹³⁶ Of particular importance to youth, unless specifically contraindicated family should be an active participant in treatment planning and treatment services.¹³⁷ As noted by Dr. Lee, the provision of treatment services should be documented in the record and include information concerning the youth's participation in and response to treatment.¹³⁸

Youth with behavioral health-related symptoms also should be assessed by a psychiatrist and provided appropriate treatment and support, which could include medication (with the youth's and parental consent), as well as supportive therapies.¹³⁹ The frequency of psychiatric follow up is dependent on the youth's response to treatment and whether the youth is stabilized. Psychiatric services should be documented and problem lists updated as problems resolve or new problems are identified.¹⁴⁰ For purposes of this report, the OIJFO analyzed documented treatment services provided by the psychiatrist separately from that provided in groups or by individual therapists.

a. Group and Individual Therapy Services

For all 17 youth in the sample, treatment services in their behavioral health treatment plans included group and individual therapies and assessment and treatment by a psychiatrist. Dr. Lee found in his review of the records that treatment plans for youth in the sample *did not* reflect "appropriately tailored treatment interventions," and that youth were receiving "insufficient treatment for a variety of problems, such as substance abuse, disruptive behavior disorders, conduct disorders, including firearm- and carjacking-related behaviors and trauma-

¹³⁶ Attachment 2 at page 7.

¹³⁷ *Id.*

¹³⁸ *Id.* Dr. Lee indicated that to meet the standard of care, all behavioral health problems must be included on the youth's problem list and addressed in his treatment plan, and the youth must be provided with behavioral health services consistent with his evident behavioral health needs. *Id.* at page 8.

¹³⁹ *Id.* at page 7.

¹⁴⁰ *Id.*

related symptoms.”¹⁴¹ Consequently, Dr. Lee concluded that, none of the youth were provided with services to address *all* of their behavioral health needs.¹⁴² However, as explained more fully below, all of the youth in the sample were provided appropriate psychiatric services, including medication management.

Dr. Lee identified several areas of particular concern relative to treatment services. First, he concluded that substance use or disorders “were not treated or addressed in a manner that would be expected to reduce or address youth substance use in the community.”¹⁴³ Specifically, Dr. Lee found that while 15 of 17 youth in the sample had substance use identified either prior to admission or while at New Beginnings, 11 youth (73 percent) did not have evidenced-based substance use treatment group sessions documented in the EHR.¹⁴⁴ In reaching this opinion, Dr. Lee also noted as follows:

- None of the youth in the sample received a GAIN-Q or other specific substance abuse assessment to identify the scope of the youth’s substance abuse, amenability to treatment, or the kind of treatment most likely to positively impact substance use.
- There was a lack of evidenced-based substance abuse services in New Beginnings.
- Available substance use services were minimal in breadth and depth and not tailored to the youth’s needs.
- There were no documented individualized relapse prevention plans.
- There was inadequate opportunity for youth at New Beginnings to practice the skills that the youth could use in the community.

¹⁴¹ *Id.* at page 8.

¹⁴² The treatment plans for all 17 youth in the sample provided for individual therapy services, generally on a weekly basis. Individual therapy notes were found for each youth and documented youth’s participation in or refusal of individual therapy. Similar themes were found in therapy notes across all youth, including counseling on use of self-control skill, discussions around substance use, and addressing issues around trauma and grief. There is evidence that while youth are at New Beginnings some have continued to engage in illicit drug use. *See, e.g.*, Incident Report (IR) No. 14202 (one youth test positive for heroin metabolite), IR No. 15393 (one youth tests positive for amphetamine and cannabis), IR No. 15394 (one youth tests positive for cannabinoids), IR No. 14074 (two youth test positive for cannabinoids), and IR No. 14201 (four youth test positive for fentanyl). Additionally, incident reports at the facility document youth either altering their urinalysis specimen (IR No. 14656), or refuse urinalysis, which the agency tracks as a positive test (IR Nos. 14059, 14184, 14406, 15165, 16719, 16720, 17034, 17035, 17957, and 17958).

¹⁴³ *Id.* at page 8.

¹⁴⁴ *Id.* at page 9 (MB, JB, KD, JE, JHA, JHE, KK, JL, BM, RM, EP, DW, CW, and MW)

- There were no evident discussions of risk and protective factors in the multiple domains known to influence substance use such as peer relations, family dynamics and leisure activities.¹⁴⁵

The treatment for the four youth that received substance use therapies was minimal at best; Dr. Lee reports that, according to the EHRs, one youth attended nine substance use group sessions, one attended one substance use group, one attended three substance use groups, and one attended six substance use groups.¹⁴⁶ He further opined that “[t]he group activities, such as watching videos then discussing, coupled with other documented substance use and mental health and treatment activities, would not be expected to effectively address substance use behaviors post-release.”¹⁴⁷ He also notes that there was inadequate parent/caregiver education of potential strategies for them to use to address the youths’ substance use post-release, and that use of proven therapies such as multi-dimensional family therapy and functional family therapy to address substance use was not evident in the records.¹⁴⁸

Dr. Lee also found that “treatment for disruptive behavior was ineffective in producing meaningful short-or long-term improvements.”¹⁴⁹ Specifically while Dr. Lee noted that New Beginnings staff met or attempted to meet with youth weekly or every two weeks, the frequency was insufficient to generalize any treatment gains once the youth returned to the community. He stated, “youth must frequently practice skills in settings and situations more similar to their post-release environments; this was not evidenced in the records reviewed.”¹⁵⁰ Dr. Lee observed that the limited time youth spent directly in therapy was insufficient to effect meaningful change and that time spent outside of therapy should be used as additional opportunities for rehabilitation

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* MB (9 attended nine substance abuse groups), EP (attended one substance abuse group), RW (attended three substance abuse groups), and MW (six substance abuse groups).

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

and meaningful behavioral change. He commented “[t]he differences between the NB environment and the communities to which a youth will return limit opportunities for developing skills youth will need post-release. In addition, the use of restrictive programming, including room and unit confinement, imposes external controls and inhibits self-regulation skill development which will be needed once the youth is released.”¹⁵¹ Dr. Lee found that while some treatment notes reflect discussion, teaching, and the practice of specific skills during the sessions, the records evidenced few references to youth actually using those skills (or addressing barriers to a youth’s using the skills) between sessions including after high-risk behaviors. He noted “[t]here was no observable evidence of coaching skills in the moment in the NB milieu, particularly when a youth exhibited negative behaviors, behavioral or emotion dysregulation, or was involved in conflict with peers or staff.”¹⁵²

It is noteworthy that documentation of the specific nature and goals for group treatments was lacking in many cases and thus it is unclear what opportunities were presented during groups for learning self-regulation skills. For 14 of 17 youth, there were noticeable gaps in the completion of group notes in the EHR, and when group notes were completed they often were not particularly informative of the specific treatment provided in the group sessions or the youth’s response to the group treatment.¹⁵³ Presumably treatment was occurring during these

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ For example, for KB only one group note for his entire 15-month admission was found in the record; MB, only one group note for the first seven months of his admission was found in the record; DB, no group notes were found for two of seven months of his admission; JB, no group notes between August 2023 - December 2023 and February 2024 to June 2024 were found in the record; JE, no group notes in April 2023 and from August 2023 - March 2024 were found in the record; JHA, no group notes between March 2024 and June 2024 were located in the record; JHE, no group notes from August 2023 to his May 2024 discharge were found in the record; KK, no group notes between September 2023 through November 2023 were located in the record; JL, no group notes for January 2024, July 2024, and August 2024 - January 2025 were found in the record; BM, no group notes for April 2023, July 2023, January 2024, July 2024, and August 2024 - January 2025 were found in the record; RM, no group notes for March 2024 to April 2024 were found in the record; EP, no group notes at all were located in the record; DW, no group notes from March 2024 to July 2024 were located in the record; RW, no group notes from March 2023 to June 2023

undocumented periods, but the extent, type, and youth's response to the treatment is not clear from the records as required by the standard of care.

Dr. Lee also concluded that there was insufficient involvement of family in the youths' treatment.¹⁵⁴ Family therapy or other family involvement in a youth's treatment was specifically recommended for 13 of the 16 youth for whom independent evaluations were completed.¹⁵⁵ Yet the records for any of these 13 youth did not evidence regular family involvement in treatment. Further, a review of the records relating to 13 youth who had been discharged as of the time of Dr. Lee's review, documentation in the EHR reflects that families for only four of the youth received a call from the therapist within one to two months of the youth's discharge and typically only one call was made.¹⁵⁶ According to Dr. Lee, the "lack of communication means that families missed out on learning strategies for supporting their children and addressing family dynamics that reduce recidivism and substance use."¹⁵⁷

Finally, Dr. Lee found that treatment services (and treatment plans) were rarely modified due to lack of the youth's progress or engagement,¹⁵⁸ treatment services were not consistently individualized to reflect the youth's strengths and needs, and that there was no evidence in the records that group curricula were adjusted to account for youths' cognitive functioning and

were located in the record; and MW, no group notes from May 2024 - July 2024 were found in the record. *Id.* There were, in some cases, notes in FAMCare that were completed by non-behavioral health staff, but those notes did not address clinical issues and progress related thereto.

¹⁵⁴ *Id.* at page 9.

¹⁵⁵ KB, MB, JB, KD, JE, JHA, KK, JL, RM, EP, DW, RW, and MW. As Dr. Lee notes in his report, "[p]arent/caregiver involvement is central to many effective treatments for adolescent disruptive behavior and substance use." *Id.* at pages 9-10 and footnote 33.

¹⁵⁶ KB (one call to family prior to discharge), JHA (two calls to family prior to discharge), BM (one call to family prior to discharge), and MW BM (one call to family prior to discharge).

¹⁵⁷ *Id.* at page 10. In several cases (KD, RM, and EP), independent evaluators diagnosed a youth with Parent/Child Relational Disorder, but this was not added to problem list or referenced in the treatment plan nor were appropriate related services provided to the families.

¹⁵⁸ *Id.* For example, in the JB, DB, and MB cases, medication compliance was identified as an issue, and the psychiatrist recommended incentivizing medication compliance in each case. There is no evidence, however, that the treatment plan was updated or that this recommendation was implemented.

learning concerns.¹⁵⁹ In some cases, problem lists did not include references to cognitive functioning or learning concerns despite the availability of the relevant diagnoses to support addressing the problem in the treatment plan.¹⁶⁰ In others, interventions specified in the treatment plans were inconsistent with the known cognitive limitations of a youth. For example, the independent evaluators for two youths specifically recommended *against* use of traditional talk therapy due to the youths' impairment in verbal expression and instead recommended use of "active and goal-oriented therapy" such as art or recreational therapies, yet their treatment plan interventions included individual talk therapy.¹⁶¹ One facility manager informed OIJFO staff that at times they have to modify the assessment process for youth petitioning for the next level on their success plan because the youth do not understand the scoring, a vital part of the behavior modification program.¹⁶²

b. Psychiatric Services

Performance Standard #5: For youth on psychotropic medication, conduct weekly psychiatric assessments until the youth have been stabilized, and thereafter, the psychiatric assessments shall be conducted as clinically indicated.

All 17 youth in the sample were prescribed psychotropic medication for at least some period during their admission at New Beginnings. Dr. Lee reviewed each case to assess whether these youth were seen weekly until stabilized and then seen periodically thereafter as clinically

¹⁵⁹ *Id.*

¹⁶⁰ *See, e.g.,* JB, JHA, JHE, KK, BM, RM, and DW. In each of these cases, independent evaluators detailed cognitive deficits identified during their evaluations but these were not incorporated into written treatment plans and there was no evidence programming was modified in recognition of the youth's needs. Attachment 2 at page 8.

¹⁶¹ *See, e.g.,* KD and KB.

¹⁶² In its response to the draft version of this report, DYRS "agrees that increased clarity in documenting group modalities and individualized adaptations is needed" but seems to suggest that changes to youths' success plans so that they now include specific group enrollment references combined with additional training on SMART goal documentation address the issues identified by Dr. Lee and described above. Attachment 3 at page 2. However, this does not address Dr. Lee's concerns that treatment services are not individualized to the youth. Rather, it appears that each youth must complete the same programming regardless of his or her needs and regardless of the youths' level of intellectual functioning.

indicated.¹⁶³ Dr. Lee concluded that each youth “received proper psychiatric treatment, which included appropriate initial and follow-up care, and assessments of symptoms, medication effectiveness, and side effects.”¹⁶⁴ He also found that each youth received psychiatric education, was provided informed consent, and was seen at appropriate intervals, including through rescheduled appointments missed due to a youth’s refusal to be seen.¹⁶⁵

In each of the 17 reviewed cases, Dr. Lee found that the record indicated a clinical basis for each medication prescribed and, as applicable, for any changes to medication, dosage, frequency or timing of the medication administration.¹⁶⁶ The treating psychiatrist was responsive to concerns expressed by youth concerning a particular medication. For example, when youth complained that the medication made them drowsy during the day, the psychiatrist adjusted the timing of medication administration.¹⁶⁷ Similarly the records evidenced a concerted effort by the psychiatrist to address concerns expressed by the youth and/or family relating to a particular medication or dosage or medication noncompliance.¹⁶⁸ In all 17 cases reviewed,

¹⁶³ Dr. Lee’s review did not include a review of whether DYRS was completing required baseline and follow-up monitoring of the use of psychotropic medication required by DYRS’ Medication Management Policy and PMMP. This was previously reviewed by the OIJFO and reported on in both 2023 and 2024. Comprehensive Medical Assessments, First Dose Administration, and Psychotropic Medication Management at the Youth Services Center and New Beginnings Development Center, February 16, 2023 (February 2023 Report), at pages 35-48, and July 2024 Report. During each review, the OIJFO found that some but not all, of the required baseline and follow-up tests were completed at the intervals required by policy and the PMMP. OIJFO noted in its 2024 Report, “[o]verall, there remain gaps in implementing these standards. As in prior reviews, blood tests relating to thyroid, lipids, and pregnancy continue to be missed, and completion of AIMS tests or documentation of specific observations relating to abnormal movements continues to be problematic.” July 2024 Report at page 26. At that time, while OIJFO noted that it appeared that DYRS was completing a review of its Medication Management Policy, it reiterated its previous recommendation that DYRS complete a review of the PMMP, noting it “[was] now six years old and standards may well have changed.” *Id.* Additionally, DYRS provided an updated PMMP to the OIJFO in September 2025. OIJFO has not had an opportunity to have its psychiatric expert review the revisions but notes that its preliminary review suggests the index at the end of the PMMP may not have been fully updated to reflect the changes in the updated PMMP.

¹⁶⁴ Attachment 2 at page 10.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *See, e.g.,* JHE, BM, and CW.

¹⁶⁸ *See, e.g.,* JB (added medication for sleep); JE (tried several medications for sleep; adjusted other meds based on symptoms); JHA (increased dosage based on behavior); JHE (medication adjusted); KK (medication adjusted due to side effects); RM (medication for sleeplessness); and RW (medication adjusted for sleep and for behavior).

psychiatric follow-up occurred weekly until a youth was stabilized and after any changes to medication or dosage; thereafter the youth was seen as clinically appropriate. In most,¹⁶⁹ but not all cases,¹⁷⁰ documentation by the psychiatrist referenced behavioral issues that occurred between psychiatric assessments. Finally, appropriate supplemental testing such as sleep studies¹⁷¹ or Vanderbilt studies¹⁷² were ordered by the psychiatrist, and as previously noted, recommendations for incentives to improve medication compliance were made.¹⁷³

C. Acute or Emergency Services

1. Assessments of Youth with Acute or Emergent Needs

Performance Standard #6: Youth with acute or emergent mental health needs (e.g., suicidality or thought disorder) should be assessed by a QMHP within one hour of referral to a qualified behavioral health provider.¹⁷⁴

This standard ensures that youth who evidence an acute or emergent mental health need are assessed by a qualified behavioral health provider within one hour of referral. This is intended to safeguard youth who may pose an imminent risk to self or others by providing an expedited examination so that immediate treatment or referral for inpatient psychiatric treatment as appropriate can be implemented.¹⁷⁵

Based upon Dr. Lee's review, two of the 17 youth in the sample evidenced acute or emergency mental health needs during the review period, and 15 did not. Both youth were referred to a behavioral health professional and the examinations were completed within one hour of the referral. In one case, the youth had made suicide threats and was placed on suicide

¹⁶⁹ See, e.g., DB, JB, JHA, and CW.

¹⁷⁰ See, e.g., KB and KD.

¹⁷¹ See, e.g., MB, KD, JHE, JL, EP, and DW.

¹⁷² EP.

¹⁷³ See footnotes 158 and 200.

¹⁷⁴ This performance measure corresponds to Jerry M. Work Plan Goal V.A.3.a.i., which had not been met at the time the Jerry M. lawsuit was settled and dismissed.

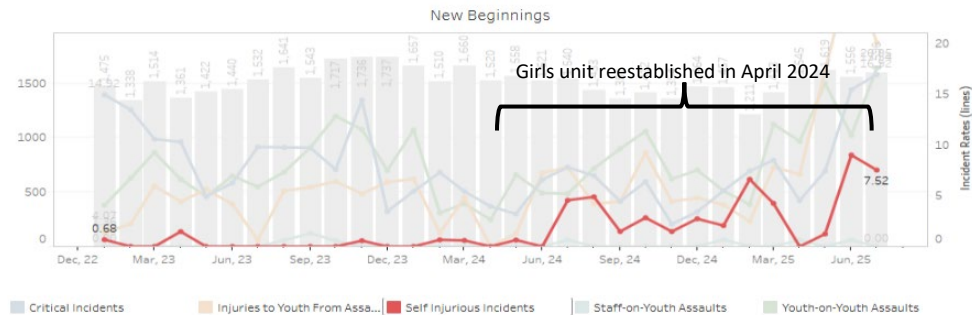
¹⁷⁵ Attachment 2 at page 11 and footnote 41.

precaution status for a total of 16 days, first on SPS-1 and then stepped down to SPS-2.¹⁷⁶ The second youth was also referred after making a suicide attempt,¹⁷⁷ was assessed within one hour of referral, and placed on suicide precaution status for a total of 13 days. Dr. Lee concluded that “[t]he assessments placing each youth on suicide precaution status were comprehensive and supported the decision of the clinician that a higher level of supervision was needed.”¹⁷⁸

2. Suicide Precaution Status

Observationally, self-injurious incidents at New Beginnings are highly correlated with gender. Historically girls at New Beginnings have engaged in self-injurious incidents at much higher rates than boys. The chart below documents the rate of self-injurious behavior at New Beginnings from January 2023 to July 2025 and illustrates the significant increase in the rate of self-injurious incidents after the girls unit opened in April 2024.

**Chart 5: Self-Injurious Incidents at New Beginnings
January 2023 – July 2025**



¹⁷⁶ *Id.*

¹⁷⁷ Incident Report No. 14248, February 11, 2025 (youth “began to experience a crisis”; he made threats to hurt himself and wrapped a strip of his shirt around his neck; while he continued to make threats to hurt himself, staff secured him and used a 911 rescue tool to remove his clothing for his safety).

¹⁷⁸ Attachment 2 at page 11 and footnote 42.

Performance Standard #7: A QMHP shall assess, supervise, and provide appropriate interventions to youth on suicide precaution status as clinically indicated.¹⁷⁹

OIJFO monitored the use of suicide precaution status (SPS) at New Beginnings in two phases. First, in early 2024, OIJFO reviewed records to determine whether staff at DYRS were meeting the supervision and documentation requirements of DYRS's Suicide Prevention Policy.¹⁸⁰ This review included six episodes of use of SPS for six youth at New Beginnings between September 1, 2022 to December 31, 2023. That review, the results of which are reflected in Table 1 below, which *did not* include a review of the clinical decision-making around use of SPS at New Beginnings, found that staff at New Beginnings met the supervision and documentation requirements for 15 of the 25 requirements¹⁸¹ in all six episodes reviewed; this compared with 19 of 26 during a prior 2020 review that the Special Arbiter conducted.¹⁸² Additionally, the 2024 review found that staff met 22 of 25 applicable requirements in at least 80 percent of the SPS episodes at New Beginnings.¹⁸³

¹⁷⁹ This performance measure corresponds to Jerry M Work Plan requirement V.A.3.e., which had not been met at the time the Jerry M. lawsuit was settled and dismissed.

¹⁸⁰ Attachment 9, Supervision of Youth on Suicide Precaution Status at the Youth Services Center and New Beginnings Youth Development Center, Office of Independent Juvenile Justice Facilities Oversight. This review included samples of youth placed on SPS at both the YSC and New Beginnings during 2023.

¹⁸¹ During this review, one of the 26 requirements (relating to notification of behavioral health staff if direct care staff noticed a change in a youth's behavioral while the youth is on SPS) was not applicable, as there were no cases during this review where such change was observed.

¹⁸² In 2020, the Special Arbiter completed an assessment of the practices around the use of suicide precaution status at YSC and New Beginnings. See The Special Arbiter's Abbreviated Report to the Court Regarding Defendants' Progress Toward Meeting Work Plan Requirements Related to Behavioral Health Services at the Youth Services Center and the New Beginnings Youth Development Center, filed June 15, 2020 (Special Arbiter's June 2020 Report).

¹⁸³ Attachment 9 at page 10. Areas where policy requirements were not met at New Beginnings included those related to the signing of observation monitoring forms by SYDRs, timely documentation of monitoring by staff every ten minutes when SPS-2 was used, and documentation of a face-to-face encounter when there was a change in SPS. *Id.* at pages 10-13.

Subsequently, because two of the 17 youth in the sample of records reviewed by Dr. Lee had episodes of SPS,¹⁸⁴ OIJFO requested that Dr. Lee complete a clinical review of the decisions to place the two youths on SPS, including the decision to use SPS for the youth, the level of SPS assigned, the quality of the clinical assessments while the youth was on SPS, and the decision to remove the youth from SPS.

Dr. Lee found “[t]he assessments placing each youth on suicide precaution status were comprehensive and supported the decision of the clinician that a higher level of supervision was needed.”¹⁸⁵ He noted that one youth who had evidenced suicidal thoughts was seen within one hour of referral and was placed on suicide precaution status for 16 days, closely monitored by staff. Likewise, the second youth¹⁸⁶ was also assessed within one hour of referral to behavioral health staff of evidencing an acute or emergent mental health need in two events, first a suicidal gesture and a subsequent suicide attempt.¹⁸⁷ As noted above, he also was placed on suicide precaution status and was closely monitored until removed from SPS.

Coincident with the clinical reviews in these two cases, OIJFO reviewed the additional episode of SPS involving a youth in the sample that was not previously reviewed for purposes of compliance with the policy’s monitoring and documentation requirements. These results are included in Table 1 below. The review found that documentation reflected the required Suicide Precaution Notification and Change Forms, development of a Special Management Plan with

¹⁸⁴ The two youth were included in the original supervision and monitoring review completed by OIJFO in early 2024 and described in Attachment 9. However, one of those youth had a second episode of SPS in February 2024 that was not reviewed as part of the prior review because it was outside of the report period. Because the 2024 review was limited to a review of compliance with the supervision and documentation requirements of the Policy and did not include an evaluation of the related clinical decision-making, OIJFO requested that Dr. Lee review the three episodes of SPS that occurred in 2023 and 2024 for these two youths in the sample. OIJFO then completed the supervision and documentation requirement review for this additional case; the findings are presented below.

¹⁸⁵ Attachment 2 at page 11.

¹⁸⁶ An earlier episode of SPS for this youth was included in the report found in Attachment 9.

¹⁸⁷ See footnote 177.

each of the six required elements, and completion of the required daily and post SPS follow up assessments. Additionally, monitoring forms were provided for each day the youth was on SPS. Each form included the date, time and activity of the youth, and documentation was completed at the intervals required based upon the youth’s SPS. Further there was documentation that a face-to-face encounter occurred when the youth was changed from SPS-1 to SPS-2. However, monitoring forms were signed by the supervisor as required by policy less than half the time.¹⁸⁸

TABLE 1: PERCENT OF REVIEWED CASES MEETING SELECT 2016 SUICIDE PREVENTION POLICY DOCUMENTATION REQUIREMENTS AT NEW BEGINNINGS SINCE 2020¹⁸⁹			
POLICY REQUIREMENT	2020 % Met (n=7)	2023 % Met (n=6)	2024 % Met (n=1¹⁹⁰)
SPS-1 Observation forms completed for entire SPS-1 episode	40	100	100
SPS-1 Observation forms signed by direct care and supervisor	100	0	0 ¹⁹¹
SPS-1 Observations documented 5 times per hour	40	100	100
SPS-2 Observations documented at least every ten minutes	43	50	100
Immediate notification of BH staff if direct care staff notice change in youth	100	n/a	n/a
BH staff assess youth at least once per day and document same in record	86	83	100
BH daily assessment includes evidence BH staff considered need for acute care	100	100	100
BH daily assessment reflects current behavior	100	100	100
BH daily assessment reflects changes in thoughts/behavior in last 24 hours	100	100	100
BH daily assessment reflects basis for continued level of observation	100	100	100
BH staff completed Suicide Precaution Notification Form	100	100	100
Record includes Special Management Plan	100	100	100
Special Management Plan was completed by BH staff	100	100	100
Special Management Plan reflects items to be removed from youth	100	100	100
Special Management Plan includes specific problem behaviors and issues	100	83	100
Special Management Plan identifies triggers and precipitants	100	83	100
Special Management Plan includes early warning signs and unsafe behaviors	100	83	100
Special Management Plan includes prevention and early intervention strategies	100	100	100
Special Management Plan includes crisis management strategies	100	83	100
Youth who had been on SPS-1 is on SPS-2 at least 24 hours before being taken off	100	100	100
Suicide Precaution form is used whenever SPS level is changed	86	100	100
Upon change of SPS level, change is documented in record	100	100	100

¹⁸⁸ In its comments on the draft version of this report DYRS states that the agency “confirms that SPS compliance is tracked through monthly CQI metrics. Each SPS case is reviewed at the facility’s behavioral health committee, with corrective action plans developed for deviations. Historical record review was not possible of the sampled youth due to EHR archiving limitations.” Attachment 3 at page 3. Historically, SPS monitoring forms, which are completed by YDR staff, were archived in youth FAMCare records rather than EHR records.

¹⁸⁹ Some policy requirements did not apply to each case reviewed. The audit findings in individual cases from the current review are not included with this report; however, they will be provided upon request.

¹⁹⁰ As noted above, two of the cases in the sample reviewed by Dr. Lee involved episodes of SPS); in one case the episode occurred in November 2023, and in the other case, SPS episodes occurred in January 2023 and in February 2024. Because the 2024 review was limited to a review of compliance with the supervision and documentation requirements of the Policy and did not include an evaluation of the related clinical decision-making, OIJFO requested that Dr. Lee review the three episodes of SPS that occurred in 2023 and 2024 for these two youths in the sample. However, because two of three episodes were already included in the 2023 review relating to supervision and documentation, only the episode from February 2024 was reviewed during the most recent evaluation.

¹⁹¹ Fourteen of 27 forms were not signed by the supervisor.

Upon change of SPS level, documentation reflects face-to-face encounter	20	0	100
Post SPS monitoring for five days	100	83	100
Post SPS monitoring weekly for two weeks	83	83	100
Post SPS monitoring monthly unless documentation supports discontinuation	100	100	100

3. Repeated Behaviors That Put Self or Others At Risk

Performance Standard #8: Behavioral health assessments of youth who engage in repeated self-injurious behavior, or any other type of repeated behavior which puts them, or others, at serious risk of harm shall be conducted. As indicated and appropriate, within 24 hours of such repeated behavior, management strategies aimed at reducing the risk of the identified behaviors shall be implemented consistent with the youth’s treatment plan, including any revisions to such plan resulting from the assessment.¹⁹²

This standard provides that youth who engage in repeated self-injurious behavior or other type of repeated behaviors that put them or others at serious risk of harm shall be assessed within 24 hours and that management strategies aimed at reducing the risk shall be implemented consistent with the youth’s treatment plan, including any revisions to the treatment plan resulting from the assessment. Sixteen of the 17 youth in the sample engaged in repeated high-risk behaviors that put themselves or others at risk, and one youth did not. The repeated high-risk behaviors involved self-injurious behaviors, assaults on staff, fights among youth, or significant damage to property.¹⁹³

The high-risk assessments completed for these 16 youth were reviewed by Dr. Lee. All 16 youth were referred to behavioral health staff and assessments were completed within 24

¹⁹² This performance standard incorporates several Jerry M. Work Plan requirements that had not been met at the time of the Jerry M. dismissal and thus are subject to monitoring by the OIJFO. These include Work Plan Goals V.A.5.c.i. and V.A.5.c.ii., providing in part whether documentation of the behavioral health assessment addressed the repeated self-injurious behaviors or behaviors that put others at serious risk or harm, and related symptoms and included a clinically-based theory for the behavior, whether the assessment resulted in a management plan that included specific and individualized strategies to reduce the risk of the high-risk behavior, whether the youth’s treatment plan was impacted by the results of the assessment, and finally whether the updated treatment plan was implemented.

¹⁹³ Attachment 2 at page 12.

hours for each referral.¹⁹⁴ Dr. Lee found that the assessments for five of the 16 youth addressed the repeated high-risk behaviors, the related symptoms and included a clinically-based theory for the behavior, but the assessments for 11 youth did not.¹⁹⁵ Dr. Lee found that “[s]ymptoms were not described nor was behavior linked to any problem on the problem list. The youth’s participation and engagement in treatment were not reviewed in these assessments.”¹⁹⁶ Dr. Lee found that while the youth’s explanation for the behavior was often included, there was no “*clinical* assessment of the behavior or the youth’s rationale for his actions.”¹⁹⁷

Indeed, Dr. Lee noted that plans which included specific and individualized management strategies to reduce the high-risk behavior were not found in any of the applicable 16 cases.¹⁹⁸ The case review found that documented strategies included advising the youth to use self-control skills¹⁹⁹ but there were no documented new *management* strategies identified for implementation by staff, and no updates to any of youths’ treatment plans.²⁰⁰ In none of the applicable records was there evidence that incentives were considered as strategy to reduce the high-risk behavior.

¹⁹⁴ *Id.* It is noteworthy that all 16 youth in the sample who engaged in repeated high-risk behavior were referred to behavioral health staff on multiple occasions. Specifically, KB was seen by behavioral health staff for high risk behavior on 21 different dates, MB on 11 dates, DB on 9 dates, JB on 16 dates, KD on 39 dates, JE on 5 dates, JHA on 9 dates, JHE on 6 dates, KK on 9 dates, JL on 30 dates, BM on 11 dates, RM on 14 dates, EP on 5 dates, DW on 15 dates, RW on 10 dates and MW on 10 dates. Assessments were completed on each occasion.

¹⁹⁵ *Id.* at page 12 and footnotes 44 and 45.

¹⁹⁶ *Id.* at page 12.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ This was described in notes as “stop, listen and walk-away” and was the strategy identified in each of the 16 cases. For one youth (KB), in a note relating to the first of the 21 referrals, a reference was made to use of a reward system/contingency contract to reinforce improved anger control, but there was no indication this was incorporated into the youth’s treatment plan or otherwise implemented.

²⁰⁰ *Id.* at pages 12-13. For a number of youth (KB, MB, DB, JB, JL, EP, CW, and RW) psychiatric notes referenced behavioral issues or medication compliance issues and medications were adjusted, but these medication-related issues were not referenced or identified in the behavioral assessments as possibly contributing to the behaviors, and no other changes to the treatment plans relating to group and individual therapies or creation of other management strategies such as incentive programs were found. In fact, the high-risk assessments for each of the 16 youth consistently noted that no changes to treatment plans were needed, despite the repeated high-risk referrals for each of the youths in the sample.

Performance Standard #9: A QMHP shall monitor youth, as clinically appropriate, following the determination that a youth at New Beginnings is in need of emergency psychiatric hospitalization until such time as the youth is transported out of the facility.

There were no individuals in the sample to which this standard was applicable, and thus no conclusions can be made.

VI. CONCLUSION

As the sole secure facility operated by DYRS for committed youth, New Beginnings serves a vital role in the agency's array of placement options. According to facility managers, New Beginnings is used for youth with the most serious charges and behavioral health needs, often housing youth other facilities will not accept.

New Beginnings' 60-bed capacity limits the number of youth the facility can serve. Longer lengths of stay at the facility provide longer opportunities to provide treatment to youth to help them succeed in the community. At the same time, longer lengths of stay reduce the number of youth who can be admitted over time as placements remain filled for longer periods. During 2023 and 2024 approximately 60 to 70 committed youth were admitted to New Beginnings. Most of those youth remained at the facility for less than one year and none stayed for two years.

Adding complexity to its mission, in recent years New Beginnings' operations have had to adapt to changes in the populations of youth housed there. For example, there were detained, Title 16 youth housed at the facility in 2023, and at various points in 2023, 2024, and 2025 there have been youth housed at the facility while awaiting placement at another facility. While these housing practices may meet an agency need, they impact the therapeutic program at New

Beginnings and limit the number of committed youth who can be served by it and/or the duration of their stay.

As Dr. Lee documented, a review of a sample from 2023 revealed that youth admitted to New Beginnings frequently present with serious behavioral health problems, including, but not limited to, significant trauma, substance use disorders, and, in many cases, cognitive limitations. Eventually all these youth return to the community and if for no other reason, this makes DYRS's rehabilitative mission critical. Success requires that by the time youth are released, they have skills and ongoing support to avoid repeating the behaviors that led to their involvement in the juvenile justice system. Based on a review of youth admitted in 2023, however, the evidence reveals that many youth revert to delinquent behavior and return to DYRS custody, or, in some cases, face charges as adults.

Several facility managers expressed that even though youth participate in weekly therapy and regular group therapy sessions, much of what happens at New Beginnings is a security model largely overseen by YDR staff. And while YDR staff are provided a limited amount of training on youth and trauma, their primary job is to supervise youth directly.

In its comments on the draft version of this report, DYRS states that the agency has “embedded trauma-informed principles across pre-service and in-service training. Modules such as *Think Trauma*, *Suicide Prevention*, *Anger Management*, and *Cultural Sensitivity* – as well as Safe Crisis Management (SCM) certification – are mandatory for all secure program staff. SCM emphasizes de-escalation and post-incident repair consistent with trauma-informed care. Continuous coaching and CQI monitoring are ongoing.”²⁰¹ Trauma-informed care is critical in a therapeutic environment when interacting with youth who have experienced as much

²⁰¹ Attachment 3 at page 2.

documented trauma as those housed at New Beginnings. While training in trauma-informed care is important, training alone does not necessarily translate into consistent implementation of trauma-informed principles, which is necessary to effect a truly trauma-informed environment. Further, sensitively interacting with trauma victims, and even successfully treating trauma, is itself unlikely to modify behavior that may be related to or complicated by other co-occurring problems. As discussed above, during his review, Dr. Lee found that youth at DYRS present with complex problems in addition to trauma, such as substance abuse, behavioral disorders and cognitive limitations, some of which were not effectively addressed during the youth's stay at DYRS likely compromising the youth's rehabilitation.

There are substantial resources at New Beginnings to support the therapeutic model. There are unit-based team leaders, behavioral health positions for every housing unit plus a supervisor, psychiatric services, a substance abuse counsellor, juvenile justice institutional counsellors, credible messengers, care coordinators, and education staff. These staff are in addition to the YDR staff, who directly supervise and interact with youth around the clock, more than any other staff at the facility. As previously noted, Dr. Lee observed, “[i]n order to support and provide consistent rehabilitation to youth, all staff, including those who are not therapists in the conventional sense, such as administrators, teachers, custody staff, and others, must be trained to be therapeutic in their interactions with youth.”²⁰²

There is an apparent tension at New Beginnings between its operation as a secure facility and as a therapeutic, rehabilitative program. This tension was not only expressed by staff but is also apparent in the organizational structure of the facility, with behavioral staff and security staff reporting through different chains of command and not all through the superintendent. This

²⁰² Attachment 2 at page 13.

report documents strengths and shortcomings in New Beginnings' service delivery model. To achieve its goal of successfully rehabilitating youth and avoiding youth returning to a juvenile or criminal justice system, DYRS should assess whether the program is reaching its potential, effectively identifying youths' behavioral health needs and providing the appropriate treatment over an appropriate timeframe, as well as providing youth with sufficient practice exercising skills learned at New Beginnings, to increase the chances of successful reintegration into a community setting.

VII. SUMMARY OF RECOMMENDATIONS

Recommendation 1: Strengthen the Rehabilitative Model and Therapeutic Environment

Discussion: The OIJFO endorses the recommendation of Dr. Lee that the environment at New Beginnings “must evolve into a fully therapeutic environment” and that “[e]very staff member, regardless of role, must become a consistent agent of recovery and growth.”²⁰³ This requires a significant reimagining of the program where treatment and recovery become the goals and measurements of success consistent with D.C. Code § 2–1515.04 (3), and will require additional training of staff, revisions in how and who is involved in treatment planning, and changes in the provision of treatment services to ensure treatment is individualized and reflective of the youth’s strengths and needs.

Currently, youth progress through the New Beginnings program based on a level system with a defined process for advancing levels. Based on case record reviews and corroborated by facility manager interviews, it appears that too many youth are able to progress through levels without addressing in any meaningful way their significant underlying behavioral health issues. DYRS should consider whether the currently implemented level system is sufficiently individualized to meet the needs of all youth at New Beginnings and/or whether discharge should be determined based on some other formal risk assessment conducted prior to discharge.

Given the scope of this recommendation, OIJFO also recommends that DYRS consider obtaining outside consultation to assist in the planning and implementation of a more recovery-based rehabilitation program within a quasi-correctional setting by someone with experience in this type of program reform.

²⁰³ *Id.*

DYRS did not respond to this recommendation in its comments on the draft version of this report.

Recommendation 2: Ensure behavioral health treatment plans consider and reflect the full range of available information on youth and incorporate findings from independent assessments prior to admission.

Discussion: Youth admitted to New Beginnings frequently have independent psychological or psychiatric assessments completed prior to admission. Dr. Lee found, where available, “[t]hese reports reflected thorough and extensive assessments and, in many cases, formal psychological testing, and included specific diagnoses and useful recommendations for treatment and/or follow up.”²⁰⁴ While certain aspects of the level system were tied to youth behavioral health treatment plan goals, which identify behavioral health diagnoses, Dr. Lee’s review revealed that frequently evidenced behavioral health issues were not included in behavioral health treatment plans.

DYRS should consider establishing a program of grand rounds where complex cases can be presented, and where outside experts are invited to provide training to staff on issues related to behavioral health or rehabilitation in a secure juvenile settings or to introduce successful practice used in similar settings.²⁰⁵ DYRS could partner with other District agencies that operate a grand rounds program, such as the Department of Behavioral Health (*i.e.*, Saint Elizabeths Hospital).

DYRS did not respond to this recommendation in its comments on the draft version of this report.

Recommendation 3: Review the type of treatment services available to youth to ensure they appropriately meet the full range of needs and cognitive abilities of youth.

Discussion: Independent assessments of many youth reflected substance use disorders, trauma, and cognitive functioning limitations and in many cases recommended family therapy as part of a treatment plan. There were recurring gaps in services at New Beginnings that did not address the range of problems in the assessments or often the recommendations made by clinical professionals in their assessments.

Roles for family and others in the youth’s support system may need to be redefined, and new strategies to engage families should be explored. As Dr. Lee notes, “[t]he engagement and participation of family/caregiver, fictive kin/family members of choice, and caring adults are essential to successful rehabilitation. Treatment plans and rehabilitation services benefit from

²⁰⁴ *Id.* at pages 5-6.

²⁰⁵ Grand rounds can also be used to meet continuing education requirements.

intentional family involvement. Most youth will return to their families after release, and research shows that families can significantly influence youth behavior and juvenile system recidivism. Youth who do not return home will benefit from the involvement of caring adults from the settings where the youth will live.”²⁰⁶ However, Dr. Lee’s review as well as interviews with staff identified limited family involvement in treatment.

Longer, evidence-based substance abuse treatment programming should also be assessed. DYRS must consider how to tailor its programs to the cognitive functioning levels of all youth at the facility.

DYRS did not respond to this recommendation in its comments on the draft version of this report.

Recommendation 4: Develop more opportunities for youth to practice skills learned through treatment in environments with increasing levels of freedom prior to discharge.

Discussion: The transition from a secure facility to the community can be overwhelming. An abrupt transition to a highly controlled environment to one with few external controls can set youth up for failure. Dr. Lee stated, “DYRS facilities should be modified, as much as possible, to offer less restrictive and more normative home- and community-like settings. Programming should be enhanced so staff can provide coaching in the milieu. Youth who demonstrate more skillful behaviors should be provided opportunities to live in environments that more closely resemble their future living situations. Learning and practicing skills in more natural and interactive settings will increase the likelihood that treatment gains will generalize to the community.”²⁰⁷

Youth should be given opportunities to make responsible decisions with greater amounts of responsibility both in the facility and in the community on a more gradual basis, which enables the youth and DYRS to assess the youth’s readiness. This could entail increased freedoms within the facility if youth demonstrate sufficient responsibility and potentially weekend passes to slowly acclimate to living in an environment they will ultimately return to.

DYRS did not respond to this recommendation in its comments on the draft version of this report.

Recommendation 5: DYRS should develop and publish a discrete set of outcome measures to assess whether the program is achieving its goals.

Discussion: DYRS should identify a discrete set of outcome measures that address the effectiveness of the program over time, collect relevant data, and

²⁰⁶ *Id.* at page 14.

²⁰⁷ *Id.*

make it available to the public. Such outcome measures could include recidivism rates of those discharged by length of time in the community, youth who are engaged in educational or vocational activities at time of release, measurement of change in risk assessment from admission to discharge, or reduction in youth engaged in high-risk incidents.

DYRS did not respond to this recommendation in its comments on the draft version of this report.

Attachments

Attachment 1

CURRICULUM VITAE

Terry Git Lee, MD, DFAACAP

1) PERSONAL DATA

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2) EDUCATION

1979-1983 B.A. Cum Laude Honors Psychology, University of Minnesota
1983-1987 M.D. University of Minnesota

3) POSTGRADUATE TRAINING

1987-1991 General Psychiatry Residency: University of Washington Affiliated Hospitals
1991-1993 Child and Adolescent Psychiatry Residency: University of Washington Affiliated Hospitals

4) POSITIONS HELD

2018-present Community Health Plan of Washington Senior Behavioral Health Medical Director
2018-present Clinical Associate Professor, Department of Psychiatry & Behavioral Sciences, University of Washington School of Medicine
2014-2018 Associate Professor, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy, University of Washington School of Medicine
2008-2014 Assistant Professor, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy, University of Washington School of Medicine
2004-2008 Acting Assistant Professor, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy, University of Washington School of Medicine

- 2000-2004 Assistant Professor, Department of Psychiatry, John A. Burns School of Medicine, University of Hawaii
- 1999-2000 Acting Instructor, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy, University of Washington School of Medicine
- 1994-1999 Clinical Instructor, Department of Psychiatry & Behavioral Sciences, Division of Public Behavioral Health and Justice Policy, University of Washington School of Medicine

5) HOSPITAL/CLINICAL POSITIONS HELD

- 2018-present Psychiatrist Expert, Multisystemic Therapy-Psychiatry; Intensive Community-Based Treatment for Children and Families Involved in the Child Welfare System; Melbourne, Australia
- 2017-present Psychiatrist Expert, Multisystemic Therapy-Psychiatry; Intensive Community-Based Treatment for Children and Families Involved in the Child Welfare System; New York City
- 2014-2018 Psychiatrist Consultant, Family Integrated Transitions-Probation: Intensive Community-Based Program for King County Juvenile Court-Involved Youth with Co-Occurring Disorders
- 2006-2018 Co-Chair, Washington State Juvenile Rehabilitation Administration Psychiatry Quality Improvement Committee
- 2005-2018 Family Integrated Transitions Psychiatrist Consultant: Intensive Community Based Program for Youth with Co-Occurring Disorders Transitioning from Secure Detention to their Home Communities. Program operated in Washington State, New York State, Connecticut and the United Kingdom
- 2004-2018 Lead Psychiatrist, Echo Glen Children’s Center-Washington State Juvenile Rehabilitation Administration
- 2004-2018 Psychiatrist, King County Juvenile Detention
- 2004-2014 Psychiatrist, Prime Time Project: Intensive Community-Based Program for King County Juvenile Court-Involved Youth with Co-Occurring Disorders
- 2002-2004 Clinical Director, Family Treatment Center Queen’s Medical Center; Honolulu, HI
- 2002-2004 Psychiatrist, Family Treatment Center Queen’s Medical Center
- 2001-2002 Clinical Director, Central Oahu Family Guidance Center-Hawaii Department of Health
- 2000-2001 Medical Director, Hawaii Multisystemic Therapy Continuum of Care; Honolulu, HI
- 1999-2000 Psychiatrist, Child Study and Treatment Center
- 1999-2000 Coordinator, Behavioral Health Clinics, Children’s Hospital and Regional Medical Center
- 1997-1999 Consulting Psychiatrist, Adolescent Center, Group Health Cooperative; Bellevue, WA
- 1997-1999 Clinical Director, Continuum Health Care; Bellevue, WA
- 1996-1999 Psychiatrist, Continuum Health Care; Bellevue, WA

1996-1999 Child and Adolescent Psychiatrist, Overlake Hospital; Bellevue, WA
 1996-1999 Member, Psychiatric Physician Advisory Committee, Overlake Hospital; Bellevue, WA
 1995-1996 Consulting Psychiatrist, Center for Continuing Rehabilitation, Good Samaritan Hospital; Puyallup, WA
 1994-1996 Inpatient Consultation-Liaison Psychiatrist, Good Samaritan Hospital; Puyallup, WA
 1994-1996 Outpatient Child, Adolescent and Adult Psychiatrist, Puyallup Valley Institute; Puyallup, WA
 1994 Adolescent Inpatient Psychiatry Consultant, Northwest Mental Health Services; Renton, WA
 1993-1994 Psychiatrist, Western State Hospital

6) HONORS

2021 Mentor to 2021 American Academy of Child and Adolescent Psychiatry Marilyn R. Benoit, MD Child Maltreatment Mentorship Award awardee, Joshua Russell, MD
 2015 Outstanding Collaborator Exemplary Service Award Co-Recipient. Juvenile Justice Group Home Telepsychiatry Collaboration. Washington State Co-Occurring Disorders and Treatment Conference
 2015 Working with Gender Non-Conforming/Transgender Youth in Juvenile Justice Residential Settings (Chair). Annual Meeting of the American Academy of Child and Adolescent Psychiatry Case Conference. San Antonio, TX 10/30/15
**This was the highest rated Clinical Case Conference at the 2015 AACAP Annual Meeting.*
 2014-2015 UW Graduating Child and Adolescent Psychiatry Residents MD Teaching Award
 2013-2014 UW Graduating Child and Adolescent Psychiatry Residents MD Teaching Award
 2012-2013 Honored by 2013 Graduating UW General Psychiatry Residents as a “Best Supervisor”
 2009-2010 Honored by 2010 Graduating UW General Psychiatry Residents as One of Their Best Attendings/Supervisors
 2008 Family Integrated Transitions: From Policy to Practice to Cost-Effectiveness. Annual Meeting of the American Academy of Child and Adolescent Psychiatry Institute: The Etiology of Antisocial Behavior: A Developmental Perspective. Chicago, IL 10/31/08
**This Institute was one of the ten top-rated sessions at the AACAP Annual Meeting.*
 2003-2004 University of Hawaii Child and Adolescent Psychiatric Residency Training Program Outstanding Teacher
 2002 Elected Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry

7) BOARD CERTIFICATION

- 2020 Board Certified Addiction Medicine, American Board of Preventive Medicine ID: 61-18240
- 1994 Psychiatry, American Board of Psychiatry and Neurology, certificate number 39285
- 1994 Child and Adolescent Psychiatry, American Board of Psychiatry and Neurology, certificate number 3730

8) CERTIFIED BUPRENORPHINE PROVIDER

2011-present

9) CURRENT LICENSES TO PRACTICE

- 1987-present Physician Washington State MD00026817
- 2000-2024 Physician Hawaii MD11151

10) PROFESSIONAL ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry (AACAP)

- 2019-present Member Systems of Care Committee
- 2010-2021 Co-Chair Adoption and Foster Care Committee
- 2008-2021 Member Adoption and Foster Care Committee
- 2015-2019 Member Children and the Law Committee
- 2008-2015 Liaison to Juvenile Justice Reform Committee
- 2002-present Distinguished Fellow
- 1993-present Member

Hawaii Council of Child and Adolescent Psychiatry

- 2002-2004 President
- 2000-2004 Member

Washington State Council of Child and Adolescent Psychiatry

- 2017-present Assembly Representative
- 2004-present Member
- 1999-2000 Past-President
- 1998-1999 President
- 1997-1998 President-Elect
- 1996-1997 Secretary
- 1987-2000 Member

Washington State Council of Child and Adolescent Psychiatry Advocacy Group: 501 (c) 4 lobbying group formed while WSCCAP President

- 1999-2000 President

11) TEACHING RESPONSIBILITIES

Didactics, Courses and Seminars

- 2018 Child Clinical Psychology 522: Extreme and Complex Cases, UW Upper Campus Graduate Level Quarter Course
- 2018 Clinical Psychology 5721: Extreme and Complex Cases, UW Upper Campus Graduate Level Multi-Disciplinary Quarter Course
- 2010-2017 Psychology 543: Extreme and Complex Cases, UW Upper Campus Graduate Level Multi-Disciplinary Quarter Course

2005-2018 Echo Glen Children’s Center University of Washington General and Child Psychiatry Resident Year-Long Weekly Didactic
 2002-2004 University of Hawaii Child Psychiatry Residency Didactic Coordinator
 2002-2004 University of Hawaii General Psychiatry Child Psychiatry Seminar Series

Supervision

2019-present University of Washington General Psychiatry Training Program
 2005-2018 Site Coordinator and Supervising Psychiatrist Echo Glen Children’s Center—training site for UW General and Child Psychiatry Residents, supervise 4-5 Residents each week
 2012-2013 Off-Site Supervisor University of Washington Child Psychiatry Residency
 2006-2018 Supervisor University of Washington Psychiatry Residency Family Integrated Transitions Elective
 2001-2004 Supervising Child Psychiatrist University of Hawaii Psychiatry Residency Program

Mentoring

2023-2024	Aditi Jajirnis, MD	Brown University Assistant Professor
2023-2024	Mylan Kohler, MD	Mid-Career Child Psychiatrist Wisconsin
2021-2024	Joshua Russell, MD	SUNY- Buffalo Assistant Professor
2016-2018	Kelly Regan Gutierrez	UW School Psychology Doctoral Candidate
2016-2018	Rebecca Hopkinson, MD	UW Acting Assistant Professor
2016-2019	Nicole Sussman, MD	CHA Child Psychiatry Fellow
2014-2016	Taryn Park, MD	UW Child Psychiatry Fellow
2013-2014	Mark Demidovich, MD	Early Career Child Psychiatrist PA RTC
2012-2013	Leo Cevallos, MD	Early Career Child Psychiatrist Florida JJ
2010-2011	Mark Everard, MD	UW General Psychiatry Resident

Residency Program Director

2002-2004 Program Director Child and Adolescent Psychiatry Residency Program, John A. Burns School of Medicine University of Hawaii
 2002-2004 Co-Program Director Child Combined Pediatrics/Psychiatry/Child Psychiatry Residency Program, John A. Burns School of Medicine University of Hawaii
 2001-2002 Associate Program Director Child and Adolescent Psychiatry Residency Program, John A. Burns School of Medicine University of Hawaii
 2001-2002 Associate Program Director Child Combined Pediatrics/Psychiatry/Child Psychiatry Residency Program, John A. Burns School of Medicine University of Hawaii

12) EDITORIAL RESPONSIBILITIES

Ad Hoc Reviewer: Journal of the American Academy of Child and Adolescent Psychiatry

13) SPECIAL NATIONAL RESPONSIBILITIES

2024-present Pathways to Perinatal Mental Health Equity (PCORI-funded) Health Equity Working Group Member

- 2022-present IMPACT Center (NIMH-funded Center focused on improving MH outcomes for youth in under-resourced settings) Stakeholder Advisory Board
- 2017-present Psychiatrist Expert Multisystemic Therapy-Psychiatry Leadership Team: Intensive Community Based Program for Families with Psychiatric Concerns
- 2014-2019 American Board of Psychiatry and Neurology Maintenance of Certification Committee Member
- 2001-2014 American Board of Psychiatry and Neurology Part II Oral Examiner

14) SPECIAL LOCAL RESPONSIBILITIES

- 2024-Present Pathways to Perinatal Mental Health Equity Health Equity Working Group Member PCORI-funded
- 2024 Bree Collaborative Early Childhood Behavioral Health Intervention Workgroup-Chair
- 2023-present University of Washington Medicaid and Perinatal Mental Health Grant Advisory Team
- 2021-present UW CoLab Culturally & Responsive Mental Health (CARE) for Kids & Families Initiative Advisory Board Member
- 2021-2023 Washington Advisory Board Member Patient-Centered Outcomes Research Institute Grant Evaluating Lifelines4Moms Study
- 2018-2019 Girl’s Court Advisory Committee Member-Center for Children and Youth Justice
- 2009-2018 Public Behavioral Health and Justice Policy Grand Rounds Coordinator
- 2009-2013 University of Washington Psychiatry Residency Community Leadership Track Speaker Series Coordinator

15) EXPERT CONSULTATION

- 1) 2023-present Mental Health Consultant to Washington, DC Office of Independent Juvenile Justice Facilities Oversight
- 2) 2021-present Weaver Resentencing
- 3) 2016-24 Baranyi Resentencing
- 4) 2022-3 Eggers Resentencing
- 5) 2018 Gaeta Sentencing Hearing
- 6) 2017 McNeil Resentencing
- 7) 2017 Mantanona Culpability and Mitigation
- 8) 2017 Ferguson Culpability and Mitigation
- 9) 2014 Ronquillo Sentencing Appeal
- 10) 2013 Ramos Resentencing
- 11) 2013 Mental Health Expert Consultation to Nebraska Juvenile Justice System
- 12) 2013 Brooks Decline Hearing
- 13) 2011 Consultant to Florida Institutional Legal Services on Conditions of Confinement and Mental Health Treatment
- 14) 2007-2008 Mental Health Expert evaluation of San Joaquin County California Juvenile Hall

15) 2006-2011 Mental Health Expert to California State Department of Juvenile Justice on Conditions of Confinement and Mental Health Treatment Reform

16) BIBLIOGRAPHY

Manuscripts in Refereed Journals

- 1) Russell J, Lee T (2025). Strengthening the front lines: A child welfare programme for families and multidisciplinary professionals (2025). *Child Abuse Review*, 34:e7055 doi.org/10.1002/car.70055
- 2) Larson J, Kazura A, Fortuna L, French WP, Hodas GR, Metz P, McGinty K, Bellonci C, Lee T, Lohr D, Sharma P, Zachik A, Varma C, Kamarauche A, Adade OA, Bender E, Brown KA, Concepcion M, Naylor, Pandh S, Ugorji O, and AACAP Committee on Quality Issues (2023). Clinical update: Child and adolescent behavioral health care in community systems of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 62: 367-384.
- 3) Walker SC, Bishop AS, Schmidt H, Lee TG, Indermark JA (2022). Expert versus youth raters on measuring social and therapeutic climate in secure juvenile placement. *Journal of the American Academy of Psychiatry and the Law*, 50: 221-30.
- 4) Lohr WD, Wanta J, Baker M, Grudnikoff E, Morgan W, Chhabra D, Lee T (2021). Intentional discontinuation of psychostimulants used to treat ADHD in youth: A review and analysis. *Frontiers in Psychiatry*, doi: [10.3389/fpsy.2021.642798](https://doi.org/10.3389/fpsy.2021.642798)
- 5) Sussman N, Lee T, Hallgren K (2019). How just is manifest injustice? *American Journal of Psychiatry and the Law*, 47: 42-47.
- 6) Lee T & Morgan W (2017). Transitioning to adulthood from foster care. *Child and Adolescent Psychiatry Clinics*, 26: 283-296.
- 7) Lee T (2016). Pediatric Bipolar Disorder. *Pediatric Annals*, 45(10): e362-e366.
- 8) Lee TG, Walker SC & Bishop AS (2016). The impact of psychiatric practice guidelines on medication costs and youth aggression in a juvenile justice residential treatment program. *Psychiatric Services*, 67(2): 214-220.
- 9) Lee T, Fouras G, Brown R, et al (2015). Practice parameter for the assessment and management of youth involved with the child welfare system. *Journal of the American Academy of Child and Adolescent Psychiatry*, 54:6, 502-517.
- 10) Kerns SEU, Cevasco M, Comtois KA, Dorsey S, King K, McMahan R, Sedlar G, Lee TG, Mazza JJ, Lengua L, Davis C, Evans-Campbell T & Trupin E (2015). An interdisciplinary university-based initiative for graduate training in evidence-based treatments for children's mental health. *Journal of Emotional and Behavioral Disorders*, 10.1177/1063426615583457, April 1-13.
- 11) Lee T, Cox J & Walker (2013). Child welfare training in child psychiatry residency: A survey of training directors. *Academic Psychiatry*, 37:5, 308-312.
- 12) Lee T (2012). School-based interventions for disruptive behavior. *Child and Adolescent Psychiatry Clinics of North America*, 21:1, 161-174.
- 13) Maddox SJ & Lee T (2011). An examination of bipolar disorder in children. *Report on Emotional and Behavioral Disorders in Youth*, 11:2, 40-45.
- 14) Thompson JN, Varley CK, McClellan J, Hilt R, Lee T, Kwan AC, Lee T & Trupin E (2009). Second opinions improve ADHD prescribing in a Medicaid-insured community population. *Journal of the American Academy of Child and Adolescent Psychiatry*, 48:7, 740-748.

- 15) Lee T & DeRobertis M (2006). Overview of the FIT treatment model. *Focal Point: Research, Policy and Practices in Children's Mental Health*, 20:17-19.
- 16) Henggeler SW, Sheidow AJ & Lee T (2006). Multisystemische Behandlung Schwerwiegender Verhaltensprobleme bei Jugendlichen und Ihren Familien. *Verhaltenstherapie & Verhaltensmedizin*, 27, 491-524.
- 17) Rowland MD, Halliday-Boykins CA, Henggeler SW, Cunningham PB, Lee TG, Kruesi MJ & Shapiro S (2005). A randomized trial of multisystemic therapy with Hawaii's Felix class youths. *Journal of Emotional and Behavioral Disorders*, 13, 13-23.
- 18) Guerrero APS, Hishinuma ES, Andrade NN, Bell CK, Kurahara DK, Lee TG, Turner H, Yuen NYC, Andrus J & Stokes AJ (2003). Demographic and clinical characteristics of adolescents in Hawaii with obsessive-compulsive disorder. *Archives of Pediatrics and Adolescent Medicine*, 157: 665-670.
- 19) Henggeler SW & Lee TG (2002). What happens after the innovation is identified? *Clinical Psychology: Science and Practice*, V9 N2, 191-194.

Books Chapters

- 1) Morgan W, Lee T, Van Deusen T (2021). Supporting Connections: A Focus on the Mental Health Needs and Best Practices for Youth in Out-of-Home Care Transitioning to Adulthood. In V Chan & J Derenne (Eds), *Transition-Age Youth Mental Health Care: Bridging the Gap Between Pediatric and Adult Psychiatric Care*. New York: Springer
- 2) Lee TG & Kerns SEU (2013). Family Integrated Transitions: A Promising Program for Reducing Recidivism in a Cost-Effective Manner. In C Thomas & K Pope (Eds.) *Origins of Antisocial Behavior*. Oxford University Press.
- 3) Henggeler SW, Sheidow AJ & Lee T (2009). Multisystemic Therapy. In J Bray & M Stanton (Eds), *The Blackwell Handbook of Family Psychology*. Oxford, England: Blackwell.
- 4) Henggeler SW, Sheidow AJ & Lee T (2007). Multisystemic Treatment (MST) of Serious Clinical Problems in Youths and Their Families. In DW Springer & AR Roberts (Eds), *Handbook of Forensic Social Work with Victims and Offenders: Assessment, Treatment and Research*. New York: Springer.
- 5) Henggeler SW & Lee TG (2003). Multisystemic Treatment of Serious Clinical Problems. In AE Kazdin & JR Weisz (eds), *Evidence-Based Psychotherapies for Children and Adolescents*. New York: Guilford Press.

17) PRESENTATIONS

Selected National Invitational Lectures

- 1) Multisystemic Therapy-Psychiatry: An Alternative to Inpatient or Residential Treatment? BronxCare Hospital Center Department of Psychiatry Grand Rounds. New York City, NY 11/14/2024
- 2) Brick by Brick: Learning to Build Positive Change as a Child and Adolescent Psychiatrist Across Systems of Care Using a Problem-Based Learning Approach. American Academy of Child and Adolescent Psychiatry Annual Meeting Clinical Case Conference. Seattle, WA 10/16/2024

- 3) Breaking Down the Walls: Treating Adolescents Involved with the Juvenile Legal System Upon Re-Entry. American Academy of Child and Adolescent Psychiatry Annual Meeting Clinical Case Conference. Seattle, WA 10/15/2024
- 4) Psychotropic Medication Reduction and Discontinuation Clinical Update. American Academy of Child and Adolescent Psychiatry Annual Meeting. Member Services Forum. Seattle, WA 10/15/2024
- 5) Youth and Family Voice and the Experience of Girls. American Academy of Child and Adolescent Psychiatry Institute. Seattle, WA 10/14/2024
- 6) A Potential Alternative to Inpatient or Residential Health Treatment: Multisystemic Therapy-Psychiatry. American Academy of Child and Adolescent Psychiatry Annual Meeting. Clinical Perspective Chair and Presenter. New York, NY, 10/24/2023
- 7) A System of Care Response to the National Emergency in Child and Adolescent Mental Health. American Academy of Child and Adolescent Psychiatry Annual Meeting. Systems of Care Institute. Presenter-Multisystemic Therapy. New York, NY, 10/23/2023
- 8) With Liberty and Justice for All? System Involved Youth, Past, Present, and Future. American Academy of Child and Adolescent Psychiatry Annual Meeting. Clinical Perspective, Discussant—Inequalities in Child Serving Systems of Care. Toronto, 10/21/2022
- 9) Strengthening the Front Lines: A Child Welfare Program for Families and Multidisciplinary Professionals. American Academy of Child and Adolescent Psychiatry Annual Meeting, Poster Session. Toronto, 10/19/2022.
- 10) Implementing Community-Based Strategies for Opioid Abuse Management with Local Partners. World Conference Forum 2022 Opioid Abuse Management Summit. Nashville, TN 2/25/2022
- 11) Update on Youth at the Border: Search for Reunion 2021. Special Interest Group Presenter. American Academy of Child and Adolescent Psychiatry Virtual Annual Meeting. 10/29/2021
- 12) It Takes a Village...a Campus, and More: Examining the Impact of Programs for Youth with History of Foster Care Transitioning to Adulthood. Discussant. American Academy of Child and Adolescent Psychiatry Virtual Meeting. 10/28/2021
- 13) Children and Gun Violence During the Pandemic. Discussant. American Academy of Child and Adolescent Psychiatry Virtual Annual Meeting. 10/27/2021
- 14) Youth at the Border: Where are They/We 2020. Special Interest Group Presenter. American Academy of Child and Adolescent Psychiatry Virtual Annual Meeting. 10/24/2020
- 15) Impact of Child Maltreatment on Transitioning to Adulthood. Impact of Child Maltreatment: Child and Adolescent Psychiatry Role in Risk, Resiliency, and Systems of Care Institute Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Chicago, IL 10/19/19
- 16) Youth at the Border: How to be Involved as a Child and Adolescent Psychiatrist Special Interest Group Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Chicago, IL 10/18/19

- 17) Caring for Children in Foster Care: Managing Care Transitions and Placements. Optum Health Education webinar. 6/26/19
- 18) Transitioning to Adulthood from Foster Care. Clinical Perspectives Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Seattle, WA 10/25/18
- 19) Development of Deprescribing Guidelines in Child and Adolescent Psychiatry: Methodology and Challenges of Systemic Literature Search. Grudnikoff E, Fox K, Lee T. Poster Session. American Academy of Child and Adolescent Psychiatry Annual Meeting. Seattle, WA 10/24/18
- 20) Echo Glen: A Model Juvenile Justice Center. Clinical Practicum Chair. American Academy of Child and Adolescent Psychiatry Annual Meeting. Seattle, WA 10/23/18
- 21) Working with Gender Nonconforming Youth in Juvenile Justice Settings. Case Conference Chair. American Academy of Child and Adolescent Psychiatry Annual Meeting. Washington, DC 10/28/17
- 22) How Just is Manifest Injustice? Sussman N, Lee T, Hallgren K. Poster Session. American Academy of Child and Adolescent Psychiatry Annual Meeting. Washington, DC 10/25/17
- 23) Deprescribing in a Residential Juvenile Justice Program. Clinical Perspectives Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. New York, NY 10/27/16
- 24) Meeting the Needs of Children and Youth with Complex Behavioral Health Problems in an Integrated Healthcare World, Implications for Foster Care/Child Welfare. Special Program Discussant. American Academy of Child and Adolescent Psychiatry Annual Meeting. New York, NY 10/24/16
- 25) How Just is Manifest Injustice? Sussman N & Lee T. Systems of Care Special Presentation Poster Session. American Academy of Child and Adolescent Psychiatry Annual Meeting. New York, NY 10/24/16
- 26) The Impact of Psychiatry Practice Guidelines on Medication Costs and Youth Aggression. 60th Congress of AEPNYA (Spain's Child Psychiatry Association). San Sebastian, Spain 6/3/16
- 27) Working with Gender Nonconforming Youth in Juvenile Justice Settings. Case Conference Chair. American Academy of Child and Adolescent Psychiatry Annual Meeting. San Antonio, TX 10/30/15
**This was the highest rated Case Conference at the AACAP Annual Meeting*
- 28) Psychiatric Medications and Child Welfare. American Bar Association National Conference on Children and the Law: Advancing Justice for Children and Families. Washington, DC 7/25/15
- 29) Impact of Psychiatry Practice Guidelines on Medication Costs and Aggression. Poster Session. American Academy of Child and Adolescent Psychiatry Annual Meeting. San Diego, CA 10/23/14
- 30) Innovative and Promising Psychosocial and Systemic Interventions in Child Welfare and Foster Care. Clinical Perspectives Chair. American Academy of Child and Adolescent Psychiatry Annual Meeting. Orlando, FL 10/26/13

- 31) Maltreatment, Adoption, Foster Care, Custody and Divorce Article Review. Lifelong Learning Institute Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Orlando, FL 10/25/13
- 32) Evidence-Based Psychosocial Interventions in Juvenile Justice. Child and Adolescent Psychiatrists in Juvenile Justice: From Individual Care to System Approaches. Special Program Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Orlando, FL 10/21/2013
- 33) Practice Parameter for Working with Youth Involved with the Child Welfare System. Member Forum Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. San Francisco, CA 10/25/12
- 34) Child Welfare Training During Child Psychiatry Residency: A Survey of Program Directors. Poster Session. American Academy of Child and Adolescent Psychiatry Annual Meeting. San Francisco, CA 10/24/12
- 35) Psychiatric Medications and Child Welfare. Casey Family Programs Training, Seattle, teleconferenced to Phoenix, Oakland, Los Angeles, Boise, Austin, TX and Yakima, WA 9/23/09
- 36) Family Integrated Transitions: From Policy to Practice to Cost-Effectiveness. Institute: The Etiology of Antisocial Behavior: A Developmental Perspective. Institute Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Chicago, IL 10/31/08
**The Institute which this presentation was part of was one of the ten top-rated sessions at the AACAP Annual Meeting.*
- 37) Adapting Evidence-Based Practices: Family Integrated Transitions: A Modification of Multisystemic Therapy. Annual Meeting of the Association for the Advancement of Evidence Based Practice. Savannah, GA 9/25/08
- 38) Family Integrated Transitions: Reducing Juvenile Justice Recidivism in a Cost-Effective Manner. Research and Training Center for Children's Mental Health Annual Meeting. Tampa, FL 3/5/0
- 39) Family Integrated Transitions. Symposium Chair and Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Toronto, Canada 10/05
- 40) Multisystemic Therapy in Hawaii. Clinical Practicum Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Honolulu HI 10/01
- 41) Moving Evidence-Based Practices into Field Settings: Challenges and Strategies. Symposium Presenter. American Academy of Child and Adolescent Psychiatry Annual Meeting. Honolulu, HI 10/01
- 42) A Multisystemic Therapy Continuum of Care in Hawaii. Multisystemic Therapy Annual Conference. Savannah, GA 10/00

Selected Regional Presentations (Last 10 Years Only)

- 1) MST and MST-Psychiatry. UW Child Psychiatry Didactics. 10/28/2022.
- 2) Strategies for Overcoming Stigma Related to Substance Use and Addiction in the AANHPI Community. Presenter and Moderator. Northwest Addiction Technology Transfer Center Web-Based Presentation. 7/12/2022.

- 3) Integrating Behavioral Health in Primary Care. Comagine Health Virtual Annual Board Retreat. 11/17/2020
- 4) Health Plan Partnering Innovations. Washington State Virtual Annual Co-Occurring Disorders Conference. 10/6/2020
- 5) The School to Prison Pipeline. UW Child Psychiatry Didactics. 5/12/20
- 6) Safety Training. Multisystemic Therapy-Psychiatry Training. Melbourne, Australia 9/25-26/2019
- 7) What to Expect from Medicaid Managed Care. CBT+ Supervisors Training. Tukwila, WA 9/18/19
- 8) Transforming to a Continuous Improvement Culture to Positively Impact the Most Vulnerable. Washington Behavioral Health Conference. Vancouver, WA 6/13/19
- 9) Inspiring Innovations: Developing the Future Behavioral Health Workforce for Washington State, Panelist Discussant. Seattle, WA 4/5/19
- 10) Inspiring Innovations: Developing the Future Behavioral Health Workforce for Washington State, Panelist Discussant. Spokane, WA 4/3/19
- 11) A Fine-Grained Look at Behavioral Health Integration, Panelist Discussant. State of Reform Pre-Conference. Seattle, WA 1/9/19
- 12) Brain Science and the Adolescent Mind. Evidence-Based Practices within the Juvenile Justice System Symposium. City and County of San Francisco Juvenile Probation Department. San Francisco, CA 2/5/18
- 13) Disruptive Mood Dysregulation Disorder: Fix, Future, or Fad? Evidence-Based Practice Institute Workforce Series Webinar. Seattle, WA 1/12/17
- 14) Psychiatric Medications and Child Welfare. King County Dependency Court Appointed Special Advocates Program Workshop CLE. Seattle, WA 11/7/16
- 15) Psychiatric Medications. Friends of Youth Training. Renton, WA 11/2/16
- 16) Psychotropic Medications and Children in Foster Care. Developmentally Informed Representation of Young Children in Child Welfare. Washington State Office of Civil Legal Aid CLE. Spokane, WA 4/29/16
- 17) Psychiatric Medications. Friends of Youth Training. Kirkland, WA 4/27/16
- 18) Psychotropic Medications and Children in Foster Care. Developmentally Informed Representation of Young Children in Child Welfare. Washington State Office of Civil Legal Aid CLE. Tumwater, WA 3/25/16
- 19) Psychotropic Medications and Children in Foster Care. Developmentally Informed Representation of Young Children in Child Welfare. Washington State Office of Civil Legal Aid CLE. Mt. Vernon, WA 3/18/16
- 20) Family Integrated Transitions. University of Washington General Psychiatry Residency Community Leadership Pathway. Seattle, WA 3/17/16
- 21) Psychotropic Medications and Children in Foster Care. Developmentally Informed Representation of Young Children in Child Welfare. Office of Civil Legal Aid CLE. Seattle, WA 10/16/15
- 22) What Can You Do to Reduce Unnecessary Prescription of Psychotropic Medications to Children in Foster Care? Children's Justice Conference. Seattle, WA 5/11/15
- 23) Child Development. Psychology 101. University Behind Bars. Monroe Correctional Facility. Monroe, WA 3/27/15

- 24) Juvenile Brain Research. Washington Defender Association: Preparing Defense Counsel for Resentencing for Youth Serving Life without Parole. Seattle, WA and telecast to Olympia, Kennewick, Wenatchee and Yakima, WA 7/25/14
- 25) Psychiatric Medications and Child Welfare: Children's Justice Conference. Spokane, WA 5/12/14
- 26) Multisystemic Therapy Overview. Seattle Children's Hospital Psychiatry-Psychology Trainee Didactic. Seattle, WA 3/12/14

Attachment 2

**Behavioral Health Consultant Report
to the
Office of Independent Juvenile Justice Facilities Oversight**

Terry Lee, MD
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August 19, 2025

BACKGROUND

The Washington, DC Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) retained this writer to provide behavioral health consulting services. These services include, but are not limited to, the review of medical records of youth in the Department of Youth Rehabilitation Services (DYRS); review and analysis of DYRS records provided by authorized representatives of the OIJJFO; and production of written products as requested by authorized representatives of the OIJJFO. This report is based on consultant site visits, youth and staff interviews, discussions with OIJJFO staff, and reviews of health care and justice system records, including those of 17 youth in DYRS's New Beginnings Youth Development Center (NB), a program primarily for youth in long-term secure detention.

The OIJJFO selected 17 NB youth for review of their care and treatment based on the presence of significant behavioral health (BH) needs. All 17 of the youth were adjudicated to NB for rehabilitation services. The chart review focused on NB due to the higher expectation for providing rehabilitation services, although some documents in the Youth Services Center (YSC) charts were also reviewed because the same NB youth also resided in YSC at some point during their confinement at DYRS. NB charts received priority because most NB youth are in the post-adjudication phase of the court process, dealing with more serious behaviors and legal charges, and subject to longer commitments. This extended incarceration period escalates DYRS's responsibility to offer robust rehabilitative services, maximizing opportunities for skills training, family therapy, and addressing individual, caregiver, peer, school, and community factors to reduce negative and criminal behaviors. The role and function of NB can be contrasted with YSC, where most youth are in the pre-adjudication phase of the court process—which would be expected to affect their discussions of alleged behaviors. Additionally, youth in YSC often have shorter stays and face a broader range of charges, from status offenses to serious felonies. However, there is a subgroup of youth in YSC charged with very serious crimes, who are detained for much longer periods of time while undergoing the court process. The treatment and well-being of this subgroup of youth facing very serious charges should also be carefully evaluated in the future but was not included in this review.

This consultant, with the OIJJFO executive director, conducted site visits to NB and YSC on 9/11/2023 and 9/12/2023 respectively. This consultant also engaged in multiple discussions with the OIJJFO executive director and senior analyst both prior and subsequent to the site visits.

This report summarizes the results of my review of behavioral health screening, assessment, problem lists, treatment planning, and treatment services at NB. The sample included 17 youth who were housed at NB for a minimum of 14 days between September 1 and

December 31, 2023. For each of the 17 youth in the sample, I reviewed available psychiatric and psychological reports completed by independent evaluators as part of the youth's juvenile case. Additionally, I reviewed each youth's behavioral health record included in the youth's electronic health record.¹ A summary of my review findings are attached to this report as an appendix.

Before addressing specific findings from my review, it is noteworthy that while all the youth in the NB sample presented with complex behavioral health needs, there were several characteristics common to many of the youth. Seventeen of the 17 youth in the sample were identified as Black or African/American and one also identified as Hispanic/Latino. Problem substance use was identified as a concern for 15 of the 17 youth; and 11 of the youth were diagnosed with a substance use disorder either prior to admission through independent evaluations or while at NB. Similarly, 14 of the youth in the sample experienced some type of trauma that was noted in either the independent assessments, DYRS' assessments, or both. Among the 15 youth for whom cognitive testing was available, 14 of 15 showed a Full Scale IQ in the borderline intellectual functioning range (one standard deviation below the mean) or lower. (The validity of Full Scale IQ scores have been scrutinized when there is marked variability among subscale scores.² This observation is presented to underscore the extent of cognitive challenges identified within in the reviewed NB youth cohort.) Of particular note was the seriousness of the offenses for which many youth in the sample were committed; many offenses involved assaults, carjacking, use of firearms (16 of 16 youth for whom charges were listed), and in some cases murder and attempted murder. A significant number of youth in the sample also engaged in risk-behavior while at DYRS, and all were placed on psychiatric medication for some period during the stay at NB.

Behavioral health services represent just one component of a comprehensive rehabilitation program for youth involved with the juvenile justice system. All staff, whether in clinical roles, administrative support, security, safety, education, or other direct care capacities, play essential roles in facilitating rehabilitation. To maximize the effectiveness of the program, it is critical that each staff member understands their role in supporting youth and that all personnel work collaboratively and in an integrated manner to promote positive outcomes for the youth they serve.

CHART REVIEW

Through my engagement, OIJFO requested that I review specific performance standards that had previously been required but were not met during the now-vacated Jerry M. class action lawsuit. The standards pertained to a range of behavioral health services including initial screening; initial and ongoing assessments; psychiatric treatment; responses to repeated behaviors that put individuals in risk of danger; self-harming behavior; responses to behavioral health emergencies; and the development and implementation of behavioral health treatment

¹ My review of the electronic health record included available MAYSI-2 screenings, psychiatric notes, assessments completed by the treating psychiatrists and other behavioral health staff, problem lists, group notes, mental health SOAP notes, therapy notes, treatment plans, high risk and repeated high risk behavior assessment notes, and notes related to incidents of suicide precautions as applicable. I also reviewed incident report summaries involving the youth that was provided by OIJFO.

² Watkins MW, Glutting JJ, Lei PW (2007). Validity of the full-scale IQ when there is significant variability among WISC-III and WISC-IV factor scores. *Applied Neuropsychology*, 14(1), 13-20.

plans that meet the individual needs of each youth. Each standard and the results of my review are described below.

SCREENINGS

The standard of care requires that all youth admitted to secure youth facilities be promptly screened for mental health and substance abuse disorders, using a standardized tool designed to collect information to identify youth who may pose an emergency behavioral health concern. DYRS uses the (Massachusetts Youth Screening Instrument-(Version 2) MAYSI-2, which is a well-recognized screening instrument specifically for the use in juvenile justice settings. Thus, in reviewing the case records relating to screenings and determining if the standard of care was met, I considered whether all sections of the MAYSI-2 were completed and reviewed timely by qualified staff. I also contemplated whether staff appropriately identified and evaluated those youth whose MAYSI-2 results indicated that a youth was at increased risk of self-injury or injury to others and might require immediate intervention for a behavioral health related issue or warranted a more comprehensive evaluation based upon potential problems identified during the screening.³

***Performance Standard #1:** For any youth at New Beginnings who flags a caution or warning on suicidality and /or thought disorder of the MAYSI-2, a QMHP should complete a telephone consultation and a face-to-face assessment within 18 hours of administration of the MAYSI-2 or within a shorter specified time period if clinically appropriate.*

To assess this performance standard, I considered two criteria: (1) whether a telephone consultation assessing suicidality or presence of thought disorder was conducted and documented in applicable cases; and (2) whether a face-to-face behavioral health assessment was conducted of youth who flagged a caution or warning on suicidality and/or thought disorder within 18 hours of the administration of the MAYSI-2 or alternative screening or a lesser time if clinically appropriate.

Among the 17 youth in the sample, 12 youth had a MAYSI-2 in their health record associated with the reviewed admission to New Beginnings; there was no record of a MAYSI-2 administration for five youth nor documentation as to why the MAYSI-2 was not completed. Among the 12 youth with completed MAYSI-2 screens, two flagged a caution or warning for thought disorder and none of the 12 flagged a caution or warning for suicidality. The two criteria described above were met for only one of the two youth.

For one of the youth, a telephone consultation was conducted,⁴ but for the other youth there was no documentation that a telephone consultation occurred.⁵ Notes reflect that each youth received an appropriate face-to-face behavioral health consultation within 18 hours that

³ The assessment of the timeliness of the screenings was completed by OIJFO.

⁴ EP.

⁵ KB.

included a review of the MAYSI-2 results and an assessment of the youth; in neither case was the youth diagnosed with a thought disorder as a result of the assessment.⁶

Performance Standard #2: Youth who score a caution or warning on the substance abuse scale of the MAYSI-2 shall promptly be screened using the GAIN-Q screening and assessment.

As noted above, among the 17 youth in the sample, 12 youth had a MAYSI-2 in their health records and there was no record of a MAYSI-2 administration for five youth. One youth flagged a caution or warning on the substance abuse scale in the MAYSI-2. This youth did not receive a GAIN-Q (or a similar assessment) within five days, nor at any time during his stay at NB.⁷

It is notable that while none of the other 11 youth for whom a MAYSI was available in the record flagged a caution or warning on the MAYSI-2, independent psychological and/or psychiatric evaluations that preceded admission to NB specifically recommended either a GAIN-Q or substance abuse assessments for seven youth,⁸ but no such evaluations were included in the records. Similar recommendations were made for two youth for whom a MAYSI-2 was missing in the record, and again neither received a GAIN-Q screening nor assessment.⁹

ASSESSMENTS, PROBLEM LIST, AND TREATMENT PLAN DEVELOPMENT

Behavioral health assessments are used to identify a youth's psychological needs and form the basis for development of problem lists and treatment interventions. The standard of care requires the clinician to complete an assessment to interview the youth, contact family to obtain additional information and corroborate information provided by the youth during the interview, and review available prior assessments, independent evaluations, and treatment records. A behavioral health assessment should include an assessment of symptoms, biopsychosocial history, history of treatment, level of impairment, substance use, medication usage, and suicidal risk. Assessments should be repeated at regular intervals or if there is a change (or lack of improvement) in the youth's condition. Problems lists should be developed based upon the results of the assessments. Problem lists aid in organizing treatment and in ensuring all relevant issues are being treated. They provide a summary of the results of the clinical assessments and support the development of a clinical formulation and treatment plan. They also serve as a quick reference point for clinicians who are providing services to the youth, especially in an environment like a secure facility in which clinicians change over time.

A written treatment plan should be developed for each youth with identified behavioral health needs. The treatment plan should reflect a comprehensive, individualized plan that addresses those needs identified during the assessment process and take into consideration the

⁶ KB and EP.

⁷ EP.

⁸ KB, MB, JB, KK, RM, DW, and RW.

⁹ JHA and MW. In five other records, while substance use was noted as an issue, the independent evaluators did not specifically recommend a GAIN or other substance abuse assessment. KD, JE, JHE, JL, BM, RM. There were no independent evaluations completed for CW.

youth's strengths, intellectual functioning, and legal circumstances. The treatment plan should reflect input from the youth, the youth's family, staff involved in the youth's custody or treatment (including as applicable, the youth's psychiatrist, individual and group therapists, custodial staff, and medical staff) and be updated at regular intervals or after significant events in the youth's life or course of care. Treatment plans should reflect specific goals, objectives, interventions and timeframes and identify staff responsible for the treatment intervention and frequency of intervention. These standards were used during the instant review to assess the comprehensiveness and quality of behavioral health assessments, problem lists, treatment plans, and treatment services.

***Performance Standard #3:** Youth at New Beginnings with behavioral health needs revealed by the assessments shall have a problem list entry that is updated as indicated for each behavioral health need that is addressed in the youth's treatment plan.*

Because this standard involves completion of assessments, creation of problem lists, and development of treatment plans based upon the results of the assessments, multiple criteria were used to determine if this performance standard was met. First, I assessed whether all behavioral health needs revealed through the behavioral health assessments were identified, considering the results of the MAYSI-2, clinical assessments both prior to and during the youth's admission to NB, as well as reported behavior in the facility (e.g., assaultive, self-injurious, acute or emergent needs, etc.).¹⁰ Second, I reviewed the problem lists to determine whether a problem list entry was made for every behavioral health need revealed by each assessment (including those that should have been identified by the clinician but were not). Third, I assessed whether each youth's problem list was created and updated, as appropriate. Finally, I assessed whether each behavioral health problem was addressed in the youth's treatment plan and whether the plan included appropriate interventions. This performance standard was not met for 16 of the 17 youth in the sample for a variety of reasons.

For 16 of the 17 youth in the sample, some behavioral health problems revealed through screenings and assessments were not identified at NB or, if identified, were not added to the problem list.¹¹ Similarly, problem lists were not always updated as new problems developed or were resolved.¹² Specifically, of the 17 youth in the sample, all but one of the youth¹³ had independent evaluations by either a psychologist or psychiatrist (or both) prior to admission to NB. These reports reflected thorough and extensive assessments and, in many cases, formal psychological testing, and included specific diagnoses and useful recommendations for treatment

¹⁰ In making this determination I determined whether the documentation of assessments reflected that the clinician contacted available collateral data sources such as family and reviewed behavioral health assessments and treatment interventions from prior admissions at NB or YSC and previously completed independent psychiatric or psychological evaluations.

¹¹ The assessments completed at NB for DW identified all of the behavioral needs revealed through the MAYSI-2, independent evaluations, and clinical assessments completed at NB. He was the only youth in the sample that had all-inclusive assessments and/or problem lists.

¹² Of the 17 youth, five youth had problem lists updated appropriately and timely (JHE, KK, JL, DW, and CW), nine did not (KB, MB, DB, JB, KD, JHA, BM, RM, and EP) and three cases were not applicable because new problems were not identified nor resolved (JE, RW, and MW).

¹³ No independent evaluations were available for CW.

and/or follow up. However, for 15 of the 16 applicable youth in the sample, at least one behavioral health diagnosis identified by an independent evaluator was not identified at NB and/or not included in the problem list, or if further assessment at NB indicated that the results of the independent evaluations were no longer applicable, there was no documentation by NB staff indicating that the findings from the independent evaluations were considered but rejected based upon the youth's current clinical presentation.¹⁴

For example, in seven cases,¹⁵ trauma was not included on a problem list or was added only well after the youth evidenced symptoms, although it was described in the independent evaluations or through a score on the MAYSI-2. Conduct Disorders or Depressive Disorders had been diagnosed and documented on independent evaluations for eight youth,¹⁶ but these were not included on problem lists. In 10 cases, delinquent behaviors, including firearm charges or carjacking charges, or repeated high-risk behaviors that occurred at NB and that warranted focused assessment and attention, were not directly addressed in assessments or on problem lists.¹⁷ Parent-child relational problems identified in the independent evaluations were not incorporated on 10 problem lists.¹⁸ For four youth, substance use disorders were not included on problem lists even though it was clearly identified in the independent evaluations.¹⁹ For 14 others, low cognitive functioning or learning disorders were not included on problem lists.²⁰

With respect to whether treatment plans addressed all needs and problems, for one youth in the sample, there was no initial behavioral health treatment plan relating to the NB admission under review, but one was completed approximately six months after admission.²¹ In general, and as discussed in more detail below (see Performance Standard # 4), treatment plans for youth did not consistently address all behavioral health needs, did not adequately deal with disruptive behaviors, trauma-related symptoms, cognitive and learning concerns and disorders or substance use disorders²², and were not specifically tailored to reflect the youth's strengths and limitations, especially those with low intellectual functioning. There was also insufficient involvement of family in the youth treatment plans.²³

In many cases, the behavioral health treatment plans lacked details of the specific treatment interventions to be provided, the clinician who was to provide the treatment, and the frequency of treatment. Most treatment plans included generic statements such as "referral to psychiatry," "psychiatry follow up," "substance abuse education," "individual therapy," and "psycho-education groups" but specific groups or treatment interventions were not detailed in the

¹⁴ KB, MB, DB, JB, KP, JE, JHA, JHE, KK, JL, BM, RM, EP, RW, and MW. While these independent evaluations were completed prior to the youths' admission to NB and were available to NB staff, there is no evidence in the behavioral records that the NB behavioral health staff utilized the diagnostic or treatment information in the independent evaluations in formulating treatment for the youth.

¹⁵ KB, MB, KD, JE, KK, MW, and RM.

¹⁶ KB, DB, JE, JHA, RM, EP, DW, and MW.

¹⁷ MB, DB, JE, JHA, KK, JL, BM, EP, RW, and MW.

¹⁸ Parent child relational problems were identified in a number of independent assessments and specific treatment recommendations for this problem were specified. KB, DB, JB, JE, KD, MW, KK, BM, RM, and EP.

¹⁹ MB, JE, JHA, and RM.

²⁰ KB, MB, JB, KD, JE, JHA, JHE, KK, JL, BM, RM, EP, RW, and MW.

²¹ CW.

²² KB, MB, DB, KD, JE, JHA, JHE, BM, RM, EP, DW, RW, and MW.

²³ MB, KD, JE, JHA, BM, RM, EP, and DW.

treatment plans. Treatment plans for a number of youth did not include interventions tied to each problem on the problem list. Plans did not typically address youth behavior between treatment plans and thus it was not clear that treatment regimens were modified based upon the youth's clinical presentation and behavior and effectiveness of treatment. Except for psychiatry services, providers responsible for services were not specifically identified. The days and times of services were not specified in any of the treatment plans reviewed. Finally, in several cases, the same interventions were repeated for every problem on the problem list regardless of the nature of the problem listed.²⁴

In some cases, updated treatment plans did not include interventions for problems that had previously been treated, but these same problems remained as problems on the problem list, and there was no documentation explaining why treatment had ceased or that the problem had been resolved.²⁵ Finally, specific treatment recommendations made in the independent evaluations were often not included in the youths' treatment plans and documentation reflecting why the treatment-related recommendations were not being followed was missing.²⁶ In one case, individual therapy was included in the NB treatment plan despite recommendations against its use by independent evaluations due to the youth's cognitive challenges.²⁷

TREATMENT AND PSYCHIATRIC SERVICES

Treatment services for youth should be individualized based upon the youth's needs, response to treatment (or lack thereof) and intellectual and developmental functioning, and support the transition of youth to the planned next setting. Family should be included in the youth's treatment program to the greatest extent appropriate. Documentation in the record relating to treatment services should address the specific interventions that form the basis of the treatment plan, the frequency of treatment and provide regular, periodic updates describing the youth's participation in and response to treatment.

Psychiatric assessments should be completed for all youth with symptoms of a behavioral health need. With the consent of the youth and parent/guardian, medication should be offered and provided where indicated and medication use and monitoring should be consistent with facility standards. Assessments by a psychiatrist should be completed at appropriate intervals until a youth's condition is stabilized and reflect the youth's clinical presentation, response to treatment and his or her documented behavior in the facility. Problem lists should be updated as new problems were identified or existing problems resolved.

Performance Standard #4: Youth shall receive behavioral health services consistent with the service needs identified in their initial and updated behavioral health screenings and assessments and treatment plans.

This performance standard is closely related to Performance Standard # 3, which focuses on the development of a problem list and treatment plan. While Performance Standard # 3 is

²⁴ JE, KK, and RW.

²⁵ (Not exhaustive list) Examples include KB, JHA, KK, RM, and EP.

²⁶ KB, MB, DB, JB, KD, JHA, KK, RM, DW, RW, and MW.

²⁷ KD.

intended to ensure that comprehensive problem list and treatment plans are developed, Performance Standard # 4 focuses on whether behavioral health services consistent with the problem list and treatment plan *are delivered*. In general, behavioral health records for youth in the sample indicate that individualized treatment plans generally did not reflect appropriately tailored treatment interventions. Further, behavioral health records show insufficient treatment for a variety of problems, such as substance use, disruptive behavior disorders, conduct disorders, including firearm- and carjacking-related behaviors, and trauma-related symptoms.

To meet this standard, all evident behavioral health problems must have been included on a youth's problem list and treatment plan, and the youth had to be provided with behavioral health services consistent with their evident behavioral health needs. Treatment plan services should be likely to address the youth's identified needs in a meaningful way. For all 17 youth in the sample, I identified gaps in services and therefore found unmet or inadequately met needs.

None of the 17 youth were provided behavioral health services that were consistent with all of their behavioral health needs. As described above, the needs that were not addressed include low cognitive functioning and learning concerns or differences. There was insufficient treatment provided to youth for disruptive behavior disorders, PTSD, trauma-related symptoms, substance abuse use, and general disruptive behaviors. Additionally, there was insufficient involvement of the families in the youth's care. In some cases, updated treatment plans did not include interventions for problems that had previously been treated, but these same problems remained as problems on the problem list, and there was no documentation explaining why treatment had ceased or that the problem had been resolved.²⁸ In other cases, notes in the record suggested some kind of treatment was being provided for a specific problem, but the treatment plan did not link the provision of treatment that specific problem.²⁹ In still others, notes suggested treatment was being provided for a problem not on the problem list.³⁰

The services and interventions that were delivered were not likely to address the needs in a meaningful way. There were two areas in which treatment services were particularly problematic. Identified substance use concerns or disorders were not treated or addressed in a manner that would be expected to reduce or address youth substance use in the community. None of the youth in the sample received a GAIN or dedicated substance abuse assessment to identify the scope of the individual's substance use, amenability to treatment, or treatment most likely to effectively address the youth's use of substances. Most youth with identified substance use concerns did not receive evidenced-based substance use services while in NB.³¹ The documented substance use services provided were minimal in breadth and depth and were not tailored to specific youth needs. There were no documented individualized relapse prevention plans or skills that youth practiced and learned in NB that they could be generalized to the community. There were no substantive discussions of the risk and protective factors in the multiple domains known to influence substance use, including peer relations, family dynamics, and leisure activities. For example, 15 of the 17 youth had substance use or substance use disorder identified prior to

²⁸ (Not exhaustive list) Examples include KB, JHA, KK, RM, and EP.

²⁹ (Not exhaustive list) Examples include KB, MB, DB, JL, and DW.

³⁰ (Not exhaustive list) Examples include JE, BM, DW, and EP.

³¹ Goldman P, Wilson JD (2023). Implementation of substance use services to justice-involved youth: Examining barriers, facilitators, and best practices. *Journal of Correctional Health Care*, 29:347-354.

adjudication in court documents and/or in the NB Problem List or Treatment Plan. Of these 15 youth with identified substance use concerns, 11 did not have any evidenced-based substance use education or treatment group sessions documented in their health record while in NB. Among the four youth with documented substance use group attendance, one youth attended nine substance use treatment group sessions, a second youth attended one substance use education group, a third youth attended three substance use treatment groups, and a fourth attended six substance use treatment groups while in NB. The group activities, such as watching videos then discussing, coupled with other documented substance use and mental health and treatment activities would not be expected to effectively address substance use behaviors post-release. Parent/caregiver education on strategies for addressing their children's substance use was generally lacking or limited on the occasions when clinicians connected with caregivers. Nor was there documented evidence that strategies such as multi-dimensional family therapy or functional family therapy that were recommended by independent evaluators to address substance abuse were implemented.

Similarly, treatment for disruptive behavior was ineffective in producing meaningful short- or long-term improvements. NB clinicians usually met or tried to meet with youth approximately weekly or every two weeks. However, in order to generalize treatment gains into the community, youth must frequently practice skills in settings and situations more similar to their post-release environments; this was not evidenced in the records reviewed. Meeting with a therapist 30-60 minutes per week is insufficient compared to 110 waking hours youth spend outside of the therapy room, missing many opportunities for rehabilitation and meaningful behavior change. The differences between the NB environment and the communities to which a youth will return limit opportunities for developing the skills youth will need post-release. In addition, the use of restrictive programming, including room and unit confinement, imposes external controls and inhibits self-regulation skill development which will be needed once the youth is released.³² Treatment notes showed some discussion, teaching, and practicing of specific skills in session. However, references to using skills, and barriers to using skills, between sessions were limited, including after high-risk behaviors. There was no observable evidence of coaching skills in the moment in the NB milieu, particularly when a youth exhibited negative behaviors, behavioral or emotion dysregulation, or was involved in conflict with peers or staff. Overall, the type and frequency of skills training would not be expected to lead to more effective coping and problem-solving.

There was also a lack of sufficient involvement of the family in the youth's care. Independent evaluations of youth in the sample frequently recommended involvement of family in the youth's care and treatment, but the records reflected a lack of family involvement in most treatment for most youth in the sample. Parent/caregiver involvement is central to many effective treatments for adolescent disruptive behavior and substance use.³³ NB notes indicate that family

³² Evidence for enhancing the current approach includes high recidivism rates - 92% of the youth who are involved with or complete DYRS commitment are rearrested, and 47.6% are convicted or adjudicated on new charges within two years (referenced earlier in this report). As of the time of my record review, eight out of the 13 youth discharged from NB engaged in at least one high-risk behavior in the month before release. This indicates that at the time of release, a majority of youth were unable to effectively manage their behavior and emotions and/or resolve conflicts.

³³ McCart MR, Sheidow AJ, Jaramillo J (2022). Evidence base update of psychosocial treatments for adolescents with disruptive behavior. *Journal of Clinical and Child & Adolescent Psychology*, DOI: 10.1080/15374416.2022.2145566; Pina AA, Polo AJ, Huey SJ (2019). Evidence-based psychosocial interventions

involvement in BH treatment and transition planning is limited. For instance, of the 13 families whose children were discharged as of the time of this review,³⁴ only four received a call from a therapist within 1-2 months before release, and typically only one call was made. This lack of communication means that families missed out on learning strategies for supporting their children and addressing family dynamics that reduce recidivism and substance use. Strengthening the family component of NB treatment is essential to fostering good long-term outcomes.

Additionally, group notes reflecting the group therapies provided for each youth were completed on an inconsistent basis, sometimes completed weekly and other instances there were gaps of many months between group notes. In those cases, it was unclear if any services were being provided during these periods. Group and therapy notes frequently reported “minimal progress” or poor engagement of the youth in treatment, but treatment plans and therapy services were rarely modified due to lack of progress or engagement. A review of therapy and group notes also suggests that services were not consistently individualized to reflect the specific strengths and needs of individual youth. For example, the records did not reflect that group curricula were modified to account for a youth’s low cognitive functioning and learning concerns. Indeed, a number of records show that youth were given written materials to study or complete despite the fact evaluations reported that the youth had language and/or reading disorders, low reading skills, and/or borderline or below cognitive functioning. As noted above, the frequency and intensity of services to address disruptive behavior disorders, including conduct disorders, were inadequate and in some records, it appeared substance abuse treatment was limited to individual therapy as opposed to evidence-based treatment for problem substance use. Further, the records did not evidence specifically tailored interventions to engage youth with reported minimal participation in therapies or reflect substantive changes to treatment plans when progress was minimal.

***Performance Standard #5:** For youth on psychotropic medication, conduct weekly psychiatric assessments until the youth have been stabilized, and thereafter, the psychiatric assessments shall be conducted as clinically indicated.*

All of the 17 youth reviewed in the sample were prescribed psychiatric medications at some point during their stay in NB. All received proper psychiatric treatment, which included appropriate initial and follow-up care, and assessments of symptoms, medication effectiveness, and side effects. They also received psychiatric education and informed consent. Follow-up intervals were appropriate, and the psychiatrist consistently rescheduled appointments missed due to a youth’s refusal at weekly intervals until seen.

Documentation in the medical record by the treating psychiatrist of all 17 youth in the sample evidences the clinical basis for each medication ordered and, as applicable, for changes in dosage, frequency or timing of medication administration. The purpose of each medication was discussed with the youth (and with the consenting parent or guardian) and documentation of the

for ethnic minority youth: The 10-year update. *Journal of Clinical Child & Adolescent Psychology*, DOI:10.1080/15374416.2019.1567350

³⁴ The four other youth have been discharged since the time of my review.

discussions was found in each record. Additionally, the records reflected efforts by the psychiatrist to address the concerns about medication expressed by youth, such as sleepiness, lack of sleep, or lack of effectiveness of a certain medication.³⁵ In some cases, the psychiatric notes included references to disruptive behavior that may have occurred between visits,³⁶ but in other cases, some instances of disruptive behavior were not specifically addressed in some of the psychiatric notes.³⁷ Whenever changes were made to medications or dosages, the youth was seen weekly until the psychiatrist determined that the youth was stable.³⁸ Medication compliance was also addressed in those cases where it was deemed to be an issue,³⁹ and in several cases the psychiatrist suggested that the team consider some kind of incentive to achieve compliance, although there is no evidence that this was followed up and included in the treatment plan.⁴⁰

ACUTE OR EMERGENCY SERVICES

***Performance Standard #6:** Youth with acute or emergent mental health needs (e.g., suicidality or thought disorder) should be assessed by a QMHP within one hour of referral to a qualified behavioral health provider.*

This provision ensures that youth who evidence an acute or emergent mental health need (for example suicidality or a thought disorder) are assessed by a qualified mental health professional within one hour of referral. This ensures that youth at imminent risk of injury to self or others are examined on an expediated basis so that immediate treatment or referral for inpatient psychiatric treatment, as appropriate, can be implemented.

Of the 17 youth in the sample, two of the youth evidenced acute or emergency mental health needs during the review period, and 15 youth did not. One youth evidenced suicidal thoughts and was seen within one hour of referral to behavioral health.⁴¹ He was placed on suicide precaution status for sixteen days, and he was closely monitored by direct care staff. Similarly, the second youth⁴² was also assessed within one hour of referral to behavioral health staff of evidencing an acute or emergent mental health need, a suicidal gesture and subsequent suicide attempt. He was also placed on suicide precaution status and was closely monitored until removed from SPS status. The assessments placing each youth on suicide precaution status were comprehensive and supported the decision of the clinician that a higher level of supervision was needed.

***Performance Standard #7:** A QMHP shall assess, supervise, and provide appropriate interventions to youth on suicide precaution status as clinically indicated.*

³⁵ JHE, KK, BM, RM, CW, RW, and MW.

³⁶ DB, JB, JHA, and JHE.

³⁷ KB.

³⁸ JB, JE, and BM.

³⁹ MB, DB, JB, JHE, CW, and RW.

⁴⁰ MB, DB, and JB.

⁴¹ KD.

⁴² JHE.

As discussed above, this provision was applicable to two of 17 youth in the sample and was not applicable for 15 youth. The care provided to the two youth met the standard. For one youth there was documentation that the youth was assessed at least once per day by behavioral health staff for all but two of the days he was on suicide precaution status and for the second youth there was documentation of daily assessments for every day the youth was on suicide precaution status. In both cases, the daily assessments included consideration of whether the youth required acute psychiatric care, reported on current behavior and changes in thoughts and behavior, and addressed what level of observation was appropriate. A special management plan providing guidance to staff on interventions and triggers was present in each record and a note documenting why the youth no longer needed suicide precaution status was also found and supported the discontinuation of suicide precaution status.

***Performance Standard #8:** Behavioral health assessments of youth who engage in repeated self-injurious behavior, or any other type of repeated behavior which puts them, or others, at serious risk of harm shall be conducted. As indicated and appropriate, within 24 hours of such repeated behavior, management strategies aimed at reducing the risk of the identified behaviors shall be implemented consistent with the youth's treatment plan, including any revisions to such plan resulting from the assessment.*

Youth who engage in repeated behaviors that put themselves or others at risk of serious harm should be assessed promptly and strategies to manage the behaviors and reduce the risk to the youth and others should be developed and implemented to ensure the health and safety of the youth and others who are at risk. Treatment plans for youth should be updated if warranted based upon the assessment. Of the 17 youth in the sample, 16 youth engaged in repeated behaviors that put others at risk, and one youth did not.⁴³ The repeated high-risk behaviors for the youth in the sample involved assaults on staff, fights among youth, or significant damage to property.

Timely assessments by behavioral health staff were found for all 16 youth who engaged in repeated behaviors that put self or others at risk. The assessments of five youth addressed the repeated high-risk behaviors, the related symptoms, and included a clinically-based theory for the behavior,⁴⁴ but assessments for 11 youth did not meet this standard. In the cases in which this standard was not met,⁴⁵ the assessments did not include a clinically-based theory of the behavior. Symptoms were not described nor was behavior linked to any problem on the problem list. The youth's participation and engagement in treatment was not reviewed in these assessments. The youth's explanation for the behaviors was included, but it was not a *clinical* assessment of the behavior or the youth's rationale for his actions.

Management plans that included specific and individualized strategies to reduce the risk of repeated high-risk behaviors were not found in any of the 16 applicable cases. Documented strategies were limited to advice for the youth to use self-control skills after each incident of repeated behavior, but no new strategies were developed despite the fact the youth continued to

⁴³ CW.

⁴⁴ KB, JE, DW, RW, and MW.

⁴⁵ MB, DB, JB, KD, JHA, JHE, KK, JL, BM, RM, and EP.

evidence an inability to use their self-control skills. There was no evidence that incentives were considered as a strategy to reduce the repeated high-risk behavior. Further, there were no updates or changes to the youths' treatment plans in any of the 16 applicable cases despite the repeated high-risk behaviors. In fact, documentation consistently stated that updates to the treatment plans were not required.

***Performance Standard #9:** A QMHP shall monitor youth, as clinically appropriate, following the determination that a youth at New Beginnings is in need of emergency psychiatric hospitalization until such time as the youth is transported out of the facility.*

This was not applicable for any of the 17 youth in the sample. There were no youth in the sample for whom emergency psychiatric treatment was required, thus this was not applicable in any of the cases.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

- 1. Strengthen Rehabilitative Model and Therapeutic Environment.** To fulfill its mission of juvenile rehabilitation, DYRS must evolve into a fully therapeutic environment. Every staff member, regardless of role, must become a consistent agent of recovery and growth. The relatively high rates of youth who were involved with or completed DYRS commitment who were rearrested (92.7%) and convicted or adjudicated (47.6%) on new charges within two years⁴⁶ highlight the need for this transformation to provide durable rehabilitation. DYRS records show that a total of 30 youth adjudicated to the New Beginnings (NB) facility for rehabilitation in 2023 successfully completed the NB program and were subsequently released. Post-release information for these 30 youth show that at least 21 youth (70%) have recidivated. Sixteen youth returned to the custody of DYRS or were detained in a jail in DC or Maryland, and five have been charged with additional crimes in DC.⁴⁷ Rehabilitation cannot be compartmentalized into a few hours of individual and group therapy each week. Any and all interactions between youth and staff should be viewed opportunities for teaching and skills training. In order to support and provide consistent rehabilitation to youth, all staff, including those who are not therapists in the conventional sense, such as administrators, teachers, custody staff, and others, must be trained to be therapeutic in their interactions with youth. Youth spend more time with custody, direct care, and education staff than behavioral health clinicians. As a result, non-clinical direct care staff have great potential to influence youth behavior and rehabilitation. At the same time, DYRS licensed clinicians play critical roles in rehabilitation, including identifying treatment needs, providing individual and family therapy, educating staff, and managing

⁴⁶ Erin Partin, Criminal Justice Coordinating Council (2022) Juvenile Recidivism: A 2018 Cohort Analysis. https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/Juvenile%20Recidivism%202022%20-%20FINAL_v2.pdf. Accessed 10/30/2024

⁴⁷ OIJFO staff have stated that these figures are based only on DYRS and DC Superior Court records and not a review of broader adult criminal justice systems around the District of Columbia and thus may undercount the number of individuals who had additional contact with the juvenile or criminal justice system.

treatment plans. Licensed clinical staff should help train non-clinical staff to be therapeutic in their interactions with youth and families, and clinical and non-clinical staff should collaborate on the development of treatment and release plans. All staff must work together to teach and reinforce youth and parent/caregiver skillful behavior and ensure a consistent and supportive environment for rehabilitation. By reinvesting in comprehensive treatment resources, staff training, therapeutic programming that can be more targeted and individualized to specific youth needs, and integrating family-based services, DYRS can fulfill its mission of juvenile rehabilitation. The future of the youth adjudicated to DYRS custody, and the safety and well-being of the community depends on it.

2. **High Needs.** The NB youth whose charts were reviewed showed high behavioral health and social needs. These needs often span multiple domains, including mental health, emotion and behavioral regulation, cognitive and learning concerns, school engagement and performance, substance use, family challenges, financial difficulties, peer affiliations, racial inequities, community concerns, and other social drivers of health. Rehabilitation services and community reentry for these youth require careful and comprehensive planning and interventions.
3. **Family Engagement.** The engagement and participation of family/caregiver, fictive kin/family members of choice, and caring adults are essential to successful rehabilitation. Treatment plans and rehabilitation services benefit from intentional family involvement. Most youth will return to their families after release, and research shows that families can significantly influence youth behavior and juvenile system recidivism. Youth who do not return home will benefit from the involvement of caring adults from the settings where the youth will live. Elevating family and youth voice in assessment and treatment planning will enhance family engagement and the implementation of interventions that align with family culture and values. DYRS should facilitate and ensure regular and frequent contact and therapeutic work with families and caregivers.
4. **Diverse Treatment Programs and Environments.** DYRS must broaden the variety of treatment programs and environments in NB. Expanding the range of services and rehabilitation settings will benefit youth by providing more individualized and generalizable support. This progressive continuum is essential for the development of the skills needed for positive community reintegration. Reducing time spent in restrictive environments better prepares youth for release. Prolonged room and unit confinement can negatively impact emotional well-being, increase irritability, and inhibit the development of self-regulation skills. DYRS facilities should be modified, as much as possible, to offer less restrictive and more normative home- and community-like settings. Programming should be enhanced so staff can provide coaching in the milieu. Youth who demonstrate more skillful behaviors should be provided opportunities to live in environments that more closely resemble their future living situations. Learning and practicing skills in more natural and interactive settings will increase the likelihood that treatment gains will generalize to the community.
5. **Early Discharge Planning.** Discharge/release planning must begin at DYRS admission to ensure a smooth transition back into the community. Transition plans should be developed through regular and ongoing communication among youth, family, DYRS staff, and community partners. Detailed release preparations should include specific

plans for youth prosocial activities and schedules, family responsibilities, behavioral health treatment, school/vocational training, and DYRS and court support and oversight.

6. **Dedicated Staff.** DYRS staff and leaders are hard-working and committed to serving the youth in their care. During the site visits, staff consistently shared how much they care for the youth in their custody and advocated for the highest quality services and supports.
7. **Sufficient Staffing.** DYRS must ensure that they continue to employ and train sufficient numbers of qualified staff to provide youth effective rehabilitation services.
8. **Timely Access to Inpatient Psychiatry.** DYRS must collaborate with government and community partners to ensure timely access to inpatient psychiatric services when youth in DYRS facilities require this level of care.
9. **Competitive Compensation.** DYRS must ensure that employee compensation is sufficient to recruit and retain qualified staff, especially those in direct care, treatment, and leadership roles, to work with youth and families with complex needs.
10. **Ongoing Training.** Continuous and ongoing staff training and supervision must be prioritized and funded to promote staff skill development and mitigate any negative effects of staff turnover.

Appendix

Assessment Questions (Yes, No, or N/A if the question does not apply to youth in the sample)	KB	MB	DB	JB	KD	JE	JHA	JHE	KK	JL	BM	RM	EP	DW	CW	RW	MW	Comments why not met
V.A.1.b.i. Assess whether a telephone consultation assessing suicidality or presence of thought disorder was conducted and documented for youth who flagged a caution or warning on suicidality and/or thought disorder.	No	N/A	MAYSI MISSING	N/A	MAYSI MISSING	N/A	MAYSI MISSING	MAYSI MISSING	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	MAYSI MISSING	KB not met - no evidence of telephone consultation. In EP, note reflected that MH said they would speak to youth and face to face held, standard met.
V.A.1.b.i. Assess whether a face-to-face behavioral health assessment by behavioral health was conducted of youth who flagged a caution or warning on suicidality and/or thought disorder within 18 hours of the administration of the MAYSI-2 or alternative screening or a lesser time if clinically appropriate.	Yes	N/A	MAYSI MISSING	N/A	MAYSI MISSING	N/A	MAYSI MISSING	MAYSI MISSING	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A	MAYSI MISSING	
V.A.1.b.i. Assess whether the results of the MAYSI-2 (all relevant indicators) were incorporated into the youth's problem list and treatment plan.	No	N/A	MAYSI MISSING	N/A	MAYSI MISSING	N/A	MAYSI MISSING	MAYSI MISSING	No	N/A	Yes	N/A	No	N/A	Yes	No	MAYSI MISSING	KB not met as trauma and depression not in initial plan but added in next plan the following month. KK not met while Trauma was addressed in tx plan not added to problem list, despite MAYSI screen positive for trauma. EP not met - thought disorder. RW not met - firearm related CD/DBD, low cognitive functioning and LD missing from problem list.
V.A.5.d.i. Assess whether any youth who flagged a caution or warning on the substance abuse scale in the MAYSI-2 received the GAIN-Q within 5 days. If there is evidence of some other substance abuse assessment, that would be relevant as well.	N/A	N/A	MAYSI MISSING	N/A	MAYSI MISSING	N/A	MAYSI MISSING	MAYSI MISSING	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	MAYSI MISSING	EP not met as youth scored warning on Alcohol/Drug MAYSI but no GAIN completed.
V.A.1.c.i. Assess whether all behavioral health needs revealed through the behavioral health assessments the youth received were identified. This should consider MAYSI-2 results, clinical assessments, as well as reported behavior in the facility (e.g., assaultive, self-injurious, acute or emergent needs, etc.)	No	No	No	No (missing low cognitive functioning)	No	No (also trauma flagged on MAYSI but not on problem list. Also missing conduct d/o and marijuana use from independent evals)	No	No	No	No	No	No (Missing Major Dep d/o from independent evals and missing DBD conduct d/o cognitive concerns and learning differences)	No (also no mention of depression despite score of caution on MAYSI and dx of major depression d/O in Index eval)	Yes	UTD	No	No	KB not met due to low cognitive functioning. MB not met as DBD including carjackings, SUD, other specified trauma and stressor related DO, low cognitive functioning and LDs. DB not met because assessment failed to adequately address conduct disorder (youth met criteria for diagnosis) and failed to include history of including firearm and carjacking related behaviors nor address in tx plan. JB not met due to not considering low cognitive functioning in treatment. KD not met due to missing diagnoses of unspecified trauma and related stressors, parent-child problem, low cognitive functioning and LD. JE not met DB/CD including firearm and carjacking behaviors, SUD, cognitive and learning concerns. JHA not met as DMDD, DBD/CD including firearm and carjacking behaviors, SUD, low cognitive functioning, SLD. JHe not met conduct disorder not formally diagnosed and youth likely met criteria, cognitive concerns /ID (FSIQ 58) warrants more than borderline intel functioning dx (low cognitive functioning better statement) and treatment plan issues. KK not met DBD/CD including firearm and carjacking behaviors, low cognitive functioning, trauma-stress related DO. JL not met because missing diagnosis of conduct disorder and failure to address firearm charges and cognitive and learning concerns. BM not met no treatment plan, Prob list did not include behaviors consistent with conduct d/o (i.e., firearm charges) or cognitive concerns and learning differences. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences. EP not met DBD/Conduct DO including firearm and carjacking behaviors, learning disorders. CW unable to determine as outside evals were not available. RW not met assessment did not reflect firearm related CD/DBD diagnosis, low cognitive functioning and LDs. MW not met DBD including firearm related behaviors, other trauma and related stressors related DO, parent child relational problem, depression, low cognitive functioning and LDs.

Assessment Questions (Yes, No, or N/A if the question does not apply to youth in the sample)	KB	MB	DB	JB	KD	JE	JHA	JHE	KK	JL	BM	RM	EP	DW	CW	RW	MW	Comments why not met
V.A.1.c.i. Assess whether a problem list entry was made for each behavioral health need revealed by each assessment;	No (DMDD and Trauma not added)	No	No	No (missing low cognitive functioning)	No	No	No (Problem list did not include DMDD or SUD dx despite independent evals, nor was borderline intel functioning included)	No	No	No	No	No (Missing Major Dep d/o from independent evals missing DBD conduct d/o cognitive concerns and learning differences)	No	No (also missing DMDD and Conduct D/O)	UTD (Prob list included DMDD, Insomnia, Major Depressive Disorder, ADHD and MJ use)	No	No	KB not met due to low cognitive functioning not listed and MAYSI flag not included. MB not met, DBD, SUD, cognitive concerns. DB not met because conduct disorder, including firearm and carjacking related behaviors not included in assessment despite meeting criteria. JB not met due to not addressing low cognitive functioning. KD not met due to missing diagnoses of unspecified trauma and related stressors, parent-child problem, low cognitive functioning and LD. JE not met DB/CD including firearm and carjacking behaviors, SUD, cognitive and learning concerns. JHA not met as DMDD, DBD/CD including firearm and carjacking behaviors, SUD, low cognitive functioning, SLD. JHE not met conduct disorder not formally diagnosed and youth likely met criteria. cognitive concerns /ID (FSIQ 58) warrants more than borderline intel functioning dx (low cognitive functioning better statement) and treatment plan issues. KK not met DBD/CD including firearm and carjacking behaviors, low cognitive functioning, trauma-stress related DO. JL not met DBD consistent with conduct disorder including firearm charges and cognitive and learning concerns. BM not met no treatment plan, PL did not include/address behaviors consistent with conduct d/o including firearm charges or cognitive concerns and learning differences. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences. EP not met DBD/Conduct DO including firearm and carjacking behaviors, learning disorders and MAYSI- flags not included. DW not met DBD, CD-firearm behavior, low or borderline intellectual functioning learning disorders. CW unable to determine as outside evals were not available. RW not met firearm related CD/DBD, low cognitive functioning and LDs should have been in problem list. MW not met DBD including firearm related behaviors, other trauma and related stressors related DO, parent child relational problem, depression, low cognitive functioning and LDs.
V.A.1.c.i. Assess whether the problem list was updated, as appropriate;	No	No	No	No (missing low cognitive functioning)	No (Trauma never added to problem list)	N/A (but conducted)	No	Yes (updated with suicide attempt in February 2024)	Yes	Yes	No	No	No	Yes	Yes	N/A	N/A	KB not met because missing low cognitive functioning in treatment planning. MB , not met because missing DBD, SUD, cognitive concerns. DB not met because conduct disorder, including firearm and carjacking related behaviors should have been included on problem list and addressed in treatment plan. JB not met due to not considering low cognitive functioning. KD not met due to missing diagnoses of unspecified trauma and related stressors, parent-child problem, low cognitive functioning and LD. JHA not met not met as DMDD, DBD/CD including firearm and carjacking behaviors, SUD, low cognitive functioning, SLD. JHE not met because treatment plan, PL did not include behaviors consistent with conduct d/o including firearm charges or cognitive concerns and learning differences and these were not adequately addressed treatment plan. RM not met because DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences were not adequately addressed in problem list or treatment plan. EP not met DBD/Conduct DO including firearm and carjacking behaviors, learning disorders.
V.A.1.c.i. Assess whether each behavioral health problem was addressed in the youth's treatment plan and included appropriate interventions.	No (Recs from independent evals such as family therapy and GAIN not implemented. Index eval noted that because of deficiencies in verbal expression trad talk therapy may not be effective. Rec functional assessment by behavioral specialist)	No (Also, trauma not addressed specifically in tx plan. Plan only included generic reference to psycho-ed groups without specifying which groups. SUD groups mostly watching videos)	No (Tx plans between 6/23 and 1/29/24 missing interventions for problems)	No	No (Trauma never added to problem list. No SUD groups in tx plan. No changes in interventions in tx plan despite plans noting min progress)	No (missing trauma and marijuana use)	No	No	No (SUD per tx plan "as needed." No family therapy)	No (Until 6/2/23 tx plan, tx plans were missing frequency of interventions. No inclusion of med mgt or psych f/u included. Tx Plan said use motivational interviewing but not if for IT or group therapy or both)	No	No (Trauma not sufficiently addressed, generic interventions. Some missing plans)	No (None of tx plans included specific interventions or frequency of interventions. No group notes of any kind during this admission)	No (Problems were on tx plan but no interventions were specified, who was to do them or frequency indicated)	No (Only tx plan at NB dated 6/23. Referred to psycho-ed groups and SUD groups but not specific groups)	No	No	KB not met because missing GAIN and functional assessments recommended by indep evaluators and inappropriate intervention. MB not met due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met because conduct disorder, including firearm and carjacking related behaviors. JB not met insufficient treatment for DBD/CD, SUD, consideration for low cognitive functioning, insufficient involvement of family. KD not met because insufficient tx for disruptive behavior, SUD, and trauma symptoms, lack of consideration for cognitive and learning concerns, insufficient involvement of family. JE not met because insufficient treatment for disruptive behavior, SUD, trauma, lack of consideration for cognitive and learning concerns, insufficient involvement of family in treatment. JHA not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. JHE not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns, insufficient involvement of family. KK not met insufficient treatment for DBD/CD, SUD, trauma, insufficient consideration for cognitive concerns, insufficient involvement of family. JL not met - DBD/Conduct DO including firearm charges, SUD, PTSD, insufficient consideration for cognitive and learning concerns, insufficient involvement of family. BM not met insufficient treatment for DBD, SUD, PTSD; insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD, consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment for DBD and SUD. RW not met insufficient treatment for DBD, SUD, PTSD, cognitive and learning concerns insufficient involvement of family. MW not met insufficient treatment for DBD, SUD, trauma, cognitive and learning concerns, insufficient involvement of family.

Assessment Questions (Yes, No, or N/A if the question does not apply to youth in the sample)	KB	MB	DB	JB	KD	JE	JHA	JHE	KK	JL	BM	RM	EP	DW	CW	RW	MW	Comments why not met
V.A.5.b.i. Assess whether all of the behavioral health needs revealed in the screenings and assessments were included in the problem list and addressed in each youth's treatment plan and, if not, which needs were not included in the problem list and/or the treatment plan.	No	No	No (Tx plans between 6/23 and 1/29/24 missing interventions for problems)	Yes	No	No (tx plan included tx for depression and insomnia but not trauma or SUD)	No (No SUD groups. Trauma not addressed in tx plan. Reference to psych-ed groups but no specific groups identified. Only one tx plan in EHR)	No	No	No	No	No	No	No	UTD	No	No (only one tx plan (7/24/23) for entire admission. Plan included Trauma and Depression (neither was on prob list), ADHD, Sleep and MJ Use)	KB not met due to low cognitive functioning. MB not met due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met because conduct disorder, including firearm and carjacking related behaviors. KD not met due to missing diagnoses of unspecified trauma and related stressors, parent-child problem, low cognitive functioning and LD. JE not met because insufficient treatment for disruptive behavior, SUD, trauma, lack of consideration for cognitive and learning concerns, insufficient involvement of family in treatment. JHA not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. JHE not met because cognitive concerns/ID (FSIQ 58). KK not met insufficient treatment for DBD/CD SUD, trauma, insufficient consideration for cognitive concerns, insufficient involvement of family. JL not met because conduct disorder/DBD, SUD and PTSD missing and insufficient consideration for cognitive and learning concerns, nature of charges (firearms) and insufficient involvement of family. BM not met insufficient treatment for DBD, SUD, PTSD; insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD, consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment for DBD, SUD, cognitive concerns, PTSD, insufficient involvement of family. CW unable to determine as no outside evaluations were available, no MH treatment plan, Prob List included DMDD, MJ use and ADHD. RW not met firearm-related CD/DBD, low cognitive functioning and LDs should have been on list but were not. MW not met DBD including firearm related behaviors, other trauma and related stressors related DO, parent child relational problem, depression, low cognitive functioning and LDs.
V.A.5.b.i. Assess whether youth were provided with behavioral health services that are consistent with their behavioral health needs, including behavioral health needs that have been identified as a result of screenings and assessments as well as behavioral health needs that should have been identified by DYRS behavioral health staff but were not. Indicate if the services provided or identified were not likely to address the youth's needs in a meaningful way and the basis for the conclusion.	No (Also recs from independent evals not implemented)	No (No family therapy despite recs of indep evaluators)	No (HR assessments completed but mostly reminded to use self control skills and otherwise given coping strategy worksheets)	No (Detailed notes in JB results chart)	No (Gaps in treatment notes so unclear if and which tx occurred)	No (tx plan did not change throughout admission. Big gap in group notes unclear if tx provided and if so what tx was)	No (group notes missing for months at a time, unable to verify what tx if any was provided)	No (very few group notes in record. Unable to verify tx occurred as provided in plan)	No (no group notes reflecting SU treatment. Group notes of all kinds end in August 23)	No (gaps in group notes unable to verify tx occurred as provided for in tx plan)	No (No SUD groups referenced. Gaps in group notes Apr 23, July 23 or any in 2024)	No (no SUD groups. Gaps in group notes (Nov 23, March 24 and Nov 24 to time of review) so unable to determine tx occurred or what tx provided)	No (group notes for this short admission missing but group notes for other admissions are present. No group notes in Jan 24, July 24 and between August 24 - Jan 25. No SUD groups id in EHR)	No	No (very few group notes in EHR)	No (Group notes were inconsistent - only found for Feb and March 23 and June - July 23. Youth often refused groups)	No	KB not met due to low cognitive functioning. MB not met due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met insufficient tx for DBD, PTSD and insufficient involvement of family. JB not met insufficient treatment for DBD/CD, SUD, consideration for low cognitive functioning, insufficient involvement of family. KD not met because insufficient tx for disruptive behavior, SUD, and trauma symptoms, lack of consideration for cognitive and learning concerns, insufficient involvement of family. JE not met because insufficient treatment for disruptive behavior, SUD, trauma, lack of consideration for cognitive and learning concerns, insufficient involvement of family in treatment. JHA not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. JHE not met insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns and insufficient involvement of family. KK not met insufficient treatment for DBD/CD SUD, trauma, insufficient consideration for cognitive concerns, insufficient involvement of family. JL not met - DBD/Conduct DO including firearm charges, SUD, PTSD, insufficient consideration for cognitive and learning concerns, insufficient involvement of family. BM not met insufficient treatment for DBD, SUD, PTSD; insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD, consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment of DBD, CD, SUD, PTSD, consideration for learning differences, insufficient involvement of family. CW not met insufficient treatment for DBD and SUD. RW not met insufficient treatment for DBD, SUD, PTSD, cognitive and learning concerns insufficient involvement of family. MW not met insufficient treatment for DBD, SUD, trauma, cognitive and learning concerns, insufficient involvement of family.
V.A.5.b.i. Assess whether each youth received behavioral health services for all of his/her behavioral health needs, and, if not, which needs were not addressed and the associated impact on or risk to the youth. Indicate if the services provided or identified were not likely to address the youth's needs in a meaningful way and the basis for the conclusion.	No	No (med compliance noted as issue and rec was to incentivize meds but no evidence that was done)	No	No	No	No	No	No	No	No	No	No	No	No (no group notes located between March 24 to July 24)	No	No	No (Group notes found for Nov 23 -May 24 not group notes for May or June 24 and most of July 24)	KB not met due to low cognitive functioning. MB not met due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met insufficient tx for DBD, PTSD and insufficient involvement of family. JB not met insufficient treatment for DBD/CD, SUD, consideration for low cognitive functioning, insufficient involvement of family. KD not met because insufficient tx for disruptive behavior, SUD, and trauma symptoms, lack of consideration for cognitive and learning concerns, insufficient involvement of family. JE not met because insufficient treatment for disruptive behavior, SUD, trauma, lack of consideration for cognitive and learning concerns, insufficient involvement of family in treatment. JHA not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. JHE not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns, insufficient involvement of family. KK not met insufficient treatment for DBD/CD SUD, trauma, insufficient consideration for cognitive concerns, insufficient involvement of family. JL not met - DBD/Conduct DO including firearm charges, SUD, PTSD, insufficient consideration for cognitive and learning concerns, insufficient involvement of family. BM not met insufficient treatment for DBD, SUD, PTSD; insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD, consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment for DBD, SUD, cognitive concerns, PTSD, insufficient involvement of family. CW not met insufficient treatment for DBD and SUD. RW not met insufficient treatment for DBD, SUD, PTSD, cognitive and learning concerns, insufficient involvement of family. MW not met insufficient treatment for DBD, SUD, trauma, cognitive and learning concerns, insufficient involvement of family.

Assessment Questions (Yes, No, or N/A if the question does not apply to youth in the sample)	KB	MB	DB	JB	KD	JE	JHA	JHE	KK	JL	BM	RM	EP	DW	CW	RW	MW	Comments why not met
V.A.3.a.i. Determine whether any youth in the samples exhibited acute or emergent behavioral health needs during the review period. (For any youth that did not indicate n/a)	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
V.A.3.a.i. Determine whether youth who exhibited acute or emergent behavioral health needs were referred to behavioral health staff in a timely manner and assessed within one hour of referral (NOTE: If you identify youth with acute or emergent needs, OIJFO can assess timeliness).	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
V.A.3.a.i. Assess whether the problem list and treatment plan of a youth who exhibited acute or emergent behavioral health needs were appropriately updated. (For any youth that did not indicate n/a)	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
V.A.3.e.iii. Assess whether the clinical assessments and interventions implemented to support youth on suicide precaution status were appropriate.	N/A	N/A	N/A	N/A	Yes	N/A	N/A	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
V.A.5.c.i. and c.ii. Assess whether a timely behavioral health assessment was completed for the youth who engaged in the repeated self-injurious behavior or behaviors that put others at serious risk of harm, and note which type of behavior was involved.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Timely assessments for HRB found in all cases.
V.A.5.c.i. and ii. Assess whether documentation of the behavioral health assessment addressed the repeated self-injurious behaviors or behaviors that put others at serious risk of harm and related symptoms and included a clinically-based theory for the behavior and note which type of behavior was involved.;	Yes	No (HR asmts completed on 11 occasions. Advised to use self-control skills. No tx plan changes. Notes insomnia unstable at times, meds adjusted for that issue)	No	No	No	Yes	No (Notes did not tie behavior to a problem on list or provide a clinical rationale for it. No changes to tx plan made. Meds were increased after Dec 23 episodes)	No (Notes did not tie behavior to a problem on list or provide a clinical rationale for it. No changes to tx plan made. Some meds adjusted in August 22. PTSD and Major Depression stabilize at times but not at others)	No (Notes did not tie behavior to a problem on list or provide a clinical rationale for it. No changes to tx plan made though meds were adjusted - mom refused meds for ADHD)	No	No	No (Notes did not tie behavior to a problem on list or provide a clinical rationale for it. No changes to tx plan made)	No (Notes did not tie behavior to a problem on list or provide a clinical rationale for it. No changes to tx plan made)	Yes	N/A	Notes reflect DMDD dx added in February 2023 after several HR referrals Med compliance an issue.	Yes	Not met in JB as quality of the clinical formulation and treatment plan insufficient to address problem behavior. KD not met because quality of formulation and treatment plan insufficient to address problem behavior. MB not met due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met insufficient tx for DBD, PTSD and insufficient involvement of family. JHA not met as continued high-risk behaviors up to release. JHE not met because insufficient treatment for DBD, SUD, PTSD, insufficient consideration for cognitive concerns, insufficient involvement of family. JK not met insufficient treatment for disruptive behaviors and insufficient involvement of family. JL not met - DBD/Conduct DO including firearm charges, SUD, PTSD, insufficient consideration for cognitive and learning concerns, insufficient involvement of family. BM not met because quality of formulation and treatment plan insufficient to address problem behavior. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD consideration for learning differences, insufficient involvement of family.
V.A.5.c.i. and ii. Assess whether the behavioral health assessment resulted in a management plan that included specific and individualized strategies to reduce the risk of recurrence of the repeated self-injurious behaviors or behaviors that put others at serious risk of harm and note which type of behavior was involved.	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plans result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	Yes	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	No (No mgt plan located, no changes to tx plan as result of HRB assessment)	Not met in KB due to insufficient tx for DBD, SUD, PTSD, insufficient consideration of low cognitive functioning and insufficient involvement of family. Not met in MB due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met insufficient tx for DBD, PTSD and insufficient involvement of family. JB not met insufficient treatment for DBD/CD, SUD, consideration for low cognitive functioning, insufficient involvement of family. KD because of insufficient understanding and treatment of the function of youth suicidality. JE not met because no management plan developed and no changes to treatment despite HR behavior. JHA not met as continued high-risk behaviors up to release. JHE not met because insufficient treatment for DBD, high risk behaviors during the month before release. JK not met insufficient treatment for disruptive behaviors and insufficient involvement of family. JL not met - DBD/Conduct DO including firearm charges, SUD, PTSD, insufficient consideration for cognitive and learning concerns, insufficient involvement of family. BM not met because treatment/interventions insufficient to address problem behavior. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment for DBD, SUD, cognitive concerns, PTSD, insufficient involvement of family. RW not met insufficient treatment for DBD, SUD, PTSD, cognitive and learning concerns, insufficient involvement of family. MW not met insufficient treatment for DBD, SUD, trauma, cognitive and learning concerns, insufficient involvement of family.

Assessment Questions (Yes, No, or N/A if the question does not apply to youth in the sample)	KB	MB	DB	JB	KD	JE	JHA	JHE	KK	JL	BM	RM	EP	DW	CW	RW	MW	Comments why not met	
V.A.5.c.i. and ii. Assess whether the youth's treatment plan was impacted by the results of the behavioral health assessment of repeated self-injurious behaviors or behaviors that put others at serious risk of harm, and, if so, whether it was modified appropriately and note which type of behavior was involved.	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted)	No (No changes in tx plan though some meds adjusted)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	No (Tx plans lacked any interventions)	N/A	No (No changes in tx plan though some meds adjusted at times)	No (No changes in tx plan though some meds adjusted at times)	Not met in KB case due to insufficient tx for DBD, SUD, PTSD, insufficient consideration of low cognitive functioning and insufficient involvement of family. Not met in MB due to insufficient tx of DBD, SUD, trauma, consideration for cognitive and learning concerns and insufficient involvement of family. DB not met insufficient tx for DBD, PTSD and insufficient involvement of family. JB not met insufficient treatment for DBD/CD, SUD, consideration for low cognitive functioning, insufficient involvement of family. KD because of insufficient understanding and treatment of the function of youth suicidality. JE not met because insufficient treatment for disruptive behavior, SUD, trauma, lack of consideration for cognitive and learning concerns, insufficient involvement of family in treatment. JHA not met because continued high risk behaviors up to discharge. JHE not met because insufficient treatment for DBD, high risk behaviors during the month before release. KK not met insufficient treatment for disruptive behaviors and insufficient involvement of family. JL not met not modified in the face of high-risk behaviors. BM not met insufficient treatment for DBD, SUD, PTSD; insufficient consideration for cognitive concerns and learning differences, insufficient involvement of family. RM not met DBD including conduct D/O related behaviors, SUD, PTSD, cognitive concerns and learning differences and insufficient involvement of family. EP not met insufficient treatment of DBD, CD, SUD, PTSD consideration for learning differences, insufficient involvement of family. DW not met insufficient treatment for DBD, SUD, cognitive concerns, PTSD, insufficient involvement of family. RW not met continued high risk behaviors before release. MW not met because no management plan was developed and the treatment plan did not include sufficient interventions for DBD, SUD and trauma, and not tailored to cognitive and learning limitations.
V.A.5.c.i. and ii. Assess whether the updated treatment plan addressing the self-injurious behaviors or behaviors that put others at serious risk of harm was implemented by behavioral health staff and note which type of behavior was involved.	No	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	No	N/A	N/A	N/A	Not met in KB case due to insufficient tx for DBD, SUD, PTSD, insufficient consideration of low cognitive functioning and insufficient involvement of family. DW not met insufficient treatment for DBD, SUD, cognitive concerns, PTSD, insufficient involvement of family.	
V.A.3.d.ii. For youth that has been determined to be in need of psychiatric hospitalization, assess whether youth received appropriate clinical monitoring by a behavioral health specialist following the determination that the youth is in need of emergency psychiatric hospitalization until the youth is transferred to an emergency psychiatric facility. Includes a review of both the frequency and the quality of monitoring.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
V.A.6.a.i. For youth on psychotropic medication, assess whether the youth was seen weekly by the psychiatrist until stabilized;	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
V.A.6.a.ii. If the youth was seen weekly, whether the psychiatric assessments were clinically appropriate (addressed symptoms, efficacy of medication, responsiveness to medication, youth's wishes etc.);	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
V.A.6.a.iii. If the youth was stable, whether the youth was seen by the psychiatrist at appropriate intervals;	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
V.A.6.a.ii. If the youth was not seen weekly, whether the youth was stable	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
V.A.6.a.ii. If the youth was not stable and not seen, what was the impact, if any, on the youth.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

Attachment 3



Behavioral Health Services Oversight Report Response

I. Introduction

The Department of Youth Rehabilitation Services (DYRS) appreciates the opportunity to review and respond to the draft report prepared by the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) regarding behavioral health services at the New Beginnings Youth Development Center (NB).

DYRS values independent oversight and is committed to continuous quality improvement. This response is submitted pursuant to the **BH Oversight Report Response 2025 protocol**, ensuring factual accuracy, transparency, and alignment with agency corrective action processes.

DYRS acknowledges and supports the report's recognition that rehabilitation cannot be compartmentalized into clinical encounters alone, and that all staff—clinical and non-clinical—must operate as therapeutic agents. This principle underpins the agency's integrated approach to rehabilitation, which merges behavioral health, educational, and youth development services.

II. General Observations

1. **Interdisciplinary Rehabilitation Model:**

DYRS concurs that the New Beginnings program operates as an integrated therapeutic community. The “core support team” model (including behavioral health, education, credible messenger, and unit leadership staff) ensures coordinated support across domains. This model aligns with the OIJJFO's observation that all staff interactions are opportunities for therapeutic engagement

2. **Documentation and Data Accessibility:**

DYRS recognizes that certain documentation—particularly historical MAYSI-2 results and early behavioral health plans—were not readily retrievable due to legacy software and backlog in electronic health record (EHR) uploads. Corrective actions are in place to resolve these gaps, including EHR integration and workflow modernization.

3. **Staff Availability vs. Position Fill Rate:**

While the report noted that behavioral health positions were “frequently filled,” the agency clarifies that filled positions do not equate to full-time availability. During the review period, coverage was impacted by extended staff absences, requiring temporary reassignments across facilities.

III. Responses to Key Findings

1. **MAYSI-2 Screening Administration**

Finding: Delays and gaps in MAYSI-2 administration and documentation.

Response: The outdated instrument software contributed to document access delays. As of May 2024, DYRS has transitioned to an **online integrated MAYSI-2 platform**. All youth now receive screening upon intake, with quality checks embedded in the admission workflow. **Substance Abuse Screening and Treatment**

Finding: Limited evidence of standardized substance abuse assessments and interventions.

Response: DYRS has embedded the **GAIN-SS** into the behavioral health intake process and added the **CRAFFT** tool in medical assessments, ensuring universal substance use screening. The **Substance Abuse Treatment Coordinator** role was reinstated in FY24, with certification completed in May 2024. DYRS recognizes that one FTE is insufficient and will assess staffing augmentation in FY26.

2. Use of Independent Evaluations

Finding: Dr. Lee found “no evidence” that independent diagnostic reports informed treatment planning.

Response: Independent evaluations are consistently referenced in each youth’s **NB Success Plan**, which integrates diagnostic and treatment recommendations into individualized programming. DYRS acknowledges that these linkages were not always visible in EHR documentation and will implement a documentation crosswalk to explicitly reflect the source of diagnostic inputs within each plan.

3. Treatment Plan Quality and Individualization

Finding: Treatment plans lacked specific interventions, group references, or scheduling detail.

Response: DYRS agrees that increased clarity in documenting group modalities and individualized adaptations is needed. Each youth’s **Success Plan** now specifies evidence-based group enrollment (TGCTA, SPARCS, WAIT, etc.), with session logs uploaded weekly. Additional training will be provided to clinicians on SMART goal documentation and fidelity tracking within **FAMCare**.

4. Trauma-Informed and Therapeutic Culture

Finding: Youth Development Representatives (YDRs) require greater therapeutic integration.

Response: DYRS has embedded trauma-informed principles across pre-service and in-service training. Modules such as *Think Trauma*, *Suicide Prevention*, *Anger Management*, and *Cultural Sensitivity*—as well as **Safe Crisis Management (SCM)** certification—are mandatory for all secure program staff. SCM emphasizes de-escalation and post-incident repair consistent with trauma-informed care. Continuous coaching and CQI monitoring are ongoing

5. Suicide Precaution Status (SPS) Monitoring

Finding: Inconsistent record review and unclear SPS compliance evidence.

Response: DYRS confirms that SPS compliance is tracked through **monthly CQI metrics**. Each SPS case is reviewed at the facility's behavioral health committee, with corrective action plans developed for deviations. Historical record review was not possible for the sampled youth due to EHR archiving limitations.

6. "Awaiting Placement" Youth

Finding: The Report suggests these youth did not receive full clinical programming.

Response: Clarification: "Awaiting placement" youth receive **psychiatric care, individual therapy, and trauma-focused CBT groups**, consistent with their length of stay and stability status. Access to education and enrichment programming is maintained per DYRS policy.

V. Release and Transition Procedures

Consistent with the **New Beginnings Release Procedure**

- Each youth's **Treatment and Re-entry Plan** includes individualized transition goals in education, housing, employment, and health services.
- Team Decision-Making (TDM) meetings are convened **at least 30 days prior to release**, ensuring continuity of behavioral health care in the community.
- The **Facility Review Committee** and **Superintendent** approve all release recommendations, with discharge summaries documenting treatment progress and continuing service needs.

DYRS reaffirms its commitment to a **continuum of care** that extends from admission through community reintegration.

VI. Conclusion

The Department appreciates the OIJFO's comprehensive evaluation and recognizes the value of constructive oversight in improving youth outcomes. Many of the identified concerns were already known to DYRS and have been or are being addressed through corrective measures. Other findings reflect differences in documentation visibility rather than substantive service deficiencies.

DYRS remains committed to transparency, quality care, and adherence to national standards for juvenile rehabilitation.

Attachment 4

YLS/CMI 2.0™

Youth Level of Service / Case Management Inventory 2.0

By R. D. Hoge, Ph.D. & D. A. Andrews, Ph.D.

Profile Report

Name:	[REDACTED]
ID Number:	[REDACTED]
Age:	15
Sex:	Male
Gender Identity:	-
Race/Ethnicity:	N/A
Current Location:	DYRS Care Coordination > [REDACTED]
Assessment Date:	[REDACTED]
Interview Date:	[REDACTED]
Assessor's Name:	[REDACTED]
Normative Option:	US Community
Offender Type:	No Client Types Provided



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YLS/CMI 2.0 test items and normative data © 2011 Multi-Health Systems Inc.
All rights reserved.
P.O. Box 950, North Tonawanda, NY 14120-0950
3770 Victoria Park Ave., Toronto, ON M2H 3M6

Narrative Report

[REDACTED] YLS/CMI 2.0 Total Score is 24, which categorizes him as High risk relative to other US Community males. High risk/need factors include Family Circumstances/Parenting, Peer Relations, and Leisure/Recreation. Moderate risk/need factors include Attitudes/Orientations, Prior and Current Offenses/Dispositions, Education/Employment, and Personality/Behavior. Low risk/need factors include Substance Abuse. Recommended supervision level is Maximum Supervision.

General Notes for Evaluation

Youth Interview ([REDACTED]) Conducted F2F at YSC on [REDACTED] follow-up conducted Virtually on [REDACTED]
 Parent Interview with [REDACTED] Conducted Virtually on [REDACTED] to gain clarity on home-life school, and community behaviors.
 Phone Interview PO [REDACTED] conducted on [REDACTED] to gain knowledge on how [REDACTED] did while under court social services (CSS-probation).
 Psychiatric Evaluation Formatted by Dr. [REDACTED] and Conducted on [REDACTED]
 Educational Records Received from DYRS Education (Attendance, Transcript for [REDACTED] school year)
 Police Report ([REDACTED]) Received on [REDACTED]
 CSS (Status Report) Formatted by PO [REDACTED] and completed on [REDACTED]
 CSS Court Summary Formatted by PO [REDACTED] on [REDACTED]

Overall Assessment Based on YLS/CMI 2.0 Total Risk/Need Level

The graph below displays the YLS/CMI 2.0 Total Score and indicates the classification level associated with that score (using user-defined cut-off scores)

Total Score



The Total Risk/Need Level is High, with a score of 24. The following table shows the cut-off scores used to determine Total Risk/Need Level.

Standard Cut-Offs

Range	Risk Level
0 - 9	Low
10 - 21	Moderate
22 - 31	High
32 - 42	Very High

Comparison to Young Offenders

The score is as high or higher than 93.0% of a US Normative Group* of adjudicated male young offenders serving sentences in the community (e.g., parole, probation).

Note: For details on the normative group, please see Page 33-38 of the YLS/CMI 2.0 User's Manual

Assessment of Risks and Needs

The graph below displays the risk level for each area of assessment.



The following table shows the standard cut-off scores used to determine risk level for each area of assessment.

Area of Assessment	Low	Moderate	High
1. Offenses/Dispositions	0	1-2	3-5
2. Family/Parenting	0-2	3-4	5-6
3. Education/Employment	0	1-3	4-7
4. Peer Relations	0-1	2-3	4
5. Substance Abuse	0	1-2	3-5
6. Leisure/Recreation	0	1	2-3
7. Personality/Behavior	0	1-4	5-7
8. Attitudes/Orientation	0	1-3	4-5

Assessment of Other Needs and Special Considerations

The following factors should be considered when developing a case management plan:

Family/Parents

Financial/Accommodation Problems

Significant Family Trauma (Specify): During parent interview, [REDACTED] reported that she has requested an emergency move through crime victims when [REDACTED] was shot at when walking through the neighborhood to come home from school. She reported that this event led to him remaining home from school for 7 months. The family originally resided in [REDACTED] however [REDACTED] uncle was stabbed to death in the home when he was 5 years of age which led to the relocation in [REDACTED]

The family reports being threatened and shot at by the victims family in [REDACTED] after the initial offense that took place, however since then there has been minimal concerns.

Comments: Financial Accommodations- [REDACTED] reported that she would like to be relocated due to the ongoing safety concerns within the community. She reported that she had filed a complaint with crime victims after [REDACTED] was shot at in their neighborhood in [REDACTED] however nothing was done to support the immediate move.

Youth

History of Weapons Use

Underachievement

Other Mental Health Issues (specify): [REDACTED] is diagnosed with ADHD. He struggles with maintaining attentiveness for long periods of time. Since being placed at YSC, he has been taking his medications which he reports has supported in him having a better attention span.

[REDACTED] and his mother also reported that due to the ongoing community beefs, there has been an increase of fear for safety for both the youth and his family. Due to the ongoing safety concerns, being shot at previously, and significant traumatic experiences, [REDACTED] has a current diagnosis of PTSD. Both his PTSD and hypervigilance appear to be significant as it relates to his most recent offense and should be further explored in both individual and family therapy.

Comments: History of Weapon Use- [REDACTED] has a history of carrying weapons which is reported to be due to ongoing feelings of not being safe within the community.

Underachievement - [REDACTED] poor performance is primarily due to poor attitude toward school or lack of motivation, but not due to intellectual, learning, or other disability. He reported that he can do the work he just does not want to.

Professional Override

The rater's estimate of risk level does not differ from that of the inventory.

Comments: No information provided

Contact Level

Level of supervision selected for this youth: Maximum Supervision

Comments: [REDACTED] is at high risk of recidivism without appropriate intervention. There has been a lack of supervision at home which has led to his acting out in the community. In addition, he has not been attending school for an extended period of time due to safety concerns in the community. Most of his peers are also engaging in delinquent behavior which is a negative influence on him. Furthermore, he appears to lack remorse for his actions and does not seem to fully appreciate the severity of his committing charges, which includes a loss of life case. Given these circumstances and his history of using weapons, [REDACTED] behavior presents a public safety threat to the community. At this time, it is evident that a secure residential placement with structure and intensive mental health services would be beneficial in minimizing the likelihood of [REDACTED] re-offending. [REDACTED] has experienced significant trauma that is unresolved and would benefit from trauma informed interventions to help him improve his coping skills. The youth and family will also benefit from family therapy to support them in being able to process the traumatic unresolved experiences that they encountered together and to help his mother identify more effective disciplinary practices. [REDACTED] would also benefit from a positive male figure that can provide mentorship/guidance. [REDACTED] is uncertain of vocational interests and has never worked, however this should be explored in placement to support in minimizing the level of idle time he has in the community.

Date Printed: Friday, [REDACTED]

Attachment 5

Success Plan : ██████████

Identifying Information

Form Type : Initial Plan Plan Update
Plan Review ████████ To : ████████
Period:
Next TDM : ████████
Next CAFAS : ████████
Assigned ████████
Case Worker : ████████
Supervisor : ████████

Action Plan

Goal : Complete Model Program at New Beginnings
Focus None Defined
Domain :
Goal Due ████████
Date :
Goal
Completed
Date :
Current Youth is currently on Level 3. ████████ did not earn his 3.5 level due to being involved in multiple physical altercations.
Progress :

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
No involvement in incident for 3 months	Youth	██████	██████			
Remain complain with unit rules and norms daily	Youth	██████	██████			
Complete level paper work each month	Youth	██████	██████			

Goal : Maintain good mental/behavioral health
Focus Health
Domain :
Goal Due ████████
Date :
Goal
Completed
Date :
Current ████████ continues to meet with Dr. ████████ from ████████ to address sexual inappropriate issues/boundaries. ████████ still
Progress : participates in Pet Therapy once a week. ████████ meets Ms. ████████ weekly to address behaviors, progress in treatment, anger and boundaries.

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
Attend pathways therapy once a week	Youth/Dr ████████	████████████████████	████████████████████			
Participate in Pet Therapy once a week	Youth/ Mental Health					
Attend individual session with Ms. ████████ once a week	Youth/Mental Health					
Attend group therapy session once a week	Youth/Mental Health					
Identify coping skills.	Youth/Mental Health					

Goal : Advance to next school grade

Focus Education

Domain :

Goal Due [REDACTED]

Date :

Goal

Completed

Date :

Current Educational Progress (Mr. [REDACTED]): Youth is currently in the 10th grade with 4.5 credits.

Progress :

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
Complete all weekly assignments	Youth (education)	[REDACTED]	[REDACTED]			
Attend school daily (no refusals)	Youth	[REDACTED]	[REDACTED]			

Sign-Off Section:

We accept this Success Plan

Printed Name : _____

Youth's Signature : _____

Family Member
Signature : _____

Family Member
Signature : _____

Social Worker Signature : _____

Comments :

Notify Supervisor via Email [REDACTED]

Saved by [REDACTED] of Department of Youth Rehabilitation Services (100001), not signed [REDACTED]

Success Plan : [REDACTED]

Identifying Information

Form Type : Initial Plan Plan Update
Plan Date: [REDACTED]
Next TDM : [REDACTED]
Next CAFAS : [REDACTED]
Assigned [REDACTED]
Case Worker : [REDACTED]
Supervisor : [REDACTED]

Action Plan

Goal : Complete Model Program at New Beginnings
Focus None Defined
Domain :
Goal Due [REDACTED]
Date :
Goal
Completed
Date :
Current Youth has challenges in participating in groups. His goal is getting his level 5 by [REDACTED].
Progress :

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
[REDACTED] will participate in group each week as evidence by getting his levels.	Youth	[REDACTED]	[REDACTED]	Minimal Progress Noted		
The CC and CM [REDACTED] will encourage [REDACTED] to get his levels by attending group each week.	CC & CM	[REDACTED]	[REDACTED]	Progress Noted		

Goal : (YLS-PB) Develop/Improve communication skills
Focus None Defined
Domain :
Goal Due [REDACTED]
Date :
Goal
Completed
Date :
Current Youth continues to use profanity and disrupt the unit by fighting peers on the unit
Progress :

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
[REDACTED] will work on communicating better without using profanity.	Youth	[REDACTED]	[REDACTED]	Minimal Progress Noted		
The CC and CM [REDACTED] will encourage [REDACTED] to participate in his therapy sessions to learn out use positive language when upset.	CC & CM	[REDACTED]	[REDACTED]	Progress Noted		

Goal : Earn GED
Focus Education
Domain :
Goal Due [REDACTED]
Date :
Goal

Completed

Date :

Current According to [redacted] [redacted] is unable to enroll into the GED program due to his behaviors at school. Once he gets those

Progress : behaviors under control, he can be enrolled.

Action Steps	Responsible Team Member	Start date	Target date	Status @ Review	Accomplished date	Discontinued date
[redacted] will work on his behavior during the GED sessions so he can get his GED.	Youth	[redacted]	[redacted]	Regression Noted		
The CC & CM [redacted] will encourage [redacted] to stay focus in class to get his GED.	CC & CM	[redacted]	[redacted]	Progress Noted		
[redacted] will take a practice test to into the GED rotation at Maya Angelou Academy.	Youth	[redacted]	[redacted]	No Progress		

Sign-Off Section:

We accept this Success Plan

Printed Name : _____

Youth's Signature : _____

Family Member
Signature : _____

Family Member
Signature : _____

Social Worker Signature : _____

Comments :

Notify Supervisor via Email [redacted]

Saved by [redacted] of Department of Youth Rehabilitation Services (100001), not signed [redacted]

Saved by [redacted] of Department of Youth Rehabilitation Services (100001), not signed [redacted]

Attachment 6



Wellness Calendar LEVEL 1



28 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASK** Complete Independent Life Skills Pre-test</p>	<p>ACCOUNTABILITY I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Demonstrate the skills needed to wash clothes</p>	<p>ACCOUNTABILITY Attend and participate in your individual sessions with MH staff. NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Learn how to write a letter and address an envelope</p>	<p>ACCOUNTABILITY Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGCTA) after a difficult moment. Save and share AT LEAST ONE during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Demonstrate the steps to enroll in school</p>
<p>EMPATHY Practiced active listening. What did you do to attend? What did you hear? How did you respond? Write a few words about how you did and put their initials on the calendar.</p>	<p>EMPATHY Write a "Thank You" Letter to someone. Use a regular letter format, explaining why you are thanking them. Make sure to include how you feel. Share with or give to a staff to receive a signature.</p>	<p>EMPATHY Volunteer to help out on the unit or in school. List what you offered to do, how you helped, and how you felt afterwards. Use the space on the back to write a few words and get the staff you helped to sign.</p>	<p>EMPATHY Do a peer pull up. Say something encouraging when you see someone having a bad day or a peer who is making bad decisions. Briefly say what you did on the back and have staff initial with the date.</p>	<p>EMPATHY Write a letter of apology to someone. Use a regular letter format and explain why you are thanking them. Make sure to include how you feel. Afterwards, share what you did with a staff to receive a signature.</p>	<p>EMPATHY Make a "Feelings Poster." Draw or cut pictures of different emotions and name them with the words you would use to describe them. Hang in your room or on the unit.</p>	<p>EMPATHY List three of your best qualities and how you expressed them today. Have staff sign who witnessed or who can confirm. List here and/or on the back:</p>
<p>TEMPERANCE Demonstrate good sportsmanship during competitions. A staff member will then sign the back of your form.</p>	<p>TEMPERANCE **CONCRETE TASK** Plan a healthy and nutritious meal: • Recipes you could prepare • Groceries you would need for meals • How to properly store food • Where to find coupons</p>	<p>TEMPERANCE Create an Anger Calendar like last month. This time, rate your anger on a scale of 1-10 and list the triggers for your anger BE SPECIFIC!</p>	<p>TEMPERANCE **CONCRETE TASK** Utilize Metro Transit web system to go from one place to another and research a place you would like to visit • Show you can read a map • Read a bus or train schedule • Show you can book a flight</p>	<p>TEMPERANCE Show dedication to self-care by remaining compliant with your treatment plan and making a checklist of the things you do each day. You need 70% compliance to receive credit. Save the checklists and present it in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK** Understand how to obtain and apply for a DC Public Library Card</p>	<p>TEMPERANCE Pray, worship or meditate. How long did you do this? List a word for how you feel.</p>
<p>RESILIENCE Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form.</p>	<p>RESILIENCE Think about a "happy place." Create a visual reminder of that place (draw a picture, write a song, write a poem, etc). Show it to staff for credit. You can then share this as your creative project in your petition.</p>	<p>RESILIENCE Create a gratitude journal for the week and write three things you are grateful for each day. Show a trusted staff what you write and have them initial on the back of this calendar. (You should have 7 initials on this one block).</p>	<p>RESILIENCE Make a poster or poem with a list of "affirmations" or positive statements that you can say to yourself to stay focused and positive. You can present this poster in your petition!</p>	<p>RESILIENCE Make a poster or vision board from one of the groups you are attending. Think of the purpose of the group and the skills you are learning. Use a collage or pictures to represent the group.</p>	<p>RESILIENCE Listen to music and try mindfulness breathing. How long were you able to sit still and breathe? List the number of breaths or the amount of time you meditated on the back and a single word to describe how you feel.</p>	<p>RESILIENCE Select a book from the GUGO library and read constantly during the week. List the page numbers on the back next to the date. Share with your CM and obtain their signature.</p>



Wellness Calendar **LEVEL 1**



Dates, Notes and Signatures





Wellness Calendar LEVEL 2



25 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASK**</p> <p>Know how to make a dental appointment and how to obtain insurance</p>	<p>ACCOUNTABILITY</p> <p>I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASK**</p> <p>Develop an emergency plan, locating the nearest hospital/emergency room</p>	<p>ACCOUNTABILITY</p> <p>Attend and participate in your individual sessions with MH staff. NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar.</p>	<p>ACCOUNTABILITY **CONCRETE TASK**</p> <p>Know how to open a bank account</p>	<p>ACCOUNTABILITY</p> <p>Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGCTA) after a difficult moment. Save and share AT LEAST THREE LOGS during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASKS**</p> <ol style="list-style-type: none"> 1) Understand how to obtain your birth certificate 2) Understand how to obtain your social security card 3) Understand how to obtain a government ID card
<p>EMPATHY</p> <p>Empathy is also knowing how to share with others. In a group or individual discussion, share something that was difficult or challenging. Have one of the facilitators or the staff you shared with initial and write a comment about your disclosure.</p>	<p>EMPATHY</p> <p>Participate in a unit activity. Rate your effort and involvement on a scale 0 (didn't try at all) to 10 (put forth full effort).</p>	<p>EMPATHY</p> <p>Engage with someone you normally don't spend time with. What game did you play and who did you play with? Write a word or two about how you felt and have a staff who witnessed sign.</p>	<p>EMPATHY</p> <p>Make a poster with the following saying and explain what the words mean to you (You can use this for your petition vision board): "No man is an island".</p>	<p>EMPATHY</p> <p>Show good sportsmanship in the gym. Go out of your way to say words of encouragement or support to a peer who is struggling. Have a staff who witnessed this sign on the back.</p>	<p>EMPATHY</p> <p>Interview four people (peers, staff, family, etc). Ask them to give you three examples of when your actions negatively impacted them. Don't argue or answer, just listen. Journal how it felt to hear their responses and share with staff or your CST for credit.</p>	<p>EMPATHY</p> <p>Pick two social skills you and your CST think you can improve. Practice, let staff know what you tried, have them observe or provide feedback and initial.</p>
<p>TEMPERANCE</p> <p>Participate in a competition and do a peer pull up. Have a staff who witnessed to sign the back.</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Write a functional job resume</p>	<p>TEMPERANCE</p> <p>Create an Anger Calendar like last month. This time, rate your anger on a scale of 1-10, list the triggers for your anger, and list the messed up thoughts (MUPS) you had. BE SPECIFIC!</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Draft a customized cover letter and address problem issues (i.e. arrests, lack of experience, previous terminations, etc)</p>	<p>TEMPERANCE</p> <p>Show dedication to self-care by remaining compliant with your treatment plan. Make a checklist of the things you do each day. You Need 75% compliance to receive credit. Save the checklists and present in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Put together a resource book for your community</p>	<p>TEMPERANCE</p> <p>Pray, worship or meditate. Try to do it for longer than last time. How long did you spend reflecting? List a word for how you feel.</p>
<p>RESILIENCE</p> <p>Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form. If you got credit for this before, do 5 more each!</p>	<p>RESILIENCE</p> <p>Complete the Emotional Wellness questionnaire. What is your score and what does it mean? What can you improve? Answer this question in a creative format (i.e write a poem, make a poster, write a song, etc) and use for your next petition!</p>	<p>RESILIENCE</p> <p>Create a gratitude journal for TWO weeks and write three things you are grateful for each day. Try to add new things you are thankful for to the list. Show your journal to a member of your team and/or present in a petition.</p>	<p>RESILIENCE</p> <p>Complete the "My Favorite Things" worksheet and create a poster or vision board to share with your Core Support Team in a meeting or petition.</p>	<p>RESILIENCE</p> <p>Make a poster with the five steps of problem solving. Hang it up in your room or ask to show it on the unit. Come up with creative pictures for each step!</p>	<p>RESILIENCE</p> <p>Listen to music and try mindfulness breathing for a longer stint of time. How long were you able to sit still and breathe? List the number of breaths or the amount of time you meditated on the back and a single word to describe how you feel.</p>	<p>RESILIENCE</p> <p>Select a book from the GUGO library and read. Read a little every night for one week. List the page numbers on the back next to the date. Share with your CM and obtain their signature.</p>



Wellness Calendar **LEVEL 2**



Dates, Notes and Signatures





Wellness Calendar LEVEL 3



20 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASK** Maintain 2.5 GPA / Attend GED Program</p>	<p>ACCOUNTABILITY I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Demonstrate ability to comparison shop and use discounts</p>	<p>ACCOUNTABILITY Attend and participate in your individual sessions with MH staff. YOU NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Register with U.S. Selective Service if 18yrs old</p>	<p>ACCOUNTABILITY Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGC-TA) after a difficult moment. Save and share AT LEAST FOUR during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Demonstrate home management skills (able to explain the responsibilities that come with home management)</p>
<p>EMPATHY Write a letter to your younger self (see template). Share this in a group when you meet with your Core Support Team or in your petition.</p>	<p>EMPATHY If you participate in chess club or have played before, list the characteristics of each piece and describe a time when you have played the role of the pawn, the king/queen, etc. How did you feel in each role? Share in chess group or in your petition to get permission.</p>	<p>EMPATHY **CONCRETE TASK** Locate nearest police station to your home and demonstrate how to file a report. Pretend you are a police officer at the department and write a letter to the community about how they can create a safe environment.</p>	<p>EMPATHY Make a poster with the following saying and explain what empathy means to you (You can use this for your petition vision board): "People who live in glass houses should not throw stones."</p>	<p>EMPATHY **CONCRETE TASK** Locate nearest fire station to your home. Research the services provided to the community by the fire department.</p>	<p>EMPATHY Create a poster or paper based on the interviews you did with family/peers and draw of the ripple effect of your actions. You can use this to share in your petition.</p>	<p>EMPATHY Pair up with someone you had a "beef" with in the past and present in a real talk together about how you mediated and learned to co-exist.</p>
<p>TEMPERANCE Participate in a unit activity or competition and show good sportsmanship. Do three peer pull-ups by the time you petition. Have a staff who witnessed initial the back.</p>	<p>TEMPERANCE **CONCRETE TASK** Identify and participate in culturally enriching activities</p>	<p>TEMPERANCE Create an Anger Calendar like last month. This time, rate your anger on a scale of 1-10, list the triggers for your anger, list the messed up thoughts (MUPS) you had AND how you would correct each one. BE SPECIFIC!</p>	<p>TEMPERANCE **CONCRETE TASK** Connect with social organizations (DV, parental assistance, NAACP)</p>	<p>TEMPERANCE Show dedication to self-care by remaining compliant with your treatment plan. Make a checklist of the things you do each day. You Need 80% compliance to receive credit. Save the checklists and present in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK** Demonstrate Money Management</p>	<p>TEMPERANCE Pray or worship or meditate each morning or each night for a week. List a word for how you feel each time.</p>
<p>RESILIENCE Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form. If you got credit for this before, do 5 more each!</p>	<p>RESILIENCE If you participate in Animal Assisted Therapy (AAT), make a flyer explaining what the benefits this program can offer and what you enjoy. We may use this to advertise the program in the future! Share with your CST, the AAT staff or in your petition for credit.</p>	<p>RESILIENCE If you participate in or have participated in Horticulture, make a flyer explaining what the benefits this program can offer and what you enjoy. We may use this to advertise the program in the future! Share with your CST, or in your petition for credit.</p>	<p>RESILIENCE Create a gratitude journal for THREE weeks and write three things you are grateful for each day. Try to make them different or find something new and specific to list. Show your journal to a member of your team and/or present in a petition.</p>	<p>RESILIENCE Choose one affirmation from your list or poster each week and list on your NB Success Plan. Staff will use this statement to encourage you all week.</p>	<p>RESILIENCE Listen to music and try mindfulness breathing for longer than before. How long were you able to sit still and breathe? List the number of breaths or the amount of time you meditated on the back and a single word to describe how you feel.</p>	<p>RESILIENCE Select a book from the GUGO library and read. Read a little every night for one week. List the page numbers on the back next to the date. Share with your CM and obtain their signature.</p>



Wellness Calendar **LEVEL 3**



Dates, Notes and Signatures





Wellness Calendar LEVEL 4



15 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASK** Locate (2) reproductive health clinics</p>	<p>ACCOUNTABILITY I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASKS** 1) Apply and obtain your Social Security card 2) Apply and obtain a Government ID card 3) Apply for Voter Registration card</p>	<p>ACCOUNTABILITY Attend and participate in your individual sessions with MH staff. YOU NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar.</p>	<p>ACCOUNTABILITY **CONCRETE TASKS** Complete (3) job applications and demonstrate or explain your: *dress code, *Interview strategies, *email etiquette to/from job, *Time management and transferable skills</p>	<p>ACCOUNTABILITY Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGC-TA) after a difficult moment. Save and share AT LEAST FOUR during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASKS** 1) Apply to obtain your Birth Certificate 2) Apply for your Learner's permit</p>
<p>EMPATHY Choose a peer to work with. Do you see a resident on your unit having a difficult time adjusting? Take them under your wing and help them. Discuss with Core Support Team and the peer you choose to work with and help them get closer to their next membership.</p>	<p>EMPATHY Interview a member of the RJ team. Find out the qualities of someone who would be a good RJ facilitator and the use of RJ to initiate change in the community. Present your interview in group or to the CST for credit.</p>	<p>EMPATHY Write a letter of apology to someone for something you did. Use a letter format Use a regular letter format, explain why you are thanking them. Make sure to include how you feel. Share with or give to a staff to receive a signature.</p>	<p>EMPATHY Make a vision board on Loyalty. You can complete this project on your own or as a unit. Draw, write, create appropriate symbols to represent 5 benefits of loyalty and 5 negative traits/circumstances. Present to your staff or your CST for credit.</p>	<p>EMPATHY Research the impact of crimes you have been charged with in the past. Gather information on the statistics of the crimes, the impact on individuals, and the community. List the Messed Up Thinking/Cognitive Distortions you have used to justify your actions.</p>	<p>EMPATHY Get with MH and call the family members you interviewed before. Ask them how you can make it right once you return. Include this on your ripple effect poster and show how you could make those changes.</p>	<p>EMPATHY Do three random acts of kindness. Write a word about how you felt, let a staff know each time you do, and have them confirm and initial (you should have three words and three initials).</p>
<p>TEMPERANCE Plan a group with the staff assigned to you in the gym to focus on team building. Lead the activity and get their feedback on your leadership. Have them write a word on the back of this calendar and initial.</p>	<p>TEMPERANCE **CONCRETE TASK** Identify (3) positive activities for when you are not working or in school. LIST and let your staff know how you will incorporate into life in the community (THIS INFORMATION WILL BE REQUIRED FOR YOUR HOME PETITION)</p>	<p>TEMPERANCE Choose your "DAY OF NO!" and, let your staff know. Your team will say "NO" to all of your requests so you can practice dealing with frustration, make adjustments, and achieve your goals! If you have too much difficulty, you can try another day but you need to successfully manage ALL no's to get credit.</p>	<p>TEMPERANCE **CONCRETE TASK** Develop a weekly health plan to include: 1. exercise/fitness (what will you do each week?) 2. meals/recipes you could prepare 3. Groceries you would need for meals 4. How to properly store food 5. Where to find coupons (THIS INFORMATION WILL BE REQUIRED FOR YOUR HOME PETITION)</p>	<p>TEMPERANCE Show dedication to self-care by remaining compliant with your treatment plan. Make a checklist of the things you do each day. You Need 85% compliance to receive credit. Save the checklists and present in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK** Role play refusal skills to turn away negative peers or choices (THIS MAY BE USED AS AN ACTIVITY FOR PETITIONS)</p>	<p>TEMPERANCE Pray, worship or meditate each morning or each night for a while week. List a word for how you feel each time.</p>
<p>RESILIENCE Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form. If you got credit for this before, do 5 more each!</p>	<p>RESILIENCE Celebrate yourself by respectfully announcing an accomplishment to your unit in a non disruptive way.</p>	<p>RESILIENCE **CONCRETE TASK** Write a letter demonstrating your understanding of Restorative Justice Practices and how you have applied them. **Make sure to include areas of growth** (THIS INFORMATION WILL BE REQUIRED FOR YOUR HOME PETITION)</p>	<p>RESILIENCE Create a Gratitude calendar for the month and write three things you are grateful for each day. Try to make them different or find something new and specific to list. **Show your calendar to a member of your team and/or present in a petition.</p>	<p>RESILIENCE **CONCRETE TASKS** 1) Observe a traffic or criminal court session 2) Learn how to obtain legal services 3) Write a letter explaining the qualities you would want a judge and prosecuting attorney to know about you</p>	<p>RESILIENCE Select a book from the GUGO library and read. Read a little every night for one week. List the page numbers on the back next to the date. Share with your CM and obtain their signature.</p>	<p>RESILIENCE Make a poster or vision board of 5 people you respect who are current or historical figures in leadership, sports, entertainment, etc. List the qualities you admire and how you could develop or demonstrate these qualities.</p>



Wellness Calendar **LEVEL 4**



Dates, Notes and Signatures





Wellness Calendar LEVEL 5



15 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASKS**</p> <p>1) Open a personal checking account 2) Open a personal savings account</p>	<p>ACCOUNTABILITY</p> <p>I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASK**</p> <p>Learn how to read and understand a lease agreement.</p>	<p>ACCOUNTABILITY</p> <p>Attend and participate in your individual sessions with MH staff. NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar.</p>	<p>ACCOUNTABILITY **CONCRETE TASK**</p> <p>Create roommate criteria and house rules</p>	<p>ACCOUNTABILITY</p> <p>Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGCTA) after a difficult moment. Save and share AT LEAST FIVE during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASKS**</p> <p>Create a furniture plan and budget</p>
<p>EMPATHY</p> <p>Team up with Ms. White/Mr. Jackson to plan and lead a competition or activity on peer pressure and wanting to belong.</p>	<p>EMPATHY</p> <p>Participate in and successfully complete training as a RJ facilitator.</p>	<p>EMPATHY</p> <p>Interview your care coordinator about the harm you caused when in the community. Identify three actions you can take to repair harm (apology letters, community service, participate in a panel, etc).</p>	<p>EMPATHY</p> <p>Organize a dance party on the unit. Work with staff to select appropriate songs and encourage your unit to spend some time dancing.</p>	<p>EMPATHY</p> <p>Write a letter of self forgiveness to yourself and share with a trusted staff for credit.</p>	<p>EMPATHY</p> <p>Write index cards of 10 high risk situations, thoughts, feelings, you may face in the community. On the back of the card, put yourself in the shoes of someone who wants to help you and write what you will say to yourself to challenge high risk thoughts/situations.</p>	<p>EMPATHY</p> <p>Write a letter to MH staff about being a cofacilitator for a Core group that meant a lot to you. Let them know how you would contribute as a cofacilitator and why you would be a good candidate.</p>
<p>TEMPERANCE</p> <p>Create a vision board of people you trust and who you can turn to in your life. Fill the page with pictures, symbols.</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Learn how to purchase a used automobile/insurance.</p>	<p>TEMPERANCE</p> <p>Create a Temperance calendar for the month in which you mark each time you stop yourself from doing something negative or reacting impulsively to a situation. **You can combine this calendar with the Gratitude calendar** Present to your staff, CST, or in your petition for credit.</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Understand how to keep a car maintained.</p>	<p>TEMPERANCE</p> <p>Show dedication to self-care by remaining compliant with your treatment plan. Make a checklist of the things you do each day. You Need 90% compliance to receive credit. Save the checklists and present in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK**</p> <p>Enroll in a driver's education class.</p>	<p>TEMPERANCE</p> <p>Pray or worship or meditate each morning or each night for a week. List a word for how you feel each time.</p>
<p>RESILIENCE</p> <p>Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form. If you got credit for this before, do 5 more each!</p>	<p>RESILIENCE</p> <p>Ask permission to interview a staff you admire. Ask them about their career choice, motivation to succeed, values, and recommendations to you. Present the interview in a group or to your CST.</p>	<p>RESILIENCE **CONCRETE TASK**</p> <p>Obtain learners permit / driver's license.</p>	<p>RESILIENCE</p> <p>Create a Gratitude calendar for the month and write three things you are grateful for each day. Try to make them different or find something new and specific to list. **You can combine this with your Temperance calendar. Show your calendar to a member of your team and/or present in a petition**</p>	<p>RESILIENCE **CONCRETE TASKS**</p> <p>1) Observe a traffic or criminal court session 2) Learn how to obtain legal services 3) Write a letter explaining the qualities you would want a judge and prosecuting attorney to know about you</p>	<p>RESILIENCE</p> <p>Choose a community issue that you think is important to improve to create a better environment for families and young adults and create a poster or pamphlet for a program you would create to improve.</p>	<p>RESILIENCE</p> <p>Select a book from the GUGO library and read. Read a little every night for one week. List the page numbers on the back next to the date. Share with you CM and obtain their signature.</p>



Wellness Calendar **LEVEL 5**



Dates, Notes and Signatures





Wellness Calendar LEVEL 6



15 needed to complete



<p>ACCOUNTABILITY **CONCRETE TASKS** Develop an initial grocery list with 1 weeks' worth of meals YOU WILL NEED THIS FOR HOME PETITION</p>	<p>ACCOUNTABILITY I attended all scheduled CORE group sessions, wrote reflections on my Program Checklist, and obtained needed signatures every day of the month.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Develop a monthly budget</p>	<p>ACCOUNTABILITY Attend and participate in your individual sessions with MH staff. NEED TO GO AT LEAST 4X in the month to obtain staff signature on this calendar.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Develop a list of (2 or more) trusted adults in the community and their contact info. YOU WILL NEED THIS FOR HOME PETITION</p>	<p>ACCOUNTABILITY Complete a Hassle Log (from WAIT), LETMGO (from SPARCS), Thinking report (from Power Source), or SLOW DOWN from (TGCTA) after a difficult moment. Save and share AT LEAST FIVE during your petition.</p>	<p>ACCOUNTABILITY **CONCRETE TASK** Complete Independent Life Skills Post-test</p>
<p>EMPATHY Organize a "Celebration of Life" activity to honor recent losses or significant losses for the unit.</p>	<p>EMPATHY Facilitate at least one RJ circle or intervention with your peers if you are a trained facilitator.</p>	<p>EMPATHY Create a list of people from your neighborhood that are currently at the facility and submit the names to RJ. Cofacilitate a circle with CM, RJ, and BH and discuss strategies to reduce conflict/beefs in the community.</p>	<p>EMPATHY Facilitate a gratitude circle with your unit and open the group by complimenting yourself and your peers (without cracking jokes). Have each youth discuss strengths they could develop and utilize as a future credible messenger.</p>	<p>EMPATHY Initiate a conversation with a staff you have been bothered by or had conflict with while here. Tell them how felt (use feeling words, and I statements) to express how you were affected.</p>	<p>EMPATHY Organize a poetry slam in where residents on the unit have the opportunity to express themselves through art, music, poem, etc and you offer encouragement and support.</p>	<p>EMPATHY Co-facilitate a group module (the whole cycle) with MH and Credible Messengers.</p>
<p>TEMPERANCE Organize a dance party on the unit. Work with staff to select appropriate songs and that will motivate and encourage your unit to keep doing their best to succeed.</p>	<p>TEMPERANCE **CONCRETE TASK** Fully participate in developing your discharge plan. Create a Wellness Calendar for your first month after discharge. What will you do each day to show your four values? YOU NEED TO PRESENT YOUR PLAN FOR HOME PETITION</p>	<p>TEMPERANCE Choose an affirmation from your poster/NB Success Plan that has been most helpful and put it on a T-shirt. Wear during your home petition and explain.</p>	<p>TEMPERANCE **CONCRETE TASK** Have lunch with DYRS program administrators</p>	<p>TEMPERANCE Show dedication to self-care by remaining compliant with your treatment plan. Make a checklist of the things you do each day. You Need 90% compliance to receive credit. Save the checklists and present in your petition.</p>	<p>TEMPERANCE **CONCRETE TASK** Role play refusal skills to turn away negative peers or choices (THIS MAY BE USED AS AN ACTIVITY FOR PETITION)</p>	<p>TEMPERANCE Pray, worship or meditate each morning or each night for a week. List a word for how you feel each time.</p>
<p>RESILIENCE Exercise: how many pushups, squats, lunges did you do? List that number and get a staff to sign your form. If you got credit for this before, do 5 more each!</p>	<p>RESILIENCE Make a vision board with a timeline of your placement at NB. Identify the most difficult situations/conflicts you had to overcome.</p>	<p>RESILIENCE **CONCRETE TASK** Write thank you notes or cards to all of the staff/peers whose help you have appreciated along the way. You can share these as part of your petition</p>	<p>RESILIENCE Create a game on your own or with your unit. Make jeopardy questions on group sessions and life skills. Your questions may be used in competition with other units!</p>	<p>RESILIENCE **CONCRETE TASK** Have a luncheon with staff you want to thank, meet with, talk with, etc. Write an invitation to staff with a day and time to meet in culinary or elsewhere if possible</p>	<p>RESILIENCE Choose a community issue that you think is important to improve to create a better environment for families and young adults.</p>	<p>RESILIENCE Write "Words of Wisdom" for new youth coming into complete the program. List 10 words of encouragement or things to know. If selected, your wisdom will be shared in orientation packets.</p>



Wellness Calendar **LEVEL 6**



Dates, Notes and Signatures



Attachment 7

9/10/25

Name:

Date:

Page 1 of 6

PETITION FOR NEXT LEVEL:

List the Feedback you received in your last petition:

1) Target Outcomes (per you and Core Support Team) What were the specific goals you were asked to work on to show improvement on your target domains and to advance to your next level?:

YLS/PYJ Domain on your Success Plan	List ways you have shown improvement on each domain:

2) Core Values: What specific behaviors have you demonstrated to reflect New Beginnings Core Values?

Core Values	List ways you have shown improvement on each domain:
Empathy	
Temperance	
Accountability	
Resilience	

Name:
 Date:
 Page.2 of 6

3) REVIEW YOUR PROGRAM CHECKLIST:

How many individual sessions have you attended in the last month? List the skills you have been working on and examples of your progress? Reflect on any struggles or barriers you face:

DATE OF SESSION (LIST MISSED SESSIONS)	TOPIC/SKILL COVERED OR REASON FOR MISSED SESSIONS	Do you notice changes in yourself? **If so, explain what you learned and how you have been using skills/support. List ways others can tell you are changing **If not, what challenges have you faced and what will be helpful?

4) REVIEW YOUR PROGRAM CHECKLIST:

- How many CORE group sessions have you participated in the last month? _____
- How many group sessions did you miss? List the reasons:
- List three specific sessions that were helpful and why.
List specific sessions that were challenging and explain why.

CORE GROUP NAME	Title of sessions that were helpful	Explain what you learned and how you could use the material covered and discussed in your life
1)		
2)		
3)		
CORE GROUP NAME	Title of session that were challenging	Explain the challenges and what you would change
1)		
2)		
3)		

Name:

Date:

Page 3 of 6

5) What are some challenges you have faced over the past month?

- List specific incidents (major or minor) you had in which you required redirection from staff
- Triggers for those incidents
- Thinking/Feeling that contributed to the incidents
- What steps are you taking to progress toward your goals when faced with these challenges?

Incident	Internal or External Triggers	Thinking/Feeling Patterns that contributed to incident	Actions demonstrated in incident	What steps have you taken to progress and improve? What steps could you take in the future to avoid the incident?

Name:

Date:

Page 4 of 6

- 6) How many Wellness Activities have you completed?
Describe three that were helpful. Describe any that were not. Describe activities you would like to focus on next month.

- 7) What skills are you developing in Real Talk/Life Skills groups?

- 8) What specific social/emotional/ behavioral outcomes will you focus upon for your next petition?

- 9) What skills have you demonstrated over the past month to earn the next level?

- 10) CORE SUPPORT TEAM WILL SELECT A SPECIFIC QUESTION/ACTIVITY/ETC TO ADDRESS SPECIFIC NEEDS AND GROWTH AREAS OF YOUTH. **IN PERSON PRESENTATION**

- 11) ****What do you want the team to know about your efforts and growth? (Be creative, you can use art, music, poetry, vision board etc). Consider any goals, affirmations, relationships, RJ practices that are helping you to progress**

Attachment 8

9/10/25

RESIDENT NAME:
LEVEL PETITIONING:



STAFF NAME:
DATE:

STAFF PETITION SCORING

STAFF ONLY: List behavior below

Using scale below, rate your observations of the resident's behavior. How consistent are the youth's actions with the youth's self-report:

- 0 (no evidence, no demonstrated effort observed)
- 1 (minimal evidence of behavior; requires repeated redirection)
- 2 (some evidence of behavior, but inconsistent)
- 3 (consistently demonstrates behavior- **ONLY** rate a 3 if they have consistently met the weekly goals they outline on NB Success Plan)

List score below and any feedback

1) Target Outcomes (per you and Core Support Team) What were the specific goals you were asked to work on to show improvement on your target domains and to advance to your next level?

COMMENTS:

Target Outcomes	
	/3
	/3
	/3
Total Score (Include scores from school and Gym)	/9

2) Core Values: What specific behaviors have you demonstrated to reflect New Beginnings Core Values?

COMMENTS:

Core Values	
Empathy	/3
Temperance	/3
Accountability (automatic 0 if they tear up any paperwork)	/3
Resilience	/3
Total Score (Include scores from school and Gym)	/12

RESIDENT NAME:
LEVEL PETITIONING:



STAFF NAME:
DATE:

STAFF ONLY: List behavior below	<p>Per scale below, rate your observations of the resident's use of skills listed above and/or youth's attitude towards individual sessions. How willing has the resident been to attend, participate in, and learn in individual sessions?:</p> <p>0 (no evidence, no demonstrated effort observed) 1 (minimal evidence of attendance/participation) 2 (some evidence of attendance/participation) 3 (consistently demonstrates behavior- ONLY rate a three if they have attended all scheduled for the month and put forth concerted effort per MH and observations) List score below and any feedback</p>
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3) REVIEW YOUR PROGRAM CHECKLIST

How many individual sessions have you attended in the last month? List the skills you have been working on and examples of your progress? Reflect on any struggles or barriers you face:

COMMENTS:

Program Checklist	
Attendance to and participation in sessions/ demonstrated attitude toward sessions	/3
Demonstrated use of skills listed on a daily basis	/3
Total Score	/6

4) REVIEW YOUR PROGRAM CHECKLIST

- How many CORE group sessions have you participated in the last month? _____
- How many group sessions did you miss? List the reasons:
- List three specific sessions that were helpful and why.
- List specific sessions that were challenging and explain why.

COMMENTS:

Program Checklist	
Attendance to and participation in sessions/ demonstrated attitude toward group sessions	/3
Demonstrated use of skills listed on a daily basis	/3
Total Score	/6

RESIDENT NAME:
LEVEL PETITIONING:



STAFF NAME:
DATE:

STAFF ONLY: List behavior below

0 (no evidence, no demonstrated effort observed)
 1 (minimal evidence of attendance/participation)
 2 (some evidence of attendance/participation)
 3 (consistently demonstrates behavior- **ONLY** rate a three if they have attended all scheduled for the month and put forth concerted effort per MH and observations)
List score below and any feedback

5) What are some challenges you have faced over the past month?

- List specific incidents (major or minor) you had in which you required redirection from staff
- Triggers for those incidents
- Thinking/Feeling that contributed to the incidents
- What steps are you taking to progress toward your goals when faced with these challenges?

COMMENTS:

Response to redirection and use of coping skills to de-escalate	/3
Willingness to self-reflect, accept responsibility, and repair harm	/3
Total Score	/6

Use Grid Below for questions 6-9:

- 6-Describe three **Wellness Activities** you have practiced over the last month? Which ones were helpful? Which ones were not?
- 7-What skills are you developing in Real Talk/Life Skills groups?
- 8-What specific social/emotional/ behavioral outcomes will you focus upon for your next petition?
- 9-What skills have you demonstrated over the past month to earn the next level?

COMMENTS:

Attendance to and participation in sessions/ demonstrated attitude toward activities	/3
Demonstrated use of skills listed on a daily basis	/3
Total Score	/6

QUESTIONS 10 and 11 are scored in the IN-PERSON SECTION ON GRID

RESIDENT NAME:
LEVEL PETITIONING:



STAFF NAME:
DATE:

PETITION QUESTIONNAIRE POINT SHEET/FEEDBACK:

Questionnaire Score Sheet	Staff Score	Comments and Feedback
Question 1 (SHOULD INCLUDE FEEDBACK FROM SCHOOL AND GYM)	/9	
Question 2 (SHOULD INCLUDE FEEDBACK FROM SCHOOL AND GYM)	/12	
Question 3	/6	
Question 4	/6	
Question 5	/6	
Question 6-9	/6	
Overall Written Reflections	/10	
TOTAL Questionnaire	/55	
In Person Presentation	Score	In person Presentation and Questions 10 & 11
Question 10	/5	
Question 11	/5	
Overall Presentation (ATTITUDE, DEMEANOR, RESPONSE TO FEEDBACK, ETC)	/5	
TOTAL	/15	

Level Advancement Required:

- 70/100 points=Level 1
- 75/100 points=Level 2
- 80/100=Level 3
- 85/100=Level 4
- 90/100=Levels 5, 6, and Home Petition

RESIDENT NAME:
LEVEL PETITIONING:



STAFF NAME:
DATE:

CORE SUPPORT TEAM FEEDBACK:

Factor and Points	Score	Comments and Feedback
Point sheet accumulation (MAX 30-MAKE SURE POINTS INCLUDE REFERRALS FROM SCHOOL, GYM, ETC)	/30	
Petition Questionnaire (MAX 55)	/55	
In Person Presentation (MAX 15)	/15	
TOTAL (MAX 100)	/100	

Point sheet accumulation

All days youth earned the membership for the day (T, L, or C). Maximum is 30 pts since the petition period is one month.

Petition Questionnaire

- Orientation=pts for each written response
- Levels 2-6=points for demonstrated behaviors per staff observation (use NB Success Plan comments, weekly goals, YPM discussions, log book, feedback from school and gym, etc for ratings).

In Person Performance

Resident's presentation to the team, responses to questions, openness to feedback, and overall attitude/participation. Scores to be averaged by number of staff present at the petition.

Level Advancement Required:

- 70/100 points=Level 1
- 75/100 points=Level 2
- 80/100=Level 3
- 85/100=Level 4
- 90/100=Levels 5, 6, and Home Petition

Attachment 9

SUPERVISION OF YOUTH ON SUICIDE PRECAUTION STATUS AT THE YOUTH SERVICES CENTER AND NEW BEGINNINGS YOUTH DEVELOPMENT CENTER



OFFICE OF INDEPENDENT JUVENILE JUSTICE FACILITIES OVERSIGHT

MARK JORDAN
EXECUTIVE DIRECTOR

MIA CARAS
SENIOR ANALYST

I. INTRODUCTION

In early 2024, the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) undertook a review of the supervision and documentation requirements set forth in DYRS Policy No. V.b.3, *Suicide Prevention* relating to youth placed on Suicide Precaution Status (SPS) at the Youth Services Center (YSC) and New Beginnings Youth Development Center (New Beginnings). While the review did not include an evaluation of the *clinical* decisions involved in the placement, maintenance, and removal of youth from suicide precaution status, it specifically assessed both facilities' implementation of policy requirements relating to supervision of youth on suicide precaution status and documentation related. This report summarizes OIJFO's findings relating to policy compliance during that review.

II. BACKGROUND

DYRS policy requires that youth placed on suicide precaution status be assessed, supervised, and provided appropriate interventions, and establishes specific documentation relating to these actions.¹ Prior to the dismissal of the Jerry M. lawsuit in 2021, the Special Arbiter completed an assessment of the practices around the use of suicide precaution status at YSC and New Beginnings.² The Special Arbiter's 2020 assessment included two components.

¹ Attachment 1, DYRS Policy No. V.b.3, *Suicide Prevention*, effective June 28, 2016 (Suicide Prevention Policy). In part, the Suicide Prevention Policy provides for the following: a suicide risk assessment of all youth upon admission and all youth who are thought to be at risk of suicide or self-injury; placement of youth found to be at risk of suicide or self-injury on either SPS-1 (requiring trained staff within five feet of youth at all times) or SPS-2 (requiring youth are observed by staff at least every 10 minutes) depending on results of the risk assessment; daily clinical assessments of youth while on suicide precaution status; procedures for stepping youth down from SPS-1 to SPS-2; and monitoring of youth following removal from suicide precaution status on a daily basis for five days, weekly for two weeks, and monthly thereafter. *Id.* §VI.B. The policy also provides for development and implementation of Special Management Plans that include identification of triggers and precipitants and early intervention strategies to address the needs of youth in crisis. *Id.* §VI.B.8.

² See The Special Arbiter's Abbreviated Report to the Court Regarding Defendants' Progress Toward Meeting Work Plan Requirements Related to Behavioral Health Services At the Youth Services Center And the New Beginnings Youth Development Center, filed June 15, 2020 (Special Arbiter's June 2020 Report). The specific requirement in Jerry M. provided as follows:

3. Crisis Intervention and the Management of Acute Episodes

First, the health records of a sample of youth on suicide precaution status were reviewed by an outside expert to evaluate the clinical aspects of DYRS' performance relative to assessments, supervision and the development and implementation of interventions for youth on suicide precaution status.³ Then, using that same sample of cases, staff from the then Office of the Special Arbiter evaluated performance at both the YSC and New Beginnings relative to 26 specific policy requirements. Based upon those reviews, the Special Arbiter concluded that the YSC did not complete adequate risk assessments and failed to complete required follow-up assessments in some cases. She also identified shortcomings in the required monitoring by both behavioral health and direct care staff and noted other deficiencies in implementation of the DYRS Suicide Prevention Policy required by this subsection. In contrast, at New Beginnings, the Special Arbiter concluded that the clinical assessments and interventions implemented to support youth on suicide precaution status were appropriate. The Special Arbiter's evaluation identified limitations associated with discreet aspects of documentation related to the implementation of the Suicide Prevention Policy at New Beginnings; however, unlike the YSC,

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- e. Defendants shall assess, supervise, and provide appropriate interventions to youth on suicide precaution status, consistent with the draft DYRS policy, Suicide Prevention for Youth, and any related clinical protocol, as clinically indicated.
 - iii. Performance Standard: By February 1, 2009, and thereafter, at least 90 percent of youth at [New Beginnings] and 90 percent of youth at the YSC who are on suicide precaution status shall have been assessed, supervised and provided appropriate interventions consistent with the draft DYRS policy and any related clinical protocols, as clinically indicated.

³ Dr. Richard Barnum reviewed health records to assess the following: 1) whether the youth was appropriate for placement on suicide precaution status; 2) whether the youth was placed on the appropriate level of suicide precaution; 3) whether behavioral health staff fully documented the results of the assessment associated with the determination to place the youth on suicide precaution status, including the rationale for placement and a description of the symptoms and behavior warranting placement; 4) whether the documentation in the health record indicated that a face-to-face assessment was conducted; 5) whether the documentation in the health record indicated that behavioral health staff-developed appropriate interventions/recommendations for DYRS staff to manage the youth while on suicide precaution status; 6) whether the documentation in the health record reflected implementation of the recommendations and interventions formulated by DYRS staff; and 7) whether the documentation in the health record reflected appropriate decision-making insofar as maintaining youth on suicide precaution status or removing them from it, the associated rationale, and an adequate description of the youth's behavior and symptoms. Special Arbiter's June 2020 Report at pages 46-47.

as a general matter, most key documentation and supervision requirements were satisfied at New Beginnings.

To update the *non-clinical* related findings from the Special Arbiter’s 2020 SPS review, the OIJFO in early 2024 evaluated DYRS’ performance relative to the same 26 requirements established in the Suicide Prevention Policy.⁴ This evaluation included review of both electronic health records maintained for individual youth and supplemental records completed and maintained by YDRs and their supervisors. To generate samples for review, OIJFO reviewed records maintained by DYRS to identify all youth at the YSC and New Beginnings who were placed on any level of suicide precaution status during the period from to September 1, 2023 to December 31, 2023 at the YSC and the period from September 1, 2022 to December 31, 2023 at New Beginnings.⁵ After reviewing and cross-referencing all known data sources regarding youth on suicide precaution status, ten youth at the YSC⁶ who had been placed on suicide precaution status in 18 episodes during the review period,⁷ and six youth at New Beginnings who had been placed on suicide precaution status in a total of six episodes during the review period, were identified and related records were reviewed.

As noted, the Suicide Prevention Policy establishes specific procedures and timeframes for ensuring that youth placed on suicide precaution status are assessed and monitored in a

⁴ In evaluating the DYRS’ implementation of the policy, an audit tool that focused on a subset of the requirements initially used during the Special Arbiter’s 2016 assessment of behavioral health services at New Beginnings was used. Attachment 2, *DYRS Suicide Prevention Policy Review Tool*.

⁵ Based on the selection criteria, the sample included all youth at New Beginnings who were placed on suicide precaution status between September 1, 2022 and December 31, 2023. Because SPS is not used as frequently at New Beginnings, the time sample time frame for New Beginnings youth was expanded to obtain a larger sample size.

⁶ Based on the selection criteria, the youth in the final YSC sample were on suicide precaution status at least one day between September 1, 2023 and December 31, 2023.

⁷ Among the ten youth, four youth were involved in 12 episodes of suicide prevention status, including one youth with three episodes, one with five episodes, and two youth each with two episodes. The remaining six youth each had only one episode of SPS during the review period.

manner that protects the youth from self-harm. Among its provisions, the Suicide Prevention Policy requires behavioral health or medical staff to complete a Suicide Notification form to place a youth on suicide precautions,⁸ that staff supervising youth on SPS document their observations using a Suicide Prevention Observation form continuously throughout the day at specified intervals and that staff carry the form with them as the youth moves throughout the facility.⁹ Additionally, the Policy provides for an assessment of youth by behavioral health staff each day the youth is on suicide precaution status, and specifies what must be included in the assessment.¹⁰ The Policy mandates that behavioral health staff complete a Special Management Plan when a youth is placed on suicide precaution status, which is intended to provide guidance to direct care staff on triggers, warning signs, and managing the youth during his or her crisis.¹¹ Finally, the Policy also provides for post-SPS assessment of youth at gradually increasing intervals.¹²

The findings from this review are presented below.

A. YSC

OIJFO's review of the records associated with the YSC sample indicates that the YSC is meeting some, but not all of the Policy requirements relating to supervision of youth on SPS and

⁸ See Attachment 1, §§VI.B.4.v and VI.H.1.

⁹ *Id.* §VI.H.2.ii. For the purposes of this review, for each episode, all deviations from the requirement to document observations at specified intervals were identified. For a given episode, *any* deviation from the policy's recordkeeping requirements was noted. While this method ensured consistency in applying the policy requirement among distinct episodes, it did not necessarily provide a sufficiently complete assessment of the DYRS' performance: Episodes with a single deviation would be recorded as equivalently deficient when compared to episodes with significant numbers of deviations. Consequently, given the large number of observations required to be recorded each day, the extent of the deviations from documentation requirements was assessed and considered for each episode. Where deviations were of very short duration (1-3 minutes) or only at sporadic intervals during the entire episode of SPS, the reviewer exercised judgment and did *not* consider these instances to be violations of policy requirements which would have resulted in a finding in non-compliance with the policy provisions in the particular case being reviewed.

¹⁰ *Id.* §§VI.B.5.i.a. and b.

¹¹ *Id.* §§VI.B.5.i.c. and B.8.

¹² *Id.* §VI.B.7. Initially, behavioral health staff are to assess youth off SPS daily for five days, weekly for two weeks, and monthly thereafter unless documentation in the record supports discontinuation of the monitoring.

documentation related thereto. While there were certain requirements that YSC staff consistently implemented during each episode in the sample reviewed, YSC did not consistently adhere to numerous other policy requirements. Specifically, the review established that YSC met all the Policy requirements relating to the content of daily assessments by behavioral health staff in all cases where such notes were completed,¹³ in completing the Suicide Prevention Notification Form¹⁴ and in changing (and documenting the change) of a youth's suicide precaution status.¹⁵ Additionally, each of the YSC cases reviewed included a description of items to be removed from the youth while on suicide precaution status.¹⁶

In contrast, OIJFO's review also established that the YSC is not meeting other key policy components. These include implementation of the Suicide Prevention Policy's requirements related to the supervision of youth on suicide precaution status,¹⁷ daily assessment of youth on suicide precaution status,¹⁸ development of Special Management Plans,¹⁹ and in

¹³ Attachment 1, §§VI.B.5.a. and 5.b. Notes were completed and addressed all required content in the following episodes: KR, LC, JM, MB, RM (episodes #1 and #3); TJ (episodes #1, #2, #3, and #5); DS (episodes #1 and #2); and TA (episodes #1 and #2). In the episodes of SPS involving RM (episode #2), TJ (episode #4), IB, and CR at least one daily assessment was missed, but when daily assessments were completed, all required elements were included.

¹⁴ Attachment 1, §§VI.B.4.v. and VI.H.1. Notification forms were found for all episodes for all youth in the sample.

¹⁵ *Id.* §VI.B.5.2. SPS change forms were found for all episodes for all youth in the sample.

¹⁶ *Id.* §VI.B.8.i. requires behavioral health staff to develop Special Management Plans for youth placed on SPS and that each plan include identification of items to be removed from the youth. During this review, as noted below, only one of the episodes of SPS at the YSC during the review period included (or referenced) a Special Management Plan, but the Suicide Notification Forms in each case included a description of items to be removed from the youth.

¹⁷ The policy provides two levels of suicide precaution status based upon the clinical presentation of the youth. SPS-1 is the most intensive level of suicide precaution status and is used for youth who present with marked acuity; youth on SPS-1 must be directly supervised by DYRS staff at all times and staff observations of the youth must be recorded five times per hour. Attachment 1, §VI.B.3.i.a.(c). SPS-2, which is used for youth "who present with some vulnerability to harm themselves," requires that staff complete checks at staggered intervals but not less than every ten minutes. *Id.* §VI.B.3.i.b.(a). and (b).

¹⁸ *Id.* §VI.B.5.i. Daily assessments were not met in RM (episode #2, missing two daily notes), IB (missing four daily notes), TJ (episode # 4 missing one daily note), and CR (missing six daily notes).

¹⁹ *Id.* §VI.B.3.i.a.j. and VI.B.8. No Special Management plans were completed in any episode in the YSC sample other than IB.

post-SPS monitoring activities.²⁰ For example, at least one daily assessment was missed in four episodes involving four youth.²¹ Special Management Plans were completed in only one of 18 episodes of use of SPS; in 12 of the 18 episodes involving five youth, there were Special Management Plans completed in prior incidents but in none of those cases were the previously completed Plans updated or referenced at the time of subsequent SPS episode, nor were direct care staff referred to those plans.²² Similarly, in no cases was there clear documentation that a change in SPS level was communicated through a face-to-face encounter, although the policy specifically requires staff to document that a change in suicide precaution status was communicated to direct care staff through a face-to-face encounter.²³ There were also instances in which post-SPS monitoring was not completed as required. Two of 15 applicable cases did not include the required five-day follow up, three of 11 cases did not include the required weekly follow up for a two-week period, and one of six cases was missing monthly follow up assessments.²⁴

²⁰ The policy requires daily post-SPS monitoring for five days, weekly for two weeks, and then monthly thereafter unless discontinued for clinical reasons. *Id.* §VI.B.7. The following youths were missing one or more post-SPS daily monitoring (TJ episode #3), (TA episode #5) and weekly SPS- weekly monitoring (KR, TJ episode #5 and TA episode #2).

²¹ In one episode, a daily assessment was missed on two days (RM episode #2), in another, there were no daily assessments completed for four days (IB), and in the other two one daily assessment was missed (TJ episode #4 and CR).

²² Section VI.B.4.vi. of the Suicide Prevention policy provides “behavioral health staff shall deliver the plan to the direct care, medical, and/or school staff who shall implement any provisions directed to them.” This clearly contemplates that the content of Special Management Plans will be communicated directly to impacted staff when a youth is placed on SPS. Even in instances where older plans were in the record, there was no evidence that direct care or other staff were referred to such older plans for the management of the youth.

²³ *Id.* §VI.B.5.ii.e. The Policy states that changes in SPS are to be communicated through a face-to-face encounter and that “[t]his encounter shall be included as a component of the progress notes and shall be written in the medical record.” *Id.* Informing YDRs in a face-to-face meeting of changes in suicide precaution status, and documenting that meeting, ensures that direct care staff are aware of the youth’s new status and provides an opportunity for issues to be identified, discussed, and resolved. Episodes in which this was not completed include RM (all 3 episodes), KJ, TJ (episodes #1, #4, and #5), DS (episodes #1 and #2), TA (episodes #1 and #2), MB and CR. This requirement was not applicable in TJ (episodes #2 and #3), LC, JM, and IB.

²⁴ TJ episode #3 was missing one 5-day post SPS daily note and in TJ episode #5 there were no post-SPS notes upon her return from PIW. Post-SPS weekly monitoring for the next two weeks following discontinuation of SPS was not documented in three episodes, KR, TJ (episode #5) and TA (episode #2).

This review also revealed issues with the completion of the monitoring forms by direct care staff. It was noteworthy that youth at the YSC placed on suicide precaution status were often on such status for weeks at a time. In reviewing monitoring forms provided by DYRS, OIJFO was unable to locate forms for specific dates in 11 episodes of SPS-1²⁵ and for specific dates in eight episodes of SPS-2.²⁶ In some instances, forms from whole shifts were missing. In other several other instances, codes were completed on some forms with no observation times indicated and/or no staff signatures,²⁷ and OIJFO was unable to determine if youth were monitored during these periods or if forms were completed by staff in advance and not contemporaneously as required by the Policy. Where observation forms were available for review for youth on SPS-1, OIJFO staff found that some of the observation forms completed by staff monitoring the youth did not reflect observations completed five times per hour.²⁸ For youth on SPS-2, in only five of the 15 applicable episodes was the required monitoring at staggered intervals not to exceed 10 minutes consistently documented in accordance with DYRS policy.²⁹ OIJFO also compared the findings from the most recent prior review in 2020 with the current findings which is reflected in Table 1 below.³⁰

²⁵ The youth involved were RM (episodes #1, #2, and #3), KR, IB, DS (episodes #1 and #2), TA (episodes #1 and #2), MB and CR.

²⁶ The youth involved were RM (episodes #1, #2, and #3), KR, LC, IB, TA (episode #1), and CR.

²⁷ The youth involved in these instances were RM (SPS-2, episode #1; missing monitoring signatures despite time and activities noted); LC (SPS-2; observation forms missing signature of monitor though time and activity were documented); IB (SPS-1; multiple forms for same period, forms show times completed but no activity noted nor staff signature).

²⁸ RM (episodes #1, #2, and #3), KR, IB, DS (episodes #1 and #2), TA (episodes #1 and #2), MB, and CR.

²⁹ RM (episode #1); TJ (episodes #4 and #5); DS (episode #1) and MB.

³⁰ As noted, that review was completed by the Special Arbiter in 2020. *See* June 2020 Special Arbiter's Report, page 49.

TABLE 1: PERCENT OF CASES MEETING SELECT 2016 SUICIDE PREVENTION POLICY REQUIREMENTS AT THE YSC, 2020 versus 2023 ³¹		
POLICY REQUIREMENT	2020 % Met (N=6)	2023 % Met (N=18)
SPS-1 Observation forms completed for entire SPS-1 episode	100	21
SPS-1 Observation forms signed by direct care and supervisor	100	62
SPS-1 Observations documented 5 times per hour	60	15
SPS-2 Observations documented at least every ten minutes	0	34
Immediate notification of BH staff if direct care staff notice change in youth	100	100
BH staff assess youth at least once per day and document same in record	100	78
BH daily assessment includes evidence BH staff considered need for acute care	83	100
BH daily assessment reflects current behavior	83	100
BH daily assessment reflects changes in thoughts/behavior in last 24 hours	67	100
BH daily assessment reflects basis for continued level of observation	67	100
BH staff completed Suicide Precaution Notification Form	83	100
Record includes Special Management Plan	67	6
Special Management Plan was completed by BH staff	67	6
Special Management Plan reflects items to be removed from youth	83	100
Special Management Plan includes specific problem behaviors and issues	67	6
Special Management Plan identifies triggers and precipitants	67	6
Special Management Plan includes early warning signs and unsafe behaviors	67	6
Special Management Plan includes prevention and early intervention strategies	67	6
Special Management Plan includes crisis management strategies	67	6
Youth who had been on SPS-1 is kept on SPS-2 at least 24 hours before being taken off	100	100
Suicide Precaution form is used whenever SPS level is changed	60	100
Upon change of SPS level, change is documented in record	80	100
Upon change of SPS level, documentation reflects face-to-face encounter	0	0
Post SPS monitoring for five days	50	87
Post SPS monitoring weekly for two weeks	0	73
Post SPS monitoring monthly unless documentation supports discontinuation	n/a	86

As Table 1 reflects, performance improved or remained at 2020 levels in 13 of 26 requirements but declined in 11 others. The decline in compliance with the Policy provisions related to monitoring in part was attributable to the numerous missing monitoring forms from the forms provided by DYRS. While for the prior review in 2020, most monitoring forms for youth at the YSC were located in FAMCare, during this review, OIJFO was informed that forms had not been loaded into FAMCare but instead were maintained in paper format and had been stored by SYDRs for the months under review; this change in how monitoring forms are maintained may have led to lost or misplaced forms and account in part for the decline noted in the performance related to monitoring documentation requirements. Moreover, the forms were not

³¹ Some policy requirements did not apply to each case reviewed and those cases were not included in the percentage calculations in determining if the requirement was met. The audit findings in individual cases from the current review are not included with this report; however, they will be provided upon request.

maintained by youth and episode (instead are maintained in a single file), so it is not surprising that many forms could not be located. In addition, the failure to complete Special Management Plans, or at least review and, as appropriate, refer direct staff care to previously completed plans in so many cases compared with 2020 performance levels is a notable finding in the current review.

B. New Beginnings

As noted, the OIJFO reviewed all episodes of SPS at New Beginnings for the period of September 1, 2022 through December 31, 2023, which included six episodes for six youth (two episodes of SPS-1, each with a step-down to SPS-2) and four episodes of SPS-2 only. The record review conducted by OIJFO indicates that staff at New Beginnings were largely implementing DYRS Suicide Prevention Policy requirements during the review period, with a few exceptions. Fifteen of the 25 requirements³² reviewed were met in all six episodes reviewed; this compares with 19 of 26 during the 2020 review. Additionally, 22 of 25 applicable requirements were met in at least 80 percent of the episodes reviewed. A summary of findings related to implementation of the policy requirements at New Beginnings and comparing findings to the 2020 review is set forth in Table 2, below.

TABLE 2: PERCENT OF CASES MEETING SELECT 2016 SUICIDE PREVENTION POLICY REQUIREMENTS AT NEW BEGINNINGS, 2020 versus 2023³³		
POLICY REQUIREMENT	2020 % Met (n=7)	2023 % Met (n=6)
SPS-1 Observation forms completed for entire SPS-1 episode	40	100
SPS-1 Observation forms signed by direct care and supervisor	100	0
SPS-1 Observations documented 5 times per hour	40	100
SPS-2 Observations documented at least every ten minutes	43	50
Immediate notification of BH staff if direct care staff notice change in youth	100	n/a
BH staff assess youth at least once per day and document same in record	86	83
BH daily assessment includes evidence BH staff considered need for acute care	100	100
BH daily assessment reflects current behavior	100	100

³² During this review, one of the 26 requirements (relating to notification of behavioral health staff if direct care staff noticed a change in a youth’s behavioral while the youth is on SPS) was not applicable, as there were no cases during this review where such change was observed.

BH daily assessment reflects changes in thoughts/behavior in last 24 hours	100	100
BH daily assessment reflects basis for continued level of observation	100	100
BH staff completed Suicide Precaution Notification Form	100	100
Record includes Special Management Plan	100	100
Special Management Plan was completed by BH staff	100	100
Special Management Plan reflects items to be removed from youth	100	100
Special Management Plan includes specific problem behaviors and issues	100	83
Special Management Plan identifies triggers and precipitants	100	83
Special Management Plan includes early warning signs and unsafe behaviors	100	83
Special Management Plan includes prevention and early intervention strategies	100	100
Special Management Plan includes crisis management strategies	100	83
Youth who had been on SPS-1 is on SPS-2 at least 24 hours before being taken off	100	100
Suicide Precaution form is used whenever SPS level is changed	86	100
Upon change of SPS level, change is documented in record	100	100
Upon change of SPS level, documentation reflects face-to-face encounter	20	0
Post SPS monitoring for five days	100	83
Post SPS monitoring weekly for two weeks	83	83
Post SPS monitoring monthly unless documentation supports discontinuation	100	100

As Table 2 reflects, more than half of the policy requirements were met in every episode of SPS used at New Beginnings during the review period. For example, in all episodes in the sample, Suicide Notification and Change in Status forms were found, and all individuals who had been on SPS-1 were maintained on SPS-2 a minimum of 24 hours before being removed from SPS.³⁴ Each of the Suicide Notification forms included a statement of items to be removed from the youth. Daily assessments by behavioral health staff were completed in all but one episode (83 percent) (in that episode, two daily notes were missing),³⁵ but all completed daily assessments addressed each of the criteria established by the policy.³⁶ Special Management Plans were found in all cases, although one Special Management Plan failed to address four of

³⁴ Cases that met these requirements included JW, JH, KB, MP, DM, and KD.

³⁵ In the case of KD, daily assessments were missing for 11/18/23 and 11/20/23.

³⁶ Cases that met these requirements included JW, JH, KB, MP, DM, and KD. In KD's case a Mental Health SOAP note for 11/22/23 was located and included all the items expected in a SPS SOAP note and was credited as compliant.

the required elements of a Plan.³⁷ Post-SPS daily, weekly and monthly monitoring was documented as required in all but one case (83 percent).³⁸

The requirements for YDR staff to document their observations of youth on SPS Observation Forms multiple times per hour at prescribed intervals and over the course of many days includes frequent and extensive recording of observations on Suicide Observation Forms. For youth on SPS-1, per the Suicide Prevention Policy, staff must document observations of youth at least five times per hour and for youth on SPS-2, staff must document observations at staggered intervals not less than every ten minutes.³⁹ Thus, in any 24-hour period, staff are required to record at least 120 observations of a youth on SPS-1 and 144 observations of a youth on SPS-2.

The New Beginnings sample included both episodes of SPS-1 that occurred at New Beginnings during the 15-month review period. In neither of these episodes were all SPS-1 monitoring forms signed by the supervisor as required by Policy, although all forms were signed by direct care staff and reflected five observations per hour.⁴⁰ In the six instances involving SPS-2, half (three) did not include observations documented every ten minutes as required by Policy.⁴¹ Finally, as was the case with the YSC, none of the notes pertaining to change in SPS reflected a face-to-face encounter. However, a review of SPS Observation Forms reveals that in

³⁷ Cases that met these requirements include JW, JH, KB, DM, and KD; in the case of MP, some aspects of a Special Management Plan were included in the Suicide Precaution Notification Form but not all required elements were included. Missing elements are recorded in the Table as applicable.

³⁸ Cases that met these requirements include JW, JH, KB, DM, and KD, but no daily post-SPS monitoring was located for MP for one day in the daily monitoring period and no notes for the two weeks following termination of SPS. While MH SOAP notes by the therapist were located, they did not address SPS at all.

³⁹ Attachment 1, §§VI.B.3.i.a.(c) and VI.B.3.i.b.(a).

⁴⁰ In JH's case, three forms were missing supervisory signatures. In the second case (KB), none of the six forms had supervisory signature. All forms included signatures of direct care staff.

⁴¹ Monitoring forms did not document SPS-2 related observations every ten minutes in the cases of JW, JH, and KD. In KD's case, observations were not documented for more than 27 minutes on four occasions. Forms were not provided for the first day of JW's SPS-2 status, and in both JH and JW's cases there were multiple instances where documented observations exceeded ten minutes.

every case, shortly after the behavioral health staff changed a youth's suicide precaution status, YDR staffs' observation practices reflected the appropriate observation intervals, consistent with the change. Thus, the evidence indicates that changes in suicide precaution statuses were being communicated to YDR staff but not recorded in writing despite the clear requirement in the Suicide Prevention Policy.⁴²

III. CONCLUSION

OIJFO's review found that neither the YSC nor New Beginnings is meeting *all* the requirements of the Policy. Particularly notable is the absence of Special Management Plans that identify problem behaviors, triggers, early warning signs and prevention, and intervention strategies at the YSC. In neither facility is behavioral health staff documenting face-to-face encounters when changing SPS despite a clear requirement in the Policy, and documentation of monitoring continues to evidence periodic lapses. OIJFO therefore recommends that all episodes where suicide precaution status is used be reviewed by performance improvement staff for compliance with each of the Policy requirements. Additionally, OIJFO recommends that monitoring forms be maintained in separate files by individual youth and/or consistently uploaded to youth FAMCare records to facilitate review.

⁴² As noted above, the Policy requires face-to-face communication with direct care staff when lowering, upgrading, or removing a youth from SPS, and that "[t]his encounter shall be included as a component of the progress notes and shall be written in the medical record." Attachment 1, §VI.5.ii.e.

Attachment 1



**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
POLICY AND PROCEDURES MANUAL**

POLICY NUMBER:	V.b.3
RESPONSIBLE OFFICES:	Health Services Administration
EFFECTIVE DATE OF POLICY:	June 28, 2016
SUPERSEDES POLICY:	DYRS-021
SUBJECT:	Suicide Prevention

I. PURPOSE

The purpose of this policy is to protect the safety and security of youth residents at the Youth Services Center ("YSC") and the New Beginnings Youth Development Center ("NBYDC") by establishing guidelines and procedures designed to prevent suicide.

II. POLICY

DYRS is committed to providing a safe and secure environment for youth residents at the YSC and NBYDC. It is the policy of DYRS to provide on-going screening, assessments, crisis intervention, adequate staffing for supervision and communication procedures which shall ensure prompt, professional, and coordinated treatment of youth in its care and custody assessed as being at risk for self-harm or suicide.

III. AUTHORITY

This policy is governed by all applicable District of Columbia and Federal law including: DYRS Establishment Act of 2004, D.C. Official Code §§ 2-1515.01 through 2-1515.10 (2001); Mental Health Consumers' Rights Protection Act of 2001, D.C. Official Code §§ 7-1231.01 through 7-1231.15 (2001); D.C. Mun. Regs. tit. 22-A, § 500.9 (2008); Jerry M. Final Approved Amended Comprehensive Work Plan, December 5, 2007, as revised by Revised Final Approved Amended Comprehensive Work Plan, January 26, 2010, and all amendments thereto; and, District of Columbia District Personnel Manual §16.

IV. SCOPE

This policy applies to all DYRS employees at the YSC and NBYDC.

V. DEFINITIONS

Behavioral Health Program Managers: Behavioral health staff designated as clinical supervisors at NBYDC and YSC to oversee the work performed by the subordinate behavioral health staff at their respective facilities.

Child Fatality Review Coordinator: A staff person at DYRS who is responsible for investigating fatalities of youth under DYRS' care.

Court Social Services ("CSS"): Part of the District of Columbia Superior Court and is the District's juvenile probation agency. CSS is responsible for serving and supervising juveniles involved in the "front-end" of the District's juvenile justice system. Those juveniles include: all newly arrested youth entering the Court system in juvenile delinquency cases, Persons In Need of Supervision ("PINS") cases and truancy cases, probation, and diversion matters.

Crisis Debriefing: The coordinated effort of behavioral health staff to talk with youth and staff following a traumatic event such as a serious suicide attempt or a completed suicide to give them an opportunity to express their feelings and to offer strategies they might employ to recover from a traumatizing event.

Direct Care Staff: DYRS employees tasked with providing direct supervision, oversight, and therapeutic interventions to youth in DYRS facilities (i.e., Youth Development Representatives and Supervisory Youth Development Representatives).

Massachusetts Youth Screening Instrument -- Version 2 ("MAYSI-2"): A brief mental health screening tool for routine administration at entry to any juvenile justice facility or service. Its purpose is to identify youth who may need immediate attention regarding possible suicide risk and emergent mental health and substance use needs.

New Admissions: Youth who are first time admissions to a DYRS secure facility or who have not been detained/incarcerated for two weeks or more on the current admission.

Overnighters: Youth detained at YSC for one or more nights pending their return to court for arraignment hearings. These youth may or may not be securely detained following their arraignment.



Responsible Health Authority (“RHA”): Accountable for ensuring the coordination, accessibility and delivery of comprehensive quality health care within each DYRS secure facility. The RHA also monitors direct patient care, making all final medical judgments.

Self-Injurious Behavior: The non-lethal harming of oneself, including: cutting, drinking or eating non-edible substances, banging of head or fist against walls, or any other purposeful action with the potential of resulting in self-harm.

Serious Suicide Attempt: For purposes of morbidity review, any self-injurious behavior that results in transportation off-grounds for medical treatment.

Special Management Plan: A written plan that details crisis intervention strategies that are used during a crisis event to reduce or resolve immediate and future high risk behaviors in youth.

Suicidal Gesture: Any intentional behavior with the potential for self-harm, even if not intended to be lethal.

Suicide Attempt: An act to self-inflict injury with intent to cause one’s death.

Suicide Contagion: A process by which exposure to the suicide or suicidal behavior of one or more persons triggers a cluster of subsequent suicides and/or suicidal behavior. An initial suicide in a juvenile facility introduces the concept of suicide and may model behavior for other youth. Suicide Contagion may be transmitted by direct knowledge, rumor/speculation, or through the media.

Suicide Ideation: Any thoughts or ideas of taking one’s life.

Suicide Precaution Status (“SPS”): A supervision system used to ensure that youth identified as potentially suicidal are closely observed and receive appropriate behavioral health and medical services.

Suicide Prevention Panel: An advisory group convened by DYRS whose mission is to advise leadership on improving suicide prevention efforts at DYRS and to provide quality assurance and monitoring of suicide prevention policies and procedures.

Suicide-Resistant Rooms: Rooms that are free of all obvious protrusions, and provide full visibility. These rooms should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the rooms or cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each room door should contain a heavy gauge Lexan (or equivalent

grade) clear panel that is large enough to allow staff a full and unobstructed view of the room interior.

Triggers: Conditions or variables (e.g., persons, time of day, specific activities, etc.) that tend to heighten the youth's feelings of vulnerability or enhanced likelihood of hurting themselves.

VI. PROCEDURES

A. GENERAL GUIDELINES

1. All self-injury, suicidal gestures, suicide attempts or reported suicidal ideations shall be taken seriously and responded to immediately. The urgency of the response shall be determined by the seriousness of the youth's words and/or actions.
2. All youth thought to be at-risk for self-injury or suicide shall be referred immediately to behavioral health staff.
3. If on-site, behavioral health staff shall immediately assess the youth. At a minimum, the suicide risk assessment should include a brief mental status examination, listing of chronic and acute risk factors, listing of any protective factors, level of suicide risk (e.g., low, medium, or high), and a treatment plan.
4. If on-call, behavioral health staff shall respond to a call within 15 minutes and make a clinical determination about the immediacy of their on-site response, as detailed in VLB.3 below.
5. If it is determined that a face-to-face encounter is not immediately necessary, but suicidal ideation is assessed to be present after a phone conversation with the youth and consultation with on-site medical staff, the behavioral health staff member will place the youth on continuous observation (SPS-1), and the youth will be seen face-to-face within 18 hours to reassess.
6. If an immediate response is determined to be clinically necessary, the on-call clinician will contact the psychiatrist and medical officer at which point the youth will immediately be placed on continuous observation (SPS-1).
7. Both medical and behavioral health staff shall be available to DYRS direct care staff to respond to potentially suicidal youth 24 hours a day, seven days a week including weekends and holidays.



B. MANAGEMENT OF SUICIDAL OR POTENTIALLY SUICIDAL YOUTH

1. Screening for Suicidality

- i. All youth who present at the YSC or NBYDC shall be screened for suicide risk.

2. Overnighters and New Admissions

- i. All overnighters and new admissions shall receive a medical screening and mental health evaluation by appropriately trained medical staff using the Initial Medical Screening and Risk Assessment Form (Attachment A), which includes the Youth Suicide and Self Injury Questionnaire, within four hours of their admission.
- ii. The MAYSI-2 shall be administered by appropriately trained medical staff to all overnighters/new admissions within four hours of their admission.
- iii. Medical staff shall immediately notify the on-site or on-call behavioral health staff if any overnighiter/new admission flags a caution or warning on the Suicidality or Thought Disorder dimensions of the MAYSI-2 or provides an affirmative answer to any question on the Youth Suicide and Self Injury Questionnaire.
- iv. If a youth flags a caution or warning on the MAYSI-2, behavioral health staff shall immediately conduct a face-to-face assessment of the youth to determine the youth's mental status and the need for acute psychiatric hospitalization or placement on Suicide Precaution Status, if on-site.
- v. If on-call, the behavioral health staff shall respond within 15 minutes of the notification and speak with the medical staff who reviewed the Youth Suicide and Self Injury Questionnaire and MAYSI-2 results and whenever possible, speak with the youth, to determine the urgency of a face-to-face assessment and necessity of placement on a SPS.
- vi. If an immediate face-to-face encounter with the youth is determined to be clinically necessary, behavioral health staff shall proceed to the facility and conduct a face-to-face assessment within one hour of notification.
- vii. In addition to the telephone consultation, the behavioral health staff shall conduct a face-to-face assessment within 18 hours of either the administration of the MAYSI-2 or of the administration of the Youth Suicide and Self Injury Questionnaire, or within a lesser specified time period as clinically indicated.



- viii. If the overnigher youth is placed on the highest level SPS requiring one-on-one staffing (i.e., SPS-1), he/she shall be accompanied to court with the staff member assigned to supervise the youth one-on-one. Medical or Behavioral Health staff who completed the Suicide Precaution Notification form will hand deliver a copy of the Suicide Precaution Notification form to CSS staff (who are housed in the intake area of YSC).
- ix. Medical staff shall review the mental health record of all overnighters and newly admitted youth within 24 hours of admission to determine whether each youth was previously placed on suicide precaution status during a prior DYRS confinement. Any youth previously placed on an SPS status shall be referred to behavioral health staff for assessment.

3. Suicide Precaution Guidelines

- i. There are two levels of Suicide Precaution Status:
 - a. **Level One (SPS-1) (One-on-One)**
 - (a) SPS-1 requires that the youth have a trained and dedicated staff member within five feet of him/her at all times, day and night. The door to the room of a youth on one-on-one Suicide Precaution Status shall remain open at all times.
 - (b) One-on-one supervision shall be used for youth who present with marked acuity and require continuous observation. The mental status of youth on SPS-1 shall be continuously assessed by all staff for changes in the youth's mood, behavior, or thought.
 - (c) Direct care staff providing the one-on-one supervision of the youth shall document their observations at staggered intervals, no less than five times an hour on the Suicide Precaution Status Observation Form (Attachment C). The procedures contained on page two of Attachment C are incorporated herein by reference.
 - (d) Direct care staff providing one-on-one supervision shall notify behavioral health staff (or medical staff if behavioral staff is not on site) immediately if youth evidences increasing signs of changes in mood, behavior, or thought.
 - (e) If on-site, behavioral health staff shall immediately conduct a face-to-face assessment of the youth to determine the youth's mental status, and the need for acute psychiatric hospitalization.
 - (f) If behavioral health staff is on-call, staff shall bring the youth to the medical unit for assessment. Medical staff shall notify the on-call behavioral health staff. If on-call, the behavioral health staff shall speak with the referring staff, the medical staff and whenever possible, with the youth, to determine the urgency of a face-to-face

assessment. On-call behavioral health staff shall present to the facility immediately if it is determined that a face-to-face assessment is needed.

- (g) Behavioral health staff shall assess a youth on SPS-1 once per day, including weekends. Each assessment shall include consideration of whether the youth requires more acute care (i.e., transfer to an acute psychiatric facility) and shall be documented in the youth's medical record.
- (h) Medical staff shall monitor youth on SPS-1 status daily if their SPS was based on drug use or other physical health conditions. This includes visits at night, if necessary.
- (i) Upon designation that a youth requires SPS-1 supervision, behavioral health staff (or medical staff in consultation with behavioral health staff), shall complete the Suicide Precaution Status Notification Form (Attachment B).
- (j) Behavioral health staff, in-consultation with unit staff, teachers and other staff with knowledge of the youth shall develop a Special Management Plan (see Attachment D) that gives instruction about the management of the youth to medical, direct care, school and other staff.
- (k) Youth on one-on-one status shall participate in all activities including school and all usual unit and recreational activities unless contraindicated as determined by behavioral health staff.
- (l) Direct care staff providing observation of a youth on SPS-1 shall not be assigned any other responsibilities.
- (m) The duration of SPS-1 shall be based upon the clinical judgment of the behavioral health staff in consultation with unit, medical, and school-based staff.

b. Level Two (SPS-2) (Checks)

- (a) SPS-2 requires that the youth be observed by assigned unit staff at staggered intervals not to exceed every ten minutes, 24 hours a day and documented on the observation sheet.
- (b) SPS-2 shall be used for youth who present with some vulnerability to harm themselves (e.g., suicidal ideation with no plan, some erratic behavior, or some mood instability, etc.).
- (c) Checks shall be implemented by direct care staff to ensure that enhanced and regularized oversight of youth occurs and shall be documented on a Suicide Precaution Status Observation Form with information about the youth's behavior observed.
- (d) Youth on SPS-2 shall participate in school and all usual unit and recreational activities.

- (e) Behavioral health staff shall provide a face-to-face assessment of any youth on SPS-2 at least once daily, including weekends.
- (f) The duration of SPS-2 shall be based upon the clinical judgment of the behavioral health staff in consultation with unit, medical, and school-based staff.

4. Placing a Youth on Suicide Precaution Status

- i. Only behavioral health or medical staff, in consultation with behavioral health staff, shall initiate placing a youth on Suicide Precaution Status. If medical staff place a youth on SPS status, they must place youth on SPS-1 pending a face-to-face consultation with behavioral health staff.
- ii. Only behavioral health staff may upgrade, lower or remove a youth from Suicide Precaution Status.
- iii. If medical staff has placed a youth on Suicide Precaution Status, either directly or via phone consult with an on-call behavioral health staff, behavioral health staff will conduct a face-to-face assessment of the youth within 18 hours of their initial placement, or sooner if clinically indicated.
- iv. If upon their face-to-face assessment of the youth behavioral health staff makes the clinical determination that the youth does not require placement on Suicide Precaution Status, behavioral health staff may lower or remove the youth from said status.
- v. The Suicide Precaution Status Notification Form shall be completed whenever a decision has been made to place a youth on Suicide Precaution Status (this may be done by either medical or behavioral health staff).
- vi. Upon the determination that a youth requires placement on a Suicide Precaution Status (and upon completion of the Suicide Precaution Status Notification Form), behavioral health staff shall develop and implement a Special Management Plan (Attachment D). The behavioral health staff shall deliver the plan to the direct care, medical, and/or school staff who shall implement any provisions directed to them.



5. Maintaining, Lowering, Upgrading or Removing a Youth from Suicide Precaution Status

i. Maintaining a Youth on Suicide Precaution Status

- a. Behavioral health staff's daily assessment of youth shall routinely include consultation with relevant stakeholders to the youth's behavior, affect and interpersonal relations.
- b. The daily assessment shall focus on current behavior, as well as changes in thoughts and behavior during the past 24 hours. The assessment shall be documented as a progress note and provide a sufficient description of the current behavior and justification for a particular level of observation.
- c. If behavioral health staff make changes to the Special Management Plan, this shall be communicated in a face-to-face encounter with facility direct care staff. This encounter shall be included as a component of the progress note to be written in the medical record. The behavioral health staff shall deliver the revised plan to the direct care, medical, and/or school staff who shall implement any provisions directed to them.

ii. Lowering, Upgrading or Removing a Youth from Suicide Precaution Status

- a. Only behavioral health staff shall raise, lower or remove a youth from Suicide Precaution Status following a comprehensive assessment that justifies the decision in a detailed progress note.
- b. Behavioral health staff shall continually confer with facility and medical staff about the youth's behavior and mental status in forming their clinical determinations.
- c. Youth who have been on SPS-1 following a face-to-face assessment by behavioral health staff shall be lowered to SPS-2 status for a minimum of 24 hours prior to being removed from Suicide Precaution Status altogether.
- d. A Suicide Precaution Status Change Form (see Attachment E) will be utilized whenever a youth is upgraded, downgraded or removed from Suicide Precaution Status.
- e. Upon upgrading, downgrading, or removing a youth from SPS, behavioral health staff shall communicate this in a face-to-face encounter with unit direct care staff, especially with the staff performing the Suicide Precaution Status supervision. This encounter shall be included as a component of the progress notes and shall be written in the medical record.
- f. Behavioral health staff shall not lower or remove youth from Suicide Precaution Status via on-call notification.



6. Psychiatric Hospitalization

- i. Criteria for Acute Psychiatric Hospitalization
 - a. Youth in need of acute psychiatric hospitalization due to suspected suicidality based upon a determination that the youth poses an actual or imminent danger to themselves, shall be immediately transported to an inpatient psychiatric hospital immediately upon their acceptance.
- ii. Procedures for Arranging Acute Psychiatric Hospital Admissions
 - a. Only an MD, licensed Ph.D. clinical psychologist or specially trained officer agent is authorized to complete the required documentation (FD-12) attesting to the emergency nature of the referral.
 - b. The provider completing the *Application for Emergency Hospitalization by a Physician or Psychologist of the Person, Officer or Agent of Human Services or an Officer to Make an Arrest* (FD-12 826.APR) (See Attachment F) shall contact the Psychiatric Institute of Washington (“PIW”), or such other appropriate psychiatric hospital, to present the clinical severity of the youth to their admissions staff and determine the availability of bed-space.
 - c. Upon approval of the admission an MD, licensed Ph.D. clinical psychologist or specially trained officer agent shall review the youth’s medical record for pertinent information to be forwarded to PIW, or such other appropriate psychiatric hospital; these documents shall be copied, and along with the FD-12 826.APR, placed in a sealed confidential envelope to be transferred along with the youth.
- iii. Supervision of Youth Awaiting Transfer to PIW or Other Psychiatric Hospital
 - a. Youth determined to be in need of acute psychiatric hospitalization due to suicidality shall be placed on SPS-1 awaiting transfer to the hospital.
 - b. The Youth Development Representative (“YDR”) shall continue their one-on-one supervision of the youth during transfer and shall remain with the youth until he/she has been formally admitted to the psychiatric hospital.
 - c. Behavioral health or medical staff shall provide continuing supervision to youth awaiting emergency transfer to a psychiatric hospital, documenting in the medical record on the mental status of the youth at least hourly until the youth has left the DYRS facility.



iv. Procedures for Receiving Youth Back from Acute In-Patient Psychiatric Hospitalization

- a. Behavioral health or medical staff shall coordinate with the psychiatric hospital to arrange for the return of youth following an acute admission. Coordination shall include speaking with the hospital physician and arranging for the receipt of the hospital's discharge orders/summary.
- b. Youth returning from acute psychiatric hospital stays shall be brought to medical prior to being returned to their housing units. Youth shall remain on SPS-1 from the time of transport from a psychiatric hospital through readmission to a DYRS facility until released from the SPS-1 status by behavioral health staff.
- c. If on-site, behavioral health staff shall assess the youth's mental status and make a determination as to whether the youth requires being maintained on Suicide Precaution Status.
- d. Medical staff shall review the hospital discharge orders/summary ensuring that if the youth returns on medications these medications are continued uninterrupted upon the youth's return.
- e. Behavioral health staff shall review the hospital discharge orders/summary and ensure that recommendations for continuing care are implemented as appropriate.
- f. If no discharge orders/summary accompanied the youth upon his/her return from an acute psychiatric hospitalization, medical or behavioral health staff shall call the hospital and request that the information be faxed to the medical unit.

7. Behavioral Health Follow-Up for Youth Removed from Suicide Precaution Status

- i. Youth who are removed from Suicide Precaution Status and who remain in secure care shall be further assessed and provided treatment by behavioral health staff in accordance with clinical judgment, but the following shall occur, at a minimum, according to the following schedule:
 - a. Monitoring daily for five days.
 - b. Monitoring once a week for two weeks.
 - c. Continued monitoring once a month until released from custody, unless there is documentation as to why this is clinically unnecessary.
- ii. Behavioral health staff shall document these encounters on the Post Suicide Precaution Status Monitoring Form (Attachment G) which shall be maintained in the youth's medical record.

- iii. After a youth's removal from SPS status, behavioral health staff shall update the youth's treatment plan with treatment goals to address the issues underlying the most recent placement on SPS-status and shall consult with any staff person who is responsible for implementing the updated treatment goals or specific interventions about the treatment plan.

8. Special Management Plans

- i. Special Management Plans developed by behavioral health staff for youth placed on Suicide Precaution Status shall contain the following:
 - a. Items which should be removed from the youth's possession;
 - b. Specific problem behaviors and issues;
 - c. Triggers and precipitants;
 - d. Early warning signs that indicate unsafe behaviors;
 - e. Prevention and early intervention strategies; and
 - f. Crisis Management Strategies (environmental, interpersonal).
- ii. Special Management Plans shall be used to determine if there has been any change in the youth's behavior or affect and shall also include:
 - a. Whether the proposed interventions are effective;
 - b. Whether the Suicide Precaution Status can be discontinued; and
 - c. What specific type of follow-up may be necessary.

9. Housing of Youth on Suicide Precaution Status

- i. All youth on SPS shall be housed in a suicide-resistant room and every housing unit shall have at least one suicide-resistant room.
- ii. When a suicide-resistant room is not available, youth who are on SPS-2 will receive a one-on-one monitor. All other provisions of SPS-2 will be permitted.
- iii. During periods of SPS-1 observation, assigned staff shall be stationed in the entrance to the sleeping area with the room door open, absent any noted safety risk, so as to carefully observe the at-risk youth, and staff shall be prepared to intervene should the need arise.
- iv. Youth on SPS shall not have shoelaces or belts while confined to their room. Youth on SPS shall be issued security blankets.
- v. In accordance with the DYRS Policy on Identification and Searches, youth shall be searched thoroughly upon return to the housing unit from any



program area within the institution, and a visual strip search is required of youth returning from off-site.

10. Continuity of Care

- i. Youth on Suicide Precaution Status who are released to a community placement or home shall have their status communicated to their probation officer or case manager, parent/guardian or other receiving authority by behavioral health staff, who shall make a referral to community-based mental health services, as appropriate.

11. Intervention in Attempts/Suicide

- i. When intervening in a suicide or suicide attempt, staff shall act in accordance with the DYRS Medical Emergency Response Policy.

12. Essential Equipment

- i. A fully stocked First Aid Kit, CPR masks, and a 911 Rescue Tool, designed with a hooked blade to allow for rapid cutting of fibrous material utilized in hanging attempts, shall be located in a clearly marked, easily accessible location in the staff office of each housing unit.
- ii. The Supervisory Youth Development Representative ("SYDR") and Team Leader/Unit Manager shall inspect each staff office weekly to ensure that these items are in place.
- iii. Medical staff shall also inspect the completeness of the First Aid Kit weekly and replenish the kit as necessary.

C. TRANSPORTATION OF YOUTH ON SUICIDE PRECAUTION STATUS

1. Youth on SPS-1 and SPS-2 who are transported off-site shall be escorted by the staff providing continuous supervision.
2. The staff providing continuous monitoring during transportation to the court shall ensure that both the Suicide Precaution Status Observation Form and the Suicide Precaution Status Notification Form are delivered to the At-Risk Unit at the court. The DYRS At-Risk Officer shall continue the continuous supervision, record observations on the Suicide Precaution Status Observation Form, and shall ensure that the Suicide Precaution Status Notification Form is delivered to the Judge. In the event the supervising staff notices significant alterations in the youth's mood or behavior, s/he shall notify the judge, the Mayor's Liaison Office, and the DC Department of Behavioral Health ("DBH") psychiatrist on site.

D. NOTIFICATION AND POST INCIDENT RESPONSE

1. Notification

- i. The RHA shall notify the DYRS Director and the DYRS Deputy Director for Youth and Family Programs in the event that a youth attempts a suicide.
- ii. The Director or designee shall contact the youth's family within one hour of the incident. If unable to contact the family after three attempts within four hours, a staff member designated by the Director shall be dispatched to contact the family in person. Staff is required to document their attempts to contact family.

2. Reporting Attempts or Suicides

- i. The DYRS Director or designee shall ensure that all D.C. Government officials are notified and the proper reports are completed in the event of a completed suicide.
- ii. The Unusual Incident Report shall serve as the primary record for documenting suicide attempts and/or completed suicides.
- iii. An institutional "call down" sheet, listing names of all D.C. Government officials who shall be notified in the event of a completed suicide shall be maintained in the control stations of each facility. Within 24 hours of a completed suicide, the DYRS Director or designee shall at least notify the DYRS General Counsel and the Metropolitan Police Department.
- iv. An investigation shall be conducted by the DYRS Deputy Director for Youth and Family Programs or designee whenever there is a completed suicide.
- v. A full report shall be submitted to the DYRS Director within five working days of the incident and a copy of the report shall be distributed to the Suicide Prevention Panel.

3. Post Incident Response

- i. In order to neutralize the "contagion syndrome" within DYRS facilities and programs, behavioral health, medical, social services, and secure direct care staff shall collaboratively devise and provide an immediate and appropriate intervention. Crisis Debriefing shall be provided to all youth and staff affected by a serious attempt or completed suicide. This may be provided by DYRS Behavioral Health staff under the direction of the RHA, or designee, or

by Crisis Debriefing Teams maintained by DBH or the Metropolitan Police Department.

- ii. Staff requiring additional crisis intervention services shall be referred by DYRS Human Resources to the Employee Assistance Program ("EAP"), to a private mental health provider, or to a DBH Core Service Agency that has the capacity to provide grief counseling.
- iii. Youth who require additional crisis intervention (e.g., grief counseling) shall receive it from the facility's behavioral health staff.

E. SUICIDE PREVENTION POLICY OVERSIGHT

1. The DYRS Suicide Prevention Panel shall provide quality assurance of suicide prevention policies and practices. The Panel shall conduct a morbidity and/or mortality review of all incidents of serious suicide attempts or completed suicides in collaboration with the Child Fatality Review Coordinator. The review shall include a review of:
 - i. The totality of circumstances surrounding the incident;
 - ii. The appropriateness of all procedures established by policy regarding the incident;
 - iii. The appropriateness of all procedures actually undertaken in response to the incident;
 - iv. All relevant training received by involved staff;
 - v. Pertinent medical and behavioral health services, screenings and assessments involving the victim;
 - vi. The possible precipitating factors leading to the incident;
 - vii. The development of a Corrective Action Plan including recommendations, if any, for changes in policy, training, medical or behavioral health services, or operational procedures.
2. The Panel will submit a full report to the DYRS Director within 30 working days of the incident.
3. The Panel shall be comprised of the following:
 - i. RHA;
 - ii. NBYDC Behavioral Health Program Manager;
 - iii. YSC Behavioral Health Program Manager;
 - iv. Quality Assurance Manager or designee;
 - v. NBYDC Superintendent or designee;
 - vi. YSC Superintendent or designee;
 - vii. DYRS Risk Manager; and



viii. Integrity Officer.

4. The Panel shall review the Suicide Prevention Policy on an annual basis and submit recommendations, if any, for revision to the DYRS Director.

F. TRAINING REQUIREMENTS

1. Prior to the assumption of job duties, all direct care, medical, mental health, YDRs, SYDRs, education, contractors, and any other personnel who have regular contact with youth shall receive eight hours of initial suicide prevention and crisis management training, which shall include, at a minimum, the following:
 - i. Risk factors for adolescent suicide and potential predisposing factors among youth for self-injury or suicide;
 - ii. Juvenile suicide research;
 - iii. The power of place: Why institutional environments are conducive to suicidal behavior;
 - iv. High risk suicide periods for youth in the juvenile justice system;
 - v. Warning signs and symptoms, including interpreting and understanding denial among youth;
 - vi. Suicide Prevention Policy components;
 - vii. Liability issues associated with juvenile suicide in custody; and
 - viii. Responding to a suicide attempt in progress, including the appropriate use of the 911-tool.
2. All staff referenced above shall receive four hours of refresher training each year, which shall include, the following:
 - i. Risk factors for adolescent suicide and potential predisposing factors among youth for self-injury or suicide;
 - ii. Warning signs and symptoms, including interpreting and understanding denial among youth;
 - iii. Review of any changes to the agency's suicide prevention plans or policies; and
 - iv. Discussion of any recent suicides and/or suicide attempts in the facilities.

G. CONTINUOUS IDENTIFICATION OF YOUTH AT RISK

1. Staffing

- i. DYRS shall ensure that adequate numbers of direct care, behavioral health and medical staff are available to safely monitor, assess, and provide treatment to all youth in its care and custody.

- ii. Medical staff shall be on-site in DYRS secure facilities 24 hours a day, seven days a week.
- iii. Behavioral health staff shall be available 24 hours a day, seven days a week to DYRS secure facilities. Behavioral health coverage is provided by both on-site and on-call staff.
- iv. YDRs provide coverage ensuring adequate supervision of youth throughout the day/night at both YSC and NBYDC. When a youth is placed on SPS-1, described in Section VLB.3. above, an additional YDR shall be assigned to provide the one-on-one supervision.

2. Request for Care

- i. DYRS facilities shall maintain a Request for Care system for youth and staff to access medical and behavioral health services seven days a week.
- ii. Secure and confidential Request for Care boxes shall be maintained on all living units and in the schools at DYRS secure facilities.
- iii. Medical staff shall triage all requests for medical care and respond to all urgent requests immediately. If the request is non-urgent, medical staff shall see the youth within 24 hours.
- iv. Behavioral health staff shall triage all requests for behavioral health services and respond to all urgent requests immediately. If the request is non-urgent, behavioral health staff shall see the youth within 48 hours.
- v. Psychiatric consultation shall be available both on-site and on-call. The on-call psychiatrist can only be contacted by medical or behavioral health staff, and when called shall be provided information about the events leading up to placing the youth on Suicide Precaution Status and the current mental status of the youth. Documentation of the call to the on-call psychiatrist shall be recorded in the youth's medical record.
- vi. Any telephone orders for medication shall require a face-to-face consult with the youth by the psychiatrist within 72 hours of the order.



3. Urgent Referrals

- i. Any staff (i.e., direct care, administrative, school, medical, etc.) can make an urgent referral for behavioral health services 24 hours a day, seven days a week. Urgent referrals shall be made in those instances in which a youth is observed harming him/herself, evidencing marked shifts in mood, behavior, or thought, making statements about intending to self-harm or if there is any other significant concern raised in the care and management of a youth.
- ii. Urgent referrals shall be made in person, by telephone, or walkie-talkie. In addition, staff shall supplement the notification process by completing a Request for Care form. **Urgent referrals shall not be made via electronic mail or text message.**
- iii. If on-site, behavioral health staff shall immediately conduct a face-to-face assessment of the youth to determine the youth's mental status, and the need for acute psychiatric hospitalization or placement on Suicide Precaution Status.
- iv. If behavioral health staff are not on-site (i.e., are on-call) staff shall bring the youth to the medical unit for initial assessment by medical staff.
- v. Medical staff shall immediately notify the DYRS behavioral health clinician on-call.
- vi. If on-call, the behavioral health staff shall speak with the referring staff, the medical staff and whenever possible, with the youth, to determine the urgency of a face-to-face assessment and/or placement on a Suicide Precaution Status. The behavioral health staff shall respond in accordance with the timelines in VI.B.2. above.

H. DOCUMENTATION/COMMUNICATION

1. Behavioral Health Staff

Upon the clinical determination that a youth requires being placed on Suicide Precaution Status, behavioral health staff shall complete the Suicide Precaution Status Notification Form indicating the level of Suicide Precaution Status required and document any special precautions to be aware of or followed by unit staff.

- i. If on-site, behavioral health staff will speak with unit staff, teachers, and other staff who have knowledge of the youth to get their input in the development of the Special Management Plan and to communicate and review any special precautions or concerns they need to attend to in their observation of youth.

[REDACTED]

- ii. If on-site, behavioral health staff shall ensure that copies of the Suicide Precaution Status Notification Form are distributed to: the control center, the SYDR, the Team Leader/Unit Manager, Social Services, placed in the youth's chart, and catalogued in the Suicide Precaution Status Notebook located in the medical unit.
- iii. If behavioral health staff are on-call and have instructed medical staff to place a youth on Suicide Precaution Status, the medical staff completing the Suicide Precaution Status Notification Form shall distribute the form as detailed above.
- iv. When lowering or removing a youth from Suicide Precaution Status, behavioral health staff shall complete the Suicide Precaution Status Change Form, following consultation with unit staff and school-based staff.

2. Direct Care Staff

- i. Upon the clinical determination that a youth requires being placed on Suicide Precaution Status, and upon receipt of a Suicide Precaution Status Notification Form, direct care staff shall implement the requisite level of observation.
- ii. Direct care staff responsible for supervising a youth on Suicide Precaution Status shall monitor the youth's behavior, affect and speech for signs as to how the youth is feeling and document this on the Suicide Precaution Status Observation Form.
- iii. Direct care staff responsible for supervising a youth on Suicide Precaution Status shall document on the Suicide Precaution Status Observation Form continuously throughout the course of the day, carrying the form with them as the youth moves throughout the facility (e.g., to attend school, medical appointments or visits).
- iv. Direct care staff shall provide interventions consistent with any special instructions on the Special Management Plan.
- v. Direct care staff shall note any significant changes in youth's behavior, affect or speech, shall document these observations on the Suicide Precaution Observation Form, and shall immediately notify behavioral health staff of the change.
- vi. Direct care staff shall verbally inform his/her relief of the youth's progress and highlight for their relief any special instructions in the Special Management Plan.



- vii. Direct care staff shall document on the Suicide Precaution Observation Form any interventions they may have employed to maintain the youth's stability and to promote the youth's comfort and wellbeing.

3. Supervisory Youth Development Representative and the Team Leader/Unit Manager

In order to ensure the complete and accurate observation of youth on Suicide Precaution Status, the SYDR shall perform the following procedures during his or her tour of duty:

- i. Periodically visit each unit in which there is a youth on Suicide Precaution Status.
- ii. Note in the unit log when their visit was made.
- iii. Review the Suicide Precaution Status Observation Form to ensure that documentation is up-to-date and complete and reflects proper supervision.
- iv. If the form is not up-to-date or complete, the SYDR shall make his or her best efforts to obtain the missing information and include it in the form.
- v. Following their review, they shall sign and date the form verifying its completeness.
- vi. Notify the oncoming SYDR or the Team Leader/Unit Manager as to the status of all youth on Suicide Precaution Status.

In the event the SYDR is not on duty, the procedures listed above shall be performed by the Team Leader/ Unit Manager during his or her tour of duty.

4. Availability/Maintenance of Suicide Precaution Status Observation Forms

- i. Unused Suicide Precaution Status Observation Forms shall be readily available on the housing units.
- ii. While the youth is on Suicide Precaution Status, the Suicide Precaution Status Observation Form that is in use for the youth shall accompany the youth wherever s/he goes.
- iii. At the end of the shift, the Suicide Precaution Status Observation Form is picked up by the SYDR, who reviews and signs the form, and gives the form to the Supervisory JJIC who files it in the youth's social service file.




VII. REFERENCES

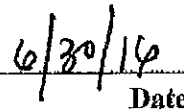
Jerry M. Order approving Final Proposed Amended Comprehensive Work Plan Final Approved Amended Comprehensive Work Plan, December 5, 2007, as revised by Revised Final Approved Amended Comprehensive Work Plan, January 26, 2010, and any amendments thereto.
NCCHC 2015 Juvenile Health Standards: Y-G-05 Suicide Prevention Program

VIII. ATTACHMENTS

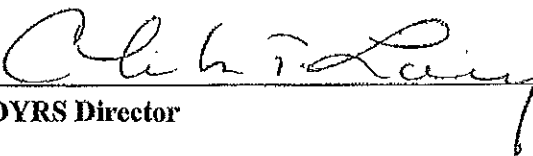
- A. Initial Medical Screening and Risk Assessment Form
- B. Suicide Precaution Status Notification Form
- C. Suicide Precaution Status Observation Form
- D. Special Management Plan
- E. Suicide Precaution Status Change Form
- F. Application for Emergency Hospitalization by a Physician or Psychologist of the Person, Officer or Agent of Human Services or an Officer to Make an Arrest (FD-12 826.APR)
- G. Post Suicide Precaution Status Monitoring Form

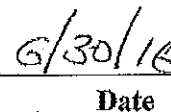
Approval of the Health Services Medical Officer:


Responsible Health Authority


Date

Approval of the Agency Director:


DYRS Director


Date

Attachment 2

DYRS' SUICIDE PREVENTION POLICY ADHERENCE REVIEW TOOL

This tool is used to assess compliance by DYRS staff in monitoring youth who are on either Level 1 or Level 2 of Suicide Precaution Status (SPS), although some indicators will apply only to SPS Level 1 youth. The indicators reflect the requirements for monitoring youth on SPS set out in DYRS Policy V.b.3., titled Suicide Prevention, issued on June 28, 2016. A separate form will be used for each episode of SPS; it is considered the same episode if the individual was placed on SPS-1 then stepped down to SPS-2 without being removed from SPS altogether.

DATA FIELDS		RESPONSE	IDENTIFYING DATA					
Reviewer			Enter your name					
Review date			Enter today's date					
Date and time SPS began			Enter the date and time the SPS began					
Level of SPS			Indicate SPS-1 or SPS-2					
Date of SPS-1			Indicate the date the individual was placed on SPS-1. If the SPS episode began with SPS-2 and the individual was not stepped up to SPS-1 as part of the episode, mark N/A.					
Date of SPS-2			If the individual went from SPS-1 to off SPS, indicate N/A					
Individual's name and ID #			Enter the name and ID number for the youth who was placed on SPS					
Admission date			Enter the individual's admission date					
Facility			Identify Youth Service Center (YSC) or New Beginnings (NB)					
Policy #	#	Policy Requirements	INSTRUCTIONS			Y	N	N/A
VI.B.3. i.a.(c)	1	Direct care staff providing one on one supervision shall document their observations at staggered intervals, no less than 5 times an hour using the Suicide Precaution Status Observation Form. (SPS-1 only)	Score as Yes, if the record includes: <ul style="list-style-type: none"> a. Suicide Precaution Status Observation Forms that are completed in their entirety for the complete period of the episode of SPS status. b. Each entry is signed by the direct care staff doing the monitoring and each sheet is to be signed by the direct care staff doing supervision. c. The form reflects documentation of constant direct observation by staff at staggered intervals of at least 5 per hour. (SPS-1 only). If the youth is on SPS-2 only, this is N/A. You may annotate on this form any discrepancies or issues with the Observation forms if noted.			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	 <input type="checkbox"/>
NOTES:								

VI.B.3. i.b.(a)	2	Direct care staff assigned to monitor youth on SPS-2 observe the youth at staggered intervals not to exceed every 10 minutes (SPS-2 only).	<p>Score as Yes, if the record includes:</p> <p>a. The form reflects documentation of monitoring by staff at staggered intervals not to exceed every ten minutes. (SPS-2 only)</p> <p>If the youth is on SPS-1 only, this is not applicable. If the youth is stepped down from SPS-1 to SPS-2, this would apply for those periods the youth is on SPS-2.</p> <p>NOTES:</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI.B.3. 1.a.(d)	3	Direct care staff providing 1:1 supervision shall notify behavioral health staff (or medical staff if BH staff is not on site) immediately if youth evidences increasing signs of changes in mood, behavior or thought.	<p>Score as Yes if the record evidences increasing signs of changes in mood, behavior, or thought AND the staff immediately notified BH staff, or in their absence, medical staff.</p> <p>Score No if there was evidence of increasing mood etc., but the staff failed to notify BH staff or medical staff in their absence, or if the notification was not immediate.</p> <p>Score NA if there was no evidence in of increasing signs of changes in mood, behavior or thought.</p> <p>NOTES:</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI.B.3. i.a.(g) and b. (e) and VI.B.5.	4	BH staff shall assess the youth at least once per day. Each assessment shall be documented in the medical record and shall include consideration of whether the youth requires more acute care.	<p>Score as Yes if</p> <p>a. BH staff assessed the youth at least once per day and documented the assessment in the record.</p> <p>b. The assessment includes evidence that the BH staff considered whether the youth required more acute care.</p> <p>c. The daily assessment reflects current behavior.</p> <p>d. The daily assessment reflects any changes in thoughts or behaviors in last 24 hours.</p> <p>e. The daily assessment provides a sufficient description to justify current level of observation.</p> <p>Score No if there is no assessment found in the record for every calendar day the youth is on SPS or if the assessment fails to include evidence the BH staff considered whether the youth required more acute care.</p> <p>NA is not an option as this requirement also applies to youth on either SPS-1 or SPS-2 status.</p> <p>NOTES:</p>	<input type="checkbox"/>	<input type="checkbox"/>	
VI.B.3. i.a.(i) and	5	BH Staff completed a Suicide Precaution Notification Form.	Score as Yes, if the record reflects the completion of Suicide Precaution Notification form at the time the youth was initially	<input type="checkbox"/>	<input type="checkbox"/>	

VI.B.5. ii.c.	7	Youth who had been on SPS-1 must be on SPS-2 for a minimum of 24 hours before being removed from SPS altogether.	<p>Score as Yes if the youth was on SPS-2 for at least 24 hours after being on SPS-1 before being removed for SPS altogether. Score NO if youth was <i>not</i> kept on SPS-2 for a minimum of 24 hours following SPS-1.</p> <p>Score NA if youth had only been on SPS-2 and was not on SPS-1.</p> <p>NOTES:</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI.B.5. d.	8	A Suicide Prevention Status Change Form will be utilized whenever a youth's SPS level is changed	<p>Score Yes if the record includes a Suicide Precaution Change Form each time a change was made to SPS level during a single episode. Score No if during an episode there is a change in SPS that was not reflected by a SPS Change Form.</p> <p>NOTES:</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI.B.5. ii.e.	9	Upon changing the SPS level (either SPS-1 or SPS-2) BH staff shall communicate the change in a face-to-face encounter with unit direct care staff and the staff doing observations, and document same in progress note.	<p>Score as Yes if the BH staff documented</p> <ul style="list-style-type: none"> a. A change in the SPS level; b. That the change was communicated to direct care staff through a face-to-face encounter and the encounter shall be documented in a progress note. <p>Score No if there was no documentation, no face-to-face encounter or if the note fails to specify the type of contact. NA may be used if there is no evidence that the SPS level was changed during the review period.</p> <p>NOTES:</p>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

