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SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	Case No.: RGO3079344 FOURTEENTH REPORT OF SPECIAL MASTER

Pursuant to paragraph 28 of the November 2004 Consent Decree, the special master submits for filing the attached report. The special master's report and its appendices were circulated to the parties in draft form. This final version reflects consideration of the parties' comments.

Dated: February 12, 2010

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Donna Brorby
Special Master

SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	)	CASE NO. RG03079344

FOURTEENTH REPORT OF SPECIAL MASTER

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APPENDICES

I. INTRODUCTION

This report reviews the 2009 report of the *Farrell* mental health experts and summarizes the status of compliance with key components of the Mental Health Remedial Plan. The office of the special master (OSM) and the experts submit these final reports after consideration of the parties' comments. The OSM filed its own monitoring report on mental health remedial plan requirements as Appendix H to the Eleventh Report of the Special Master in November 2009.

II. MENTAL HEALTH SERVICES

The mental health experts provided the special master with their prior formal report two years ago, in December 2007.[1] From December 2007 through August 2009, the experts conducted the following site visits: Preston, July 18-19, 2008; Close, October 16, 2008; Chaderjian, October 17, 2008; Ventura, December 1-2, 2008; DJJ Central Office, January 8-9, 2009; SYCRCC, April 16-17, 2009 (Dr. Lee only), and Stark, October 2-3, 2008 and May 7-8, 2009. They submitted their comprehensive report to the parties for comment and review in August 2009. DJJ did not provide comments on the report until November 17, 2009. The experts delivered their final report to the special master on January 10, 2010, and it is attached as Appendix A.[2] The experts also provided informal site visit reports to the OSM and the parties.

A. Organizational Structure and Integration of Staff to Provide Treatment

For DJJ to evolve from adult-type prisons to juvenile treatment facilities, as required by the safety and welfare and mental health plans, the staff responsible for the

[1] *See* Sixth Report of the Special Master (January 2008), Appendix A (Lee and Trupin Report) [hereinafter Lee and Trupin, 2007 Formal Report]).
[2] *See* Appendix A, Terry Lee and Eric Trupin, Farrell Mental Health Experts' 2008-2009 Site Visit Summary, January 9, 2010 [hereinafter Lee and Trupin, 2009 Formal Report].

care and treatment of youth must collaborate across professional and disciplinary lines to share and achieve treatment goals. This will require obliterating the "silos" dividing "custody" or "facility" staff and clinical staff.[3]

The need for better collaboration among clinical and facility staff is evidenced in many ways. Across the state, core SBTP therapy groups are comprised according to youth correctional counselor caseload, rather than according to clinical judgments about group composition.[4] In a similar vein, according to DJJ's compliance unit, clinical staff at Chaderjian believe that clinical needs are discounted by facility staff responsible for scheduling and staff assignments.[5] At Ventura, facility staff were administratively overriding clinical decisions about appropriate residential placement for particular youth.[6] It also appears that DJJ stopped using a local private hospital for mental health treatment

[3] "Silos" exist when some staff work in isolation according to a rigid division of roles and institutional purposes, with insufficient regard to the relationship of their work to the work of others and the achievement of what should be the shared goal of delivering appropriate services to youth. Silos impede collaborative exchanges that depend upon respect and deference to others' expertise where appropriate. They have affected all areas of DJJ's operations. For example, the disabilities expert has been concerned that the wards with disabilities program (WDP) has been relegated to the province of WDP staff, and that many facility and clinical staff members are not aware of their responsibilities under the disabilities remedial plan. *See* Tenth Report of the Special Master (September 2009), p 26; Fifth Report of the Special Master (October 2007), pp. 32-33. The medical experts found divisions among staff in 2006-2007, though they made no reference to divisions in their 2007-2008 monitoring round. *See* Fifth Report of the Special Master (October 2007), p.24, n. 93; Tenth Report of the Special Master (September 2009), Appendix G (LaMarre and Goldenson Report). They and the mental health and sexual behavior treatment experts have raised the issue in relation to conflicts between clinical and non-clinical staff and DJJ's protocol for the resolution of such disputes. *See, e.g.*, Lee and Trupin, 2007 Formal Report, p. 1 (need for interdepartmental, interdisciplinary collaboration focused on clinical autonomy and resolution of disputes between clinical and nonclinical staff); Lee and Trupin, 2009 Formal Report, pp. 5, 9; e-mail of special master to Doug McKeever, et al., September 8, 2009 (summarizing several experts' consensus regarding resolution of disputes between clinical and non-clinical staff); e-mail of special master to Doug McKeever, et al., December 9, 2009 (same). This is discussed in more detail below.

[4] Observations of monitor Aubra Fletcher during SBTP audit case note reviews, January 2009 to May 2009; statements of staff to OSM during site visit, October 2008. The SBTP expert has informed DJJ that YCC caseload assignments should not determine the composition of clinical groups. *See* e-mail of Barbara Schwartz to Erin Peel, et al., June 12, 2009 (attaching comments on draft revised remedial plan).

[5] DJJ, Fact Finding on *Farrell* SBTP Audit at N.A. Chaderjian Youth Correctional Facility, undated (provided as PoP #525, October 5, 2009), pp. 3-4.

[6] *See, e.g.*, statements of staff during Ventura site visit, December 1-2, 2009. In July 2008, Ventura staff reported that most youth who completed the drug treatment program could not be moved from the residential treatment unit, because the housing unit needed to maintain a certain population level. Terry Lee and Eric Trupin, Informal Report: Ventura, January 7, 2009, p. 13.

for young women, without consideration of clinical needs, because the hospital would not permit DJJ officers to enter the hospital with certain security equipment.[7] Facility staff regularly give youth on the mental health caseload time adds as punishment for disciplinary violations[8] which are reversed on review by the chief psychiatrist.[9] There also have been troubling allegations of personal conflict across the clinical-custody divide among individuals; these will not be elaborated upon or cited in this public report.

DJJ's protocol for resolving disputes between clinical and non-clinical staff[10] reflects the difficulty that that DJJ has approaching the divide between the disciplines. In January 2008, the mental health experts reported that there was "not a functioning protocol for resolution of perceived conflicts between clinical and other staff over professional and clinical matters."[11] By March 2008, DJJ distributed a proposed protocol, and the mental health, medical, and SBTP experts provided DJJ with their critique.[12] DJJ adopted the protocol without making any of the experts' recommended changes, [13] and the experts reiterated their critique a few times without response.[14] In the

[7] This issue is discussed in greater detail below.
[8] DJJ reports that youth on the mental health caseload received 48% of time adds given from November 2008 – July 2009. Memorandum of Randy Aguirre to Sandra Youngen, et al., September 3, 2009 (PoP #500, September 14, 2009). At the time, according to CompStat data, approximately 14% of DJJ's population was designated as "MH youth," though there was no uniform definition of "MH youth" at that time. Lee and Trupin, 2009 Formal Report [August 19, 2009 draft], p. 6; Lee and Trupin, 2009 Formal Report [December 16, 2009 draft], p. 7; e-mail of OSM to mental health experts, September 11, 2009; e-mail of Terry Lee to special master, September 11, 2009.
[9] *See* Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 4. Mr. Irby's representations are consistent with information that the special master has received directly from DJJ's Chief Psychiatrist Dr. Morales. This reflects the positive effect of the new disciplinary policy's implementation and also illustrates the divide between custody and mental health staff with respect to the utility and appropriateness of time adds.
[10] *See* Mental Health Remedial Plan Standards and Criteria, item 3.3 (requiring protocol).
[11] *See* Lee and Trupin, 2007 Formal Report, Attachment 1, p. 1.
[12] *See* e-mail of special master to Katie Riley, et al., March 26, 2008 (summarizing experts' consensus critique).
[13] *See* memorandum of Sandra Youngen and Robert Morris to superintendents, et al., December 14, 2007 (PoP #130, May 21, 2008).
[14] *See* e-mail of special master to Robert Morris, et al., November 7, 2008 (summarizing experts' concerns); e-mail of special master to Doug McKeever, et al., September 8, 2009 (same); e-mail of special master to

experts' view, the protocol does not adequately specify the kinds of disputes that may arise or the basis for facility staff to dispute a clinical decision. The experts consider the protocol almost counter-productive, as it indicates that facility staff may evaluate the judgments and directions of clinical staff. The protocol fails to clarify that facility staff should follow the direction of clinical and other professional treatment staff about the content and manner of treatment. Further, the protocol does not specify whose judgment governs pending resolution of the dispute and does not set an expectation that staff will collaborate and cooperate to ensure maximum treatment and constructive activity in a safe environment. Almost two years after the first iteration of the protocol, in response to a draft version of this report, DJJ informed the special master that the protocol is "in the process of being updated."[15]

The mental health and sexual behavior treatment experts explain that DJJ needs an organizational and supervisory structure that provides administrative and clinical supervision of treatment for all staff who are part of the treatment team, including custody staff.[16] Organization charts for central office and all facilities do not depict a clinical supervision relationship between mental health and administrative/custody personnel.[17] CDCR's own internal auditors attribute this to a "[l]ack of collaboration/communication between administrative staff, Health Care Services staff,

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Doug McKeever, et al., December 9, 2009 (same). Unless otherwise indicated, the remainder of this paragraph and the following paragraph are based on these sources.

[15] E-mail of Van Kamberian to special master, November 17, 2009 (attaching comments).

[16] *See* Lee and Trupin, 2009 Formal Report, pp. 5, 9. As the sexual behavior treatment expert has described, there is no supervisor responsible for the treatment program, whether at the system or the living unit level; neither the SBTP coordinator nor any living unit manager have the authority to direct both clinical and non-clinical SBTP staff. Twelfth Report of the Special Master (December 2009), p. 6; Eighth Report of the Special Master (February 2009), p. 17.

[17] CDCR Office of Audits and Compliance, Compliance Review, March 2009, pp. 5, 8, 14, 17, 20, 23.

MH staff, and the Court appointed [sic] experts" and between central office and facilities.[18]

The development and strategic implementation of the IBTM must address the supervision of and working relationships among DJJ personnel.[19] As a part of its implementation, DJJ must redesign policies governing interactions among staff and between staff and youth, use of force, and youth behavior management.[20] In the meantime, DJJ should identify and take reasonable steps to improve interdisciplinary and inter-departmental cooperation and collaboration directed at treatment goals.

B. Policy and Training for Management and Treatment of Potentially Self-Harming Youth

The transformation of DJJ's suicide and self-harm prevention practices has been at issue since the entry of the consent decree. DJJ is required to implement an administrative policy for the treatment and management of intentionally self-harming youth.[21] DJJ is also required to train its clinicians to treat potentially self-harming youth.[22] Last year, the mental health experts again urged DJJ to prioritize the implementation of the administrative policy and the provision of appropriate clinician training.[23] DJJ's compliance with each requirement is discussed in turn below.

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[18] *See id.*

[19] *See id.*; Mental Health Remedial Plan, pp. 6-8; Henry Schmidt and Angela Wolf, The Integrated Behavior Treatment Model Report, November 29, 2009, pp. 47-48.

[20] *See, e.g.*, Lee and Trupin, 2009 Formal Report, pp. 7-8.

[21] Consent Decree, ¶ 7.c. Specifically, the Consent Decree required defendant to "develop policies and procedures to immediately provide for the treatment and management of wards on suicide watch and those with acute psychiatric needs." *See id.* For purposes of this report, the phrase "self harm" encompasses suicide attempts, suicidal gestures, and non-suicidal self-injurious behaviors.

[22] *See* Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan; Order, December 13, 2005, ¶ 13. The special master has referred to this stipulation and order as the November 30, 2005 stipulation in past reports, resulting from a November 30, 2005 deadline that was extended by the stipulation and the effort to file the stipulation on November 30, 2005. The pleading on file was filed by the parties on December 1, and was entered as an order on December 13, 2005.

[23] *See* Ninth Report of the Special Master (June 2009), Appendix C (Experts' Priorities for Fiscal Year 2008-2009), p. 2 ("Improve management and treatment of self-harming youth: (a) Train staff on

1. Suicide Prevention, Assessment, and Response (SPAR) Policy

The Consent Decree requires DJJ to develop and implement administrative measures for managing and treating potentially self-harming youth. These measures must be in the form of "criteria that institutions must meet for these wards, including number of hours of clinical intervention per week and maximum number of in-room hours per day."[24] Since the special master last reported on this issue, DJJ directed facilities to implement a new SPAR policy aimed at minimizing isolation of potentially self-harming youth and allowing them to engage in supervised ordinary activities when appropriate.[25]

DJJ modified the SPAR policy in consultation with the mental health experts, and the experts first approved the policy as an interim measure in late 2004.[26] Under the policies and procedures, clinicians were to order one-on-one supervision where appropriate to enable youth participation in normal activities instead of isolating youth beyond the time necessary for clinical assessment and resolution of acute suicidality.[27] In April 2005, DJJ filed its Mental Health and Rehabilitation Interim Plan, which extended

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empirically-based treatment(s) on an expedited basis. (b) Implement the SPAR [Suicide Prevention and Response] policy system-wide (and continue evaluation and improvement of the policy as necessary)."); Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), pp. 2-3 ("[I]mprove management and treatment of self-harming youth. Over this next year, train all staff and implement [dialectical behavior therapy] on two mental health units for pilot. Train additional MH clinicians in preparation for system-wide dissemination. Evaluate Suicide Prevention, Assessment, and Response policy; modify and streamline policy and procedures as indicated.").

[24] Consent Decree, ¶ 7.c.

[25] The experts approved this policy as "an improvement over its predecessor" but recommend simplifying it the next time it is revised. *See* Lee and Trupin, 2009 Formal Report, p. 4. By 2007, they described an earlier version of the SPAR policy as "a great step forward" and "progressive in important respects." *See* Lee and Trupin, 2007 Formal Report, Attachment 1, #24.

[26] First Report of the Special Master (April 2006), p. 32.

[27] *Id.*, p. 33. For a detailed summary of the SPAR policy, see the Third Report of the Special Master (December 2006), pp. 8-9. Youth confined to rooms on suicide watch or suicide precaution were housed in "camera rooms," and posted staff were responsible to keep watch of the surveillance screens.

the December 2004 deadline for implementation of the SPAR policy to July 1, 2005.[28] DJJ issued Temporary Departmental Orders in early November 2005[29] and trained mental health staff in November and December 2005.[30] Yet, as of December 2005, none of the staff interviewed by the special master knew of any instance involving application of the one-on-one provision.[31] DJJ continued to confine self-harming youth and to isolate them in punitive conditions.[32]

The situation changed little over the next year. The November 2005 temporary policy remained in effect.[33] As of September 2006:

> Almost all youth on suicide or crisis watch status for more than a day receive a maximum of two to three hours out of room time for showers and unstructured day room time (often alone in the dayroom). Some have an hour or less out of their rooms in shower/holding areas. For the rest of the day and night, the youth generally are alone in observation/watch rooms, limited to suicide resistant clothing and bedding a perhaps a book . . . . Some administrative and clinical staff seemed unaware that current policy requires that youth on observation/watch status spend as much time out of their rooms as clinicians determine is clinically appropriate . . . . Others were aware of the requirements of policy but felt that their facility did not have did not have enough staff to provide one-on-one supervision for youth for whom more normal activity would have been appropriate.[34]

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[28] *See* Mental Health and Rehabilitation Interim Plan, April 8, 2005, ¶ 16.
[29] *See* First Report of the Special Master (April 2006), pp. 32-33, Appendix Z (DJJ Suicide Watch Policy). This was a time when DJJ was not promulgating new policies expeditiously. *See* Fourth Report of the Special Master (July 2007), p. 16.
[30] First Report of the Special Master (April 2006), p. 33.
[31] *Id.*
[32] *Id*.
[33] The November 2005 order was retained in effect upon its expiration by new temporary departmental orders issued in April 2006. *See* Third Report of the Special Master (December 2006), Appendices B (Temporary Departmental Order #06-38), C (Temporary Departmental Order #06-39). The April 2006 temporary departmental orders are identical to the November 2005 TDOs but for the new expiration date, extending them to April 2007.
[34] Third Report of the Special Master (December 2006), pp. 10-11.

Thus, nine months after training staff on the interim policy DJJ had not succeeded in implementing it.[35]

The mental health experts recommended that DJJ improve the interim SPAR policy and procedures that it had not implemented.[36] DJJ completed a policy revision fifteen months later, in December 2007.[37] The mental health experts supported the revised policy because it (1) hastened clinical evaluation and treatment of youth deemed to be at risk of self-harm, (2) increased mental health management oversight of the management and treatment of those youth, and (3) replaced camera surveillance with direct one-on-one supervision and limited the use of isolation and restrictions even more than prior policies had.[38] In 2008, DJJ piloted the policy at N.A. Chaderjian and further revised it.[39] At DJJ's request, the Court extended the official deadline for implementation to February 23, 2009.[40] DJJ reports that it implemented the policy on March 19, 2009.[41]

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[35] Fourth Report of the Special Master (July 2007), p. 16.
[36] *Id.*
[37] *See* Lee and Trupin, 2007 Formal Report, Attachment 1, #24.
[38] *Id.*; *see also* DJJ, Policy Revision Packet – 42, Revision # 81, Institutions and Camps Manual, Section 6263-6272, December 19, 2007 [hereinafter DJJ, December 2007 SPAR policy]. The December 2007 policy required facility staff to bring youth deemed at risk of self-harm to the facility medical clinic for prompt evaluation by health care professional staff and mental health clinicians. DJJ, December 2007 SPAR policy, p. 17. The time frames for the mental health clinicians to see the youth differed depending whether mental health clinicians were on-site. *See id.* The SPAR policies in effect before December 2007 required only that a mental health clinician see a potentially self-harming youth within 24 hours of placement on a suicide risk reduction status. Third Report of the Special Master (December 2006), p. 8 and Appendix B (Temporary Departmental Order #06-38).
[39] *See* Appendix C, DJJ, Suicide Prevention, Assessment, and Response [policy], Institutions and Camps Manual, Section 6263, January 9, 2009; DJJ Project Charter: Suicide Prevention, Assessment, and Response, November 13, 2008.
[40] *See* Order, February 20, 2009, p. 2; *see also*, DJJ Project Charter: Suicide Prevention, Assessment, and Response, November 13, 2008 (scheduling statewide SPAR implementation for February 2009).
[41] *See, e.g.*, e-mail of Robert Rollins to DJJ facility staff, et al., March 19, 2009 (officially disseminating the SPAR policy to all institutions). The experts and OSM reviewed draft SPAR training materials in January 2009 and submitted joint comments to DJJ. The experts and OSM recommended that the materials be revised to 1) advise staff as to how to manage or reduce self harming behaviors in youth and 2) explain more clearly when the different "suicide risk reduction" statuses are appropriate. *See* e-mail of Zack

DJJ reports that it has improved the treatment and management of youth at risk for self-harm as its administrative SPAR policy has evolved.[42] The new policy does require prompter clinical attention for potentially self-harming youth and more oversight by DJJ's mental health leadership.[43] The experts have not yet assessed the effects of the policy's implementation, however.[44] OSM has asked the experts to evaluate the new policy's implementation in their current audit round.[45]

2. Empirically-Based Treatment for Self-Injurious Behavior

DJJ's SPAR policy is a set of administrative procedures intended to prevent suicides in an institutional setting, but it does not address the specific clinical treatment to be provided to self-harming youth.[46] Since 2005, the mental health experts have repeatedly urged DJJ to provide training to clinical staff in the effective treatment and clinical management of self-injuring and suicidal youth.[47]

The parties stipulated in November 2005 that Dr. Trupin would develop a plan to enhance DJJ clinicians' ability to treat self-destructive youth, in consultation with DJJ

Schwartz to Doug Ugarkovich, January 6, 2009. As of this writing, OSM has received no substantive response to this feedback.

[42] *See* Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 2.

[43] *See supra* n.40.

[44] Because DJJ directed the facilities to implement the policy near the end of the mental health audit round, the experts had the opportunity to observe its implementation only at Stark and SYCRCC. They did not do so in any systematic way. *See* Terry Lee and Eric Trupin, Informal Report: Stark, undated (provided January 7, 2009), p. 10 (reporting on policy training and content only); Terry Lee and Eric Trupin, Informal Report: SYCRCC, undated (provided September 25, 2009), p. 12 (describing the experience of one youth); Lee and Trupin, 2009 Formal Report, p. 4 (limiting findings on SPAR implementation to reporting what has been reported to the experts by DJJ).

[45] *See* Consent Decree, ¶37 ("The Special Master may direct any expert to tour any CYA facility or facilities to evaluate implementation and compliance with the remedial plan."); memorandum of Aubra Fletcher and special master to mental health experts, November 6, 2009 (fact-gathering memorandum for experts' upcoming Preston audit); e-mail of special master to mental health experts, October 22, 2009.

[46] *See* Sixth Report of the Special Master (January 2008), p. 2 n.1.

[47] *See, e.g.*, *id.*; statements of Eric Trupin to DJJ director of programs during Chaderjian site visit, October 17, 2008; e-mail of Eric Trupin to Michael Brady, et al., January 6, 2009.

and taking account of DJJ's legal constraints.[48] The stipulation required DJJ to implement Dr. Trupin's plan absent compelling reasons not to do so.[49] In March 2006, Dr. Trupin introduced DJJ to Dr. Henry Schmidt, who proposed a contract to provide training and supervision to DJJ clinicians.[50] DJJ objected that the plan did not take account of a legislative restriction prohibiting it from funding new training until the completion of a training needs assessment; DJJ was also reluctant to enter into such a contract without first establishing an integrated plan for clinician training pursuant to the mental health remedial plan then being drafted.[51] At the time, the special master found DJJ's position to be reasonable.[52] DJJ did not refuse to implement Dr. Trupin's plan or negotiate alternatives with Dr. Trupin; instead, DJJ committed to providing similar training in the future.[53]

In October 2006, DJJ filed the Mental Health Remedial Plan, which mandates staff training in an evidence-based intervention targeting suicidal behavior.[54] The plan requires DJJ to train selected individuals in the treatment and clinical management of self-injurious and suicidal behaviors in "the first phase" of training on the IBTM and certain specialized treatment interventions.[55] If DJJ had met the timetable of the remedial plan, it would have had an IBTM description, manual and training materials by

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[48] *See* Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan, November 2005; Order, ¶ 13, filed December 13, 2005.
[49] *See* Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan, November 2005; Order, ¶ 13, filed December 13, 2005.
[50] Second Report of the Special Master (August 2006), p. 11; e-mail of Eric Trupin to Paul Woodward, et al., March 12, 2006 (explaining that Dr. Schmidt would make a proposal to DJJ at a March 20, 2006 meeting, pursuant to the December 2005 stipulation and order).
[51] Second Report of the Special Master (August 2006), p. 12. Drs. Trupin and Schmidt then proposed that DJJ contract with Dr. Schmidt to lead a DJJ work-group that would write a description of DJJ's IBTM. *See* e-mail of Henry Schmidt to Eric Trupin, Elizabeth Siggins, and Amy Seidlitz, May 12, 2006. This did not occur.
[52] *Id*.
[53] *See*, *e.g.*, e-mail of special master to Michael Brady, et al., December 17, 2008.
[54] *See* Mental Health Remedial Plan, pp. 47-48, 63.
[55] *Id.*, pp. 47-48.

November 15, 2008.[56] Further, it would have trained or hired IBTM trainers by April 2009 and it would have trained direct care staff in the IBTM by August 15, 2009.[57] DJJ was far behind remedial plan timetables by 2008, and the training in the treatment and clinical management of self-harming and suicidal youth remains overdue.

In early 2008, a central office manager stated that DJJ hoped to contract with Dr. Schmidt for the provision of clinician training.[58] Later, DJJ introduced a training directed at non-clinical staff in "understanding and preventing suicide" instead.[59] This training may have been educational for non-clinical staff, but it did not help develop appropriate treatment and clinical management of self-injuring and suicidal youth.[60] At the end of 2008, the mental health experts raised the clinician training issue as an urgent matter with then-new Chief of Compliance Michael Brady. The experts and the special master informed Mr. Brady that DJJ was required to train clinicians in dialectical behavior therapy (DBT) training as Dr. Trupin originally recommended, or else propose an alternative evidence-based approach.[61] Mr. Brady promptly brought this demand to the directors and Chief Deputy Secretary.[62] The experts met with DJJ's clinical and administrative managers on January 13, 2009 and were told that DJJ would proceed with DBT training.[63] As of mid-March 2009, DJJ's mental health leadership could not obtain

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[56] *See* Safety and Welfare Remedial Plan Standards and Criteria, items 4.3 and 5.3.a.
[57] *See* Safety and Welfare Remedial Plan Standards and Criteria, item 5.4a; Mental Health Remedial Plan Standards and Criteria, item 5.1.
[58] *See* statements of Amy Seidlitz to the special master, January 2008.
[59] *See* "Farrell Related Training Data – Training Attendance Report – Understanding and Preventing Suicide," June 20, 2008 (PoP #171, July 1, 2008).
[60] Statements of mental health experts during central office site visit, January 8-9, 2009.
[61] *See* e-mail of special master to Michael Brady, et al., December 17, 2008. DBT is a core of Washington JRA's integrated treatment model and is similar to the training that Dr. Schmidt would have provided in 2006 had DJJ contracted with him then. *See* e-mail of Eric Trupin to Paul Woodward, et al., March 12, 2006 (forwarding chapter by Schmidt on treatment and management of self-harming youth).
[62] *See* e-mail of Michael Brady to special master, et al., December 17, 2008.
[63] *See, e.g.*, e-mail of Juan Carlos Arguello to Drs. Trupin and Lee, et al., January 13, 2009. The mental health experts and DJJ's mental health leadership long have agreed that DBT is an appropriate evidence-

administrative approval to go forward.[64] The mental health experts were severely critical of the continuing delays.[65] In June 2009, DJJ contracted Dr. Schmidt to train select DJJ clinicians in DBT and provide a program development plan to pilot DBT in a mental health unit.[66] DJJ plans to pilot the DBT training at Ventura's female intensive treatment program unit and at Chaderjian's intensive behavior treatment program in March 2010.[67]

DJJ's failure, until recently, to take effective steps to train staff in the effective treatment of intentionally self-harming youth is an example of DJJ's failure to prioritize and to take decisive, effective action in important areas. When experts believe that there is at least one treatment intervention that reduces serious self-harming behavior, and when a significant minority of DJJ youth engage in self-injurious and suicidal acts,[68] training select staff in the intervention should become one of DJJ's highest priorities.

DJJ acknowledges that DBT "once implemented, will provide trained clinical and non-clinical staff additional alternatives to use of force to de-escalate youth engaged in

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based clinical intervention for most of the intentionally self-harming behavior in DJJ. *See, e.g.*, statements of Drs. Trupin and Lee during central office site visit, January 8, 2009; statements of Dr. Ed Morales during central office site visit, January 8, 2009.

[64] *See* statements of Ed Morales to Aubra Fletcher and Dr. Barbara Schwartz, January 30, 2009; statements of Juan Carlos Arguello to Aubra Fletcher, February 18, 2009; e-mail of Juan Carlos Arguello to the special master, March 18, 2009. In January, DJJ's administrative leadership instructed Dr. Arguello to prepare a "charter" for the project which would have to be approved. It did not approve his first attempt.

[65] *See* e-mail of Eric Trupin to Bernard Warner, March 19, 2009.

[66] Statements of Michael Brady during Court Compliance Task Force meetings, May 14, 2009 and June 4, 2009; *see also* Standard Agreement between CDCR and contractor Henry Schmidt II, Ph.D., June 12, 2009 (PoP #472, August 3, 2009). The contract was signed on June 12, 2009 and will expire September 30, 2010.

[67] Statements of Juan Carlos Arguello during Court Compliance Task Force meeting, September 10, 2009; memo of Van Kamberian to special master, November 17, 2009 (attaching comments on draft version of this report).

[68] *See* OSM Master Log of Sentinel Event Serious Incident Reports for incidents through November 2009. For the period August 2008 – November 2009, DJJ provided the OSM with "serious incident reports" documenting 29 "suicide attempts" at Stark, 25 at Chaderjian, 15 at Ventura, and one at Preston. As discussed below, DJJ is not yet able to provide data on the number of incidents of self-injurious behavior, and DJJ's serious incident reports do not appear to capture most of them.

self-injurious behavior."[69] The use of force against self-harming youth accounts at least in part for the priority that the mental health experts have placed on this training.[70] In October 2008, a youth at Chaderjian told OSM that "when [staff] see" a youth attempting or engaging in self harm, "they spray you."[71] He cited an instance in which he had been maced by staff in the recent past.[72] OSM later obtained documentation regarding the use of force against "mental health youth" at Chaderjian between August 1, 2008 and October 17, 2008 and compiled it for the experts.[73] Of 45 recorded incidents of potentially self-injurious behavior, 14 resulted in the use of force against the youth, and six of these instances involved the use of chemical force.[74] In at least four of these six instances,[75] staff utilized the Z505 Cap Stun Crowd Control, which the manufacturer recommends for "crowd control, prisons, correctional facilities, rescue operations and saturation of an indoor barricaded area where innocent individuals might be exposed to injury or death if traditional ordinance is used."[76] One written justification for the use of the Z505 reads: "Ward . . . maced for self-injurious behavior, attempting to bite

[69] *See* letter of Van Kamberian to the special master, November 17, 2009, p. 8 (providing comments on a draft version of this report).
[70] *See* Lee and Trupin, 2009 Formal Report, p. 7.
[71] *See* memorandum of Aubra Fletcher to Barry Krisberg, Eric Trupin, and Terry Lee, November 10, 2008, pp. 3-4.
[72] *See id.* Documentation confirmed that the interviewed youth was maced for self-harm behavior twice on August 4, 2008 and once on September 3, 2008. *Id.* This youth was taking psychotropic medications at the time of these and other instances of chemical force; the mental health experts have repeatedly recommended that DJJ cease the use of chemical force on youth taking psychotropics. The revised use of force policy prohibits some uses of chemical agents on youth taking psychotropics, but allows staff to use chemical agents when any youth poses an imminent threat to self, others, or the security of the facility. *See* DJJ, Crisis Prevention and Management Policy, February 6, 2009 (PoP #338, April 20, 2009).
[73] *See* e-mail of Aubra Fletcher to Eric Trupin, Terry Lee, and Barry Krisberg, November 10, 2008 and summary of incidents attached thereto. A redacted version of the summary is attached as Appendix D.
[74] *Id*.
[75] The type of chemical force used in one of the six instances was unspecified. *Id.*
[76] "Cap-Stun Weapon Systems: Z505 Crowd Control," available at http://www.zarc.com/english/cap-stun/PDFs/Z-505%20Crowd%20Control.pdf (last visited September 24, 2009). The particular youth interviewed by OSM monitors stated that staff spray the "big cans" of mace into youth cells.

himself."[77] The safety and welfare expert advises that the use of the Z505 under these circumstances "is completely inappropriate and should be stopped immediately."[78]

DJJ documented 65 incidents of "suicide attempts" for purposes of serious incident reporting, from August 2008 through November 2009.[79] According to the serious incident reports provided, there were no incidents at O.H. Close and SYCRCC, one at Preston, 15 at Ventura, 24 at Stark and 25 at Chaderjian.[80] Of those incidents, only two resulted in uses of force. These incidents represent only some of the incidents of self-injurious behavior in DJJ; the Chaderjian incident reports document three incidents of self-harm in August through October 2008, compared to the many more incidents documented for that period in other records as discussed above.

DJJ directed facilities to implement a new use of force policy in mid-April 2009.[81] Multiple specific incidents of use of force on mentally ill youth have come to the attention of the experts, plaintiff's counsel, and OSM since that time.[82] Plaintiff's counsel has asked the mental health, safety and welfare, and disabilities experts to review the use of force against DJJ's youth with mental illness and disabilities.[83] OSM has

[77] *See* e-mail of Aubra Fletcher to Eric Trupin, Terry Lee, and Barry Krisberg, November 10, 2008 (attaching OSM's use of force data compilation). OSM brought the chemical force problem to the attention of DJJ's director of facilities following the completion of Chaderjian's SPAR pilots. *See* e-mail of Zack Schwartz to Sandra Youngen, December 16, 2008.
[78] *See* e-mail of Barry Krisberg to the special master, September 27, 2009.
[79] At OSM's request, DJJ provides all serious incident reports documenting certain "sentinel events," i.e., deaths, self-harm behavior, and group fights/disturbances. These reports are the source for the remainder of this paragraph and the next note.
[80] Of the 65 incidents, 34 resulted in the youth being taken to a licensed medical facility, the Stark CTC or a hospital. Of the 34 medical care cases, 20 were evaluated only and not retained for treatment in a licensed care facility. Fourteen were retained in the CTC or a hospital, with seven of those being Stark youth treated at the Stark CTC.
[81] Eleventh Report of the Special Master (November 2009), Appendix B (Fletcher Report), p. 4.
[82] *See, e.g.*, e-mail of Doug Ugarkovich to special master, et al., June 29, 2009; e-mail of Sara Norman to Eric Trupin, et al., August 4, 2009.
[83] *See* letter of Sara Norman to special master and mental health, safety and welfare, and disabilities experts, July 24, 2009.

assisted the experts in obtaining documentation and organizing their joint effort and will provide the results of their review once available.[84]

Inappropriate physical force is only one of the negative consequences of assigning staff without appropriate training to manage emotionally dysregulated, self-injurious youth. Out of concern for the amount of self-injurious behavior among youth on the residential mental health units at Stark, DJJ's chief psychiatrist interviewed many youth there in April 2009.[85] Of the 24 youth for whom interview notes were provided, seven shared positive or neutral comments about living unit staff.[86] The remaining 17 youth variously reported that staff play favorites, "push youths' buttons," curse at youth, threaten to plant shanks in their rooms, overuse chemical force, disclose embarrassing facts about youth, and speak disparagingly about youth and their families.[87] One had seen staff make comments to other youth such as "I saw you crying like a bitch when you were suicidal."[88] Another young man recounted an incident in which he "started getting agitated" after a bad phone call; staff handcuffed him, placed him on the floor and then pepper sprayed him in the face with a large "Crowd Control" canister.[89]

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[84] During a conference call of the OSM and experts, the experts committed to complete their reviews of incidents by the third week of January. Dr. Krisberg committed to draft a report based on the reviews. The disabilities expert provided a written review of 20 incident reports on January 8, 2010, and Dr. Krisberg provided his notes on January 20, 2010.

[85] Memorandum of Dr. Ed Morales to Eric Trupin, et al., May 18, 2009 (PoP #412, May 28, 2009), p. 1.

[86] "HGSYCF Clinical Report 4/22/09 – 4/24/09" (PoP #412, May 28, 2009).

[87] *Id.*

[88] *Id.*, p. 1.

[89] *Id.*, p. 3. Note also that one of the youth who spoke positively about staff in April was maced on March 12, 2009 and May 23, 2009, each time after breaking living unit windows. This youth is diagnosed as bipolar and has a recent history of both self harm and aggression toward others. *See* memorandum of Laura Poncin to Elverta Mock, June 4, 2009 (attached to e-mail of Doug Ugarkovich to Drs. Krisberg, Trupin, and Lee, et al., June 19, 2009). The March and May incidents are now under the scrutiny of the L.A. County Public Defender's Office. *See* memorandum of Sandra Youngen and Doug McKeever to Shelan Joseph, June 17, 2009 (attached to above-referenced e-mail). DJJ administrators have determined that staff actions "were reasonable and necessary given the specifics of each incident." *Id.* DJJ's chief of security has stated that "if physical force instead [of] chemical spray had been used, it would have placed [the youth] and staff at high risk for injury due to glass [s]hards on the floor in the immediate incident area." Memorandum of Jeff Plunkett to Sandra Youngen, June 12, 2009. Dr. Trupin notes that this administrative

The special master interviewed youth and staff at two of Stark's residential mental health units in April as well. Her observations and her interviews were consistent with those of the chief psychiatrist. Three apparently high-functioning youth told the special master that about half of the facility staff were good staff and tried to help youth and about half were not.[90] Some of the latter group, they said, would disregard youth needs or deliberately disturb youth, which they identified as the main cause of self-injurious behavior on the unit. From the time she spent on the housing units and interviews of clinical staff, the special master also observed that clinical staff and facility staff operated separately from each other for the most part. Clinical staff generally were not present on the residential units but rather saw patients in their offices, and facility staff did not seek their help or take direction from them.

C. Mental Health Data and Tracking System

DJJ lacks a single, reliable source of comprehensive data regarding self-harm incidents among DJJ youth.[91] The new SPAR policy requires staff to maintain an automated tracking log,[92] and DJJ is refining a standardized system to track self-harm incidents.[93] DJJ consulted the OSM and mental health experts on the data elements,[94]

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response defending the use of chemical agents does not reflect awareness of alternative approaches to address the youth's self harming and aggressive behavior. *See* e-mail of Eric Trupin to Doug Ugarkovich, et al., June 25, 2009.

[90] *See* statements of ITP and IBTP youth during Stark site visit, April 29-30, 2009. The following sentence is also based on this source.

[91] *See, e.g.*, memorandum of Dr. Ed Morales to Eric Trupin, et al., May 18, 2009 (PoP #412, May 28, 2009), p. 1.

[92] Appendix C, DJJ, Suicide Prevention, Assessment, and Response [policy], Institutions and Camps Manual, Section 6263, January 9, 2009, p. 24.

[93] Statements of Bob Eden and Ken Sandoval during central office site visit, June 22, 2009; statements of Juan Carlos Arguello during central office site visit, September 23, 2009; memorandum of Van Kamberian to the special master, November 17, 2009 (attaching comments on draft of this report); e-mail of Juan Carlos Arguello to Aubra Fletcher, et al., December 2, 2009; statements of Rick Flynn during DJJ Court Compliance Task Force meeting, February 4, 2010.

[94] E-mail correspondence between the special master and Dr. Juan Carlos Arguello, December 7 and 8, 2009 and January 8 and 19, 2010.

and the system should capture all self-injurious behavior and document other aspects of the management of the behavior.

The remedial plan also requires DJJ to develop a system to track data showing the need for and utilization of beds at each level of care.[95] DJJ began manually tracking this information in October 2007.[96] Staff maintain lists of mental health placements, uses of clinical restraints, psychotropic medication prescriptions, WIC-1800 extensions, and intake evaluations.[97] In addition, staff produce tables indicating the number of DJJ youth in licensed beds each day.[98] DJJ has also developed a system to track and prioritize youth on waiting lists for residential mental health programs, though waiting lists are unusual.[99] DJJ produced its first quarterly report comparing resources to need in June 2009.[100]

Some of the data are not usable in their current form.[101] For example, prescribing practices are tracked through a list that notes each prescription for each youth.[102] Although such a list is useful as raw material, it is nearly impossible to take in as a whole. It is hoped that the transition to an automated tracking system will enable DJJ managers to extract summaries of this and other data. The remedial plan mandates DJJ's

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[95] *See* Mental Health Remedial Plan Standards and Criteria item, 5.21a; Mental Health Remedial Plan, p. 45.
[96] Lee and Trupin, 2007 Formal Report, Attachment 1, #12.
[97] July to August 2008 Mental Health Tracking Data (PoP #275, November 6, 2008); October 2007 Mental Health Tracking Data (PoP #79, December 6, 2007); statements of Paul Woodward to the special master during central office site visit, September 23, 2009.
[98] Statements of Paul Woodward to the special master during central office site visit, September 23, 2009.
[99] *See* Mental Health Remedial Plan Standards and Criteria, item 5.27; Mental Health Remedial Plan, p. 46; Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 10; Lee and Trupin, 2009 Formal Report, p. 14 (adequate numbers of residential mental health beds).
[100] *See* DJJ, Quarterly Report Comparing Existing and Planned Mental Health Resources to Need (PoP #450, June 29, 2009).
[101] *See* Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 28; statements of Juan Carlos Arguello and Louise Allen during central office site visit, September 23, 2009.
[102] *See* DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).

conversion to an automated tracking system,[103] and the Court recently reset this deadline from September 30, 2009 to December 31, 2010.[104] The Court also extended the deadline for DJJ to generate monthly reports on collected data.[105]

DJJ has not acquired or developed a monitoring system to analyze treatment intervention efficacy and needs, as the plan required it to do by December 31, 2007.[106]

The primary barrier to compliance with these requirements appears to be the lack of technical resources. DJJ's mental health leadership stated in March 2009 that insufficient information technology (IT) staff were assigned to mental health for these purposes.[107] Currently, only one IT staff member is assigned to mental health.[108]

D. Licensed Bed Care

As previously reported, the mental health experts evaluated DJJ's licensed mental health care facility resources and needs in May 2007 and found that many DJJ youth had sufficient access to licensed beds but that female and northern California males lacked adequate access.[109] The private hospital DJJ contracted for women requiring licensed care, Aurora Vista Del Mar, rejected patients deemed to pose a risk of aggression.

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[103] *See* Mental Health Remedial Plan Standards and Criteria, item 5.21e.
[104] *See* Order, March 27, 2009, p. 2.
[105] *See id.* DJJ was also to develop tracking systems to document certain testing information, family contact attempts, and screenings and assessments by November 1, 2007. *See* Mental Health Remedial Plan, p. 19; Mental Health Remedial Plan Standards and Criteria, item 4.1. The Court also extended this deadline to December 31, 2010. *See* Order, March 27, 2009, p. 2.
[106] *See* Mental Health Remedial Plan, p. 55; Mental Health Remedial Plan Standards and Criteria, items 6.11a-b, d-h; Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 43; Lee and Trupin, 2009 Formal Report, p. 17.
[107] *See* statements of Juan Carlos Arguello and Louise Allen during central office site visit, March 18, 2009; Terry Lee and Eric Trupin, Farrell Mental Health Experts' Headquarters Site Visit, January 8-9, 2009, p. 4 ("On July 1, 2008, Mental Health Services submitted requests for Information Technology support to the DJJ Executive Staff for budget consideration and is awaiting a response. A request for reprioritization of Information Technology support needed for mental health tracking purposes and documentation was submitted in August 2008.").
[108] Statements of Juan Carlos Arguello and Louise Allen during central office site visit, September 23, 2009; statements of Ken Sandoval during central office site visit, June 22, 2009.
[109] *See* Fourth Report of the Special Master (July 2007), pp. 14-15. This is also the source for the next two sentences.

Almost all of the licensed beds were in southern California, creating a disincentive for clinicians in the north to refer youth requiring licensed bed care.

In response to the experts' May 2007 recommendations, DJJ opened Stark's Correctional Treatment Center (CTC) to females in 2007, making licensed beds available for female patients who were or would be rejected by Aurora Vista as too aggressive.[110] Soon thereafter, however, the correctional officers' union objected to Aurora Vista's restriction on equipment permitted in the hospital, and DJJ ceased using its contract with it.[111] Although the CTC remained open to females, the decision to stop using Aurora eliminated licensed beds for young women in a facility that could provide group activities for female patients.[112] Also in 2007, DJJ reported that it was attempting to renegotiate its contract with Metropolitan State Hospital to open SYCRCC's intermediate care facility (ICF) to females and to certain youth who had been previously rejected as posing too much risk of aggression.[113]

Although it continued to send northern California males to its southern California CTC and DMH-operated ICF,[114] DJJ also described its plans to meet with representatives of two private northern California hospitals in December 2007 about the possibility of contracting for licensed bed services.[115] DJJ had ceased using a contract with one of these hospitals, Sierra Vista, in July 2006, based on the chief psychiatrist's concerns about the management and treatment of youth there.[116] Based on these facts, at

[110] *See* Lee and Trupin, 2007 Formal Report, Attachment 1, #13.
[111] *See id.*, Attachment 1, #1.
[112] The experts find the CTC less adequate for female than for male patients because there are rarely if ever enough females there at a time for group activity; usually a female patient will be the only female patient, and male and female patients are not permitted to mix. *See* Lee and Trupin, 2009 Formal Report, p. 6.
[113] *See id.*; Lee and Trupin, 2007 Formal Report, pp. 6-7.
[114] *See* Sixth Report of the Special Master (January 2008), pp. 6-7.
[115] *See id.*
[116] *See id.*, p. 8.

the end of 2007, the mental health experts found DJJ's access to licensed bed care inadequate for northern California youth and for women requiring intermediate licensed bed care.[117]

Since 2007, DJJ has resumed sending some northern California youth to Sierra Vista hospital in Sacramento.[118] Thirteen of sixty (22%) northern California youth who were admitted to licensed bed facilities in fiscal year 2008-2009 were admitted to Sierra Vista hospital.[119] Proving its limits as a resource for DJJ, Sierra Vista rejected almost 50% of DJJ's referrals in the same period.[120]

The mental health experts believe that DJJ's negotiations with DMH have resulted in some improvement of access to DMH-operated SYCRCC ICF beds for male youth.[121] However, CTC clinicians reported to the mental health experts that they refrain from referring some of the more aggressive youth to the ICF because they believe that the ICF will refuse them admission.[122]

The CTC at Stark remains the only facility providing access to acute licensed bed care for DJJ's young women.[123] In fiscal year 2008-2009, of 14 women admitted to

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[117] *See* Lee and Trupin, 2007 Formal Report, pp. 1-2, 5.
[118] Appendix E, memorandum of Zack Schwartz to Donna Brorby, October 22, 2009, p. 4 [hereinafter Licensed Bed Usage Data].
[119] *Id*., p. 8.
[120] *Id*., p. 9.
[121] *See* Lee and Trupin, 2009 Formal Report, p. 6.; e-mail of Sara Norman to Barry Krisberg, August 4, 2009 (drawing attention to use of force on one of the youth later admitted to the ICF); e-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report). DJJ data show that three youth who had been rejected for licensed bed admission later were admitted to the ICF, including a youth that the OSM knows to have a history of acting out behavior. Licensed Bed Usage Data, pp. 14-15.
[122] E-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report); Terry Lee and Eric Trupin, Informal Report: Stark, September 2009, p. 20. During fiscal year 2008-2009, 8 of 117 youth remained at the CTC longer than one month. One youth remained at the CTC for 117 days and another, for 49 days. The median length of stay at the CTC during fiscal year 2008-2009 was 10 days, and 75% of CTC admits remained there fewer than 18 days. DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).
[123] Licensed Bed Usage Data, p. 11.

licensed bed care, 13 were to the CTC.[124] DMH is an option for intermediate (longer-term) care for women over eighteen years of age[125] who are not prone to aggressive behaviors. The fourteenth licensed bed admission for a female youth was at Metro State Hospital.[126] DJJ's contract with Aurora Vista Del Mar hospital in Ventura expired and was not renewed.[127] The ICF at SYCRCC still does not admit female youth; DJJ says that it is negotiating with DMH for it to admit females,[128] as it did in 2007.[129]

The mental health experts conclude that during the last fiscal year, northern California male youth lacked adequate access to licensed acute and intermediate beds, female youth lacked adequate access to licensed acute care beds, and male and female youth with aggression all lacked adequate access to licensed intermediate care beds.[130] DJJ disagrees with the experts with respect to northern California youth;[131] the disagreement appears to concern whether it is acceptable for most northern California male youth to be transferred to southern California for treatment at facilities that the experts find to be acceptable for southern California youth.[132] The experts accept the transfers in the short-term, recognizing that appropriate facility location is an issue that

[124] *Id.*
[125] The DMH-operated ICF at SYCRCC does admit youth under the age of 18. *See* DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).
[126] Licensed Bed Usage Data, p. 11.
[127] E-mail of Juan Carlos Arguello to the special master, September 24, 2009.
[128] *See* e-mail of Van Kamberian to special master, November 17, 2009, pp. 8-9 (attachment commenting on an draft of this report).
[129] *See* Lee and Trupin, 2007 Formal Report, p. 2.
[130] *See* Lee and Trupin, 2009 Formal Report, p. 6; statements of Terry Lee to special master during teleconference, February 10, 2010.
[131] Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 3.
[132] The experts have not actually systematically evaluated the quality of care at the CTC; they find it acceptable for the treatment of southern California youth in the sense that it is licensed and its geographical location is suitable for southern California youth.

extends beyond the mental health remedial plan.[133] They believe that DJJ needs appropriately located facilities in the long-term, so that youth are not separated from their families and communities.

For the present, DJJ must meet the licensed bed care needs of its youth within the current array of options, the Stark CTC, the SYCRCC ICF, DMH hospital beds, and contracts with private hospitals. In the long-term, CDCR's repurposing of Heman G. Stark from a youth to an adult facility changes will require relocation of the licensed beds that accounted for 68% of DJJ's licensed bed admissions.[134] When CDCR announced its decision in August 2009, the mental health and medical experts immediately informed DJJ that maintaining a juvenile CTC at an adult facility is not likely feasible over the long term.[135] In response, DJJ promised an assessment of options by "CDCR facilities management," which DJJ expected to provide by December 2009 and has not yet provided.[136] The long-term options DJJ is assessing include providing five CTC beds in each of the northern and southern parts of the state and converting the Ventura medical wing to a licensed bed facility.[137]

The mental health plan requires DJJ to provide an "appropriate written plan" to "address deficiencies" in licensed bed capacity, including a "reasonable implementation

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[133] For example, there is only one facility for female youth, and northern California female youth reside at Ventura in southern California. Statements of Terry Lee during teleconference with special master, February 10, 2010. This is the source for the next sentence as well.
[134] Licensed Bed Usage Data, p. 4 (of 171 admissions, 117 were to the CTC).
[135] E-mail of special master to parties, September 4, 2009 (reporting experts' consensus regarding Stark closure and CTC).
[136] *See* e-mail of Doug McKeever to special master, et al., November 29, 2009 (assessment expected by the week of December 21, 2009), December 21, 2009 (not yet complete), January 7, 2010 (assessment expected by week of January 18), January 22, 2010 (assessment not yet complete), and February 5, 2010 (facilities management determined the Ventura medical wing could be converted to a CTC within a reasonable time and at the cost of $124,000 but it has not determined how to replace Ventura's medical wing).
[137] Statements of Doug McKeever during teleconference of parties, experts, and OSM, September 16 and November 24, 2009. Any "long term" option is years away. *Id*.

schedule."[138] An adequate written plan would be based on and reflect a comprehensive analysis of the alternatives for providing licensed bed care to female youth and youth in northern California. In 2007 and 2008, the special master found that DJJ had not provided an adequate written plan, and, in 2008, she recommended that the court order DJJ to do so.[139] It is incumbent on DJJ to file an adequate written plan for licensed bed mental health care after CDCR management completes its assessment of the options available at this time.

E. Other Issues

The experts have found that DJJ is substantially compliant with requirements concerning mental health staffing,[140] the number and size of residential mental health treatment units,[141] and most elements of diagnostic screening.[142] Their primary concern is that DJJ implement "integrated, empirically-based mental health treatment throughout DJJ,"[143] including family engagement and participation in their youths' treatment,[144] and effective behavior management in place of overreliance on the use of force and a punitive

[138] *See* Mental Health Remedial Plan Standards and Criteria, item 5.21g. DJJ's November 2007 "formal response" to the mental health experts' licensed bed report expressed its intention to meet youths' licensed bed needs, but it was not an "appropriate written plan" to "address deficiencies" and included no implementation schedule. *See* Sixth Report of the Special Master (January 2008), pp. 7-8; Lee and Trupin, 2007 Formal Report, pp. 1-2, Attachment 1, #13.

[139] Consent Decree ¶28(n). *See* Seventh Report of the Special Master (April 2008), pp. 39-40.

[140] They have not systematically reviewed the professional services provided by DJJ's mental health staff. They do not believe that such a systematic review, which they intend to undertake at a later time, would be of sufficient value given DJJ's lack of an integrated, empirically-based mental health treatment program. *See* e-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report).

[141] Lee and Trupin, 2009 Formal Report, p. 1-2,

[142] Lee and Trupin, 2009 Formal Report, p. 10, items 4.3 – 4.7.

[143] *See, e.g.*, Lee and Trupin, 2007 Formal Report, p. 3; Lee and Trupin, 2009 Formal Report, p. 4 (DJJ lacks an "overarching paradigm," and "various mental health professionals use different approaches," making it "inevitable" that "clinical and facility staff will operate independently, resulting [in] inconsistent and uncoordinated care.").

[144] *See, e.g.*, Lee and Trupin, 2009 Formal Report, p. 8.

disciplinary system.[145] For this reason, they continue to emphasize the importance of an integrated behavior treatment model that will guide the treatment of all DJJ youth.[146] They also urge DJJ to develop and implement peer review and quality management to "assess individual and aggregate clinician practice and progress towards identified desired clinical behaviors."[147]

III. CONCLUSION

The special master respectfully submits this report.

Dated: February 12, 2010

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Donna Brorby
Special Master

[145] Lee and Trupin, 2009 Formal Report, p. 7.
[146] *See, e.g.*, statements of Terry Lee during teleconference with special master, February 10, 2010.
[147] Lee and Trupin, 2009 Formal Report, pp.6-7.

Farrell Mental Health Experts' 2008-2009 Site Visit Summary
January 9, 2010
Terry Lee, MD and Eric Trupin, PhD

The Farrell Mental Health Experts visited California Division of Juvenile Justice (DJJ) facilities to assess compliance with the Mental Health (MH) Remedial Plan. The MH Remedial Plan and Standards and Criteria served as the guidelines for the site audits, but all aspects of mental health treatment were considered. In addition to information gathered during site visits, site audit reports utilized data and materials supplied by DJJ, and by the Office of the Special Master (OSM) and the other Farrell subject experts. The dates of the site audits were: Preston-July 18&19, 2008, Close-October 16, 2008, Chaderjian-October 17, 2008, Ventura-December 1&2, 2008, DJJ Headquarters-January 8&9, 2009, SYCRCC-April 16&17, 2009 and Stark-October 2&3 and May 7&8, 2009.

The first portion of this summary highlights critical areas for MH reform. These critical areas align with previously identified mental health priorities. The second part of this report provides compliance ratings for standards and criteria items.

Areas of Substantial Compliance

1. DJJ is in substantial compliance with the mental health residential living unit maximum size. The MH Remedial Plan calls for the Intensive Treatment Programs (ITPs) and Specialized Counseling Programs (SCPs) to have a maximum census of 24 youth, which is a reduction from a maximum of 48 youth in 2005. Intensive Behavior Treatment Programs (IBTPs) are opening, and their censuses have been within the maximum of 16. Psychiatric technicians have been added to residential mental health treatment units, and nursing coverage has increased from 5 to 7 days per week. As discussed below, psychologist and psychiatrist vacancies have been filled. The lower census and increased staffing on residential mental health units have resulted in a lower population density and improved staff to youth ratios. The environment on these less densely populated units is calmer and less frenzied. Staff members are more familiar with youth and their individual needs. Youth with history of MH unit placement before and after the change in maximum census report that staff members have more time to talk to them. Youth also report that mental health professionals meet with them more regularly, and are more available for youth-requested meetings outside of regularly scheduled appointments.
2. Except for an SCP at SYCRCC, DJJ has the requisite number of residential mental health treatment units as specified by the MH remedial plan. DJJ headquarters recently reported that there were 2 youth in southern California awaiting SCP placement in southern California. These youth were reported to be receiving extra mental health attention in their core treatment units while awaiting SCP placement, which is the specified adjustment in the MH Remedial Plan. Some clinicians in southern California have also reported that males, especially under the age of 18 years, occasionally have to wait for SCP beds. Though the remedial plan requires DJJ to open an SCP at SYCRCC, the

remedial plan also contemplated a reevaluation of the number of residential mental health beds needed. DJJ has indicated that it intends to combine the ITP and SCP into a single level of mental health care. The mental health experts are in agreement with this proposal, which should simplify operations and provide more flexibility for placing youth who require residential mental health treatment beds. Given the total number of residential mental health beds in southern California, combining of ITP and SCP levels of care should address any residential mental health bed capacity concerns. The MH experts will continue to monitor residential mental health treatment bed capacity.

3. By providing pay parity with CDCR Adult Operations and Adult Programs, DJJ has filled all psychology and psychiatry positions. In fact, the lower institutional population has led to plans to reduce the DJJ facility workforce, including mental health professionals. DJJ has reviewed plans with the MH experts, and the MH experts feel that the proposed eliminated positions in the facilities should not negatively impact MH care; DJJ should still have sufficient numbers of mental health professionals to treat its population, while operating more efficiently.
    a. One potential area of concern is coverage for psychiatrists on leave. DJJ's plan to use agency psychiatrists for leave coverage will be monitored during the next round of audits.
    b. Pay parity has attracted better qualified MH professionals; however, DJJ has indicated that a reduction in force will be based on seniority, rather than requisite skills. It is therefore unclear how many of DJJ's better qualified mental health professionals will be retained.
    c. The above comments on MH staff reductions refer to facility positions only. DJJ is currently undergoing a review of Headquarters positions. Some reductions in DJJ MH HQ positions have been proposed, but they have not been reviewed in detail with the MH experts. Some of these reductions, such as a reduction in the number of MH training team positions, would require a modification in the MH remedial plan. The MH experts will monitor the effects of MH position reductions, and review any additional proposed staffing changes.
4. For more than a year, DJJ has been administering the Voice-Diagnostic Interview Schedule for Children (V-DISC) to new admissions at its main reception centers at SYCRCC and Preston. The V-DISC is a structured interview that uses DSM-IV criteria to screen for mental health disorders. Youth hear questions through headphones while reading them on a computer monitor, and respond through the computer keyboard. This method allows them to complete the DISC interview regardless of their reading skill level. The V-DISC has been researched in a number of settings, and its strengths and weaknesses are relatively well-established. DJJ has published a *Final V-DISC Report* based on a year's worth of data. DJJ noticed that a number of youth were rushing through the V-DISC, so the administration protocol was modified to provide more monitoring. In addition, some facility psychologists have proposed modifying the

protocol further by administering the V-DISC later in the admission process, when youth are less inundated with screening questions and procedures. The mental health experts support this modification. Excluding youth who completed the V-DISC with "implausible short administration times," just over half of screened youth scored positive for a mental health disorder. There was less variability between Preston and SYCRCC on the V-DISC data, relative to the SPAN. One would expect a structured instrument such as the V-DISC to yield higher cross-facility concordance than the SPAN, which uses clinician-generated diagnoses. Based on the V-DISC study data, which included a component of analyzing youth psychiatric medication use, DJJ is reconsidering admission protocols, screening instruments, and specific psychosocial and psychiatric medication treatments for youth in DJJ facilities. The MH experts commend DJJ mental health leadership on the initial analysis of the V-DISC data, and their plans to use V-DISC data to improve evaluation and treatment procedures.

Areas of Less than Substantial Compliance

1. Suicidal behavior
    a. The Mental Health Remedial Plan requires staff training on specialized interventions such as Dialectical Behavior Therapy (DBT) for suicidal and self-harming behavior. DJJ currently does not have an organized treatment approach for youth with suicidal and self-harm behavior. Since 2006, the MH experts have urged DJJ to adopt and adapt DBT, or offer an alternative organized treatment, for youth in its custody. In 2006, a form of DBT modified for residential juvenile justice settings was presented to DJJ leadership. This presentation was followed with a proposal to provide DBT training to DJJ staff.
    b. DJJ's own mental health leadership, including the DJJ Chief Psychiatrist and Senior Supervising Psychiatrist, also endorsed DBT training for DJJ staff. There has been no mental health professional within DJJ's leadership or associated with Farrell v Cate who has recommended against the utilization of DBT in DJJ facilities. During 3 years of not implementing DBT, DJJ has not proffered any alternative organized approaches for treating youth with suicidal and self-harm behavior.
    c. The SPAR policy is an administrative policy. It must be paired with an effective clinical intervention. In the California Department of Justice Deputy Attorney General's November 17, 2009 letter to the MH experts, the SPAR Individual Focal Treatment Plan is proffered as a treatment for youth with suicidal and self-harming behavior. Unfortunately for the youth in DJJ custody, DJJ clinicians acknowledge that the Individual Focal Treatment Plan is a form that contains check boxes next to general assessment (such as "sleep chart") and generic intervention modalities (such as " behavioral group"), and does not specify treatment or services that address an individual youth's suicidal or self-harming behavior. The MH experts agree with DJJ clinicians' characterizations of the

inadequacy of the Focal Treatment Plan. The Individualized Focal Treatment Plan is not an organized treatment; nor does it guide the behavior of other DJJ staff to promote youth safe behavior and decrease the likelihood of future self-harm behavior.

d. The MH experts have identified the implementation of an effective treatment program for suicidal and self-harming behavior as one of DJJ's highest priorities. Three years after the initial proposal, DJJ recently entered into a contract with Behavioral Affiliates, Inc to provide DBT training for suicidal and self-harm behavior. The DBT implementation plan is still under development, but there is agreement between DJJ and the MH experts that there will be two pilot sites, where all staff will learn and work in a manner consistent with the DBT model. Some number of non-pilot site MH clinicians will also participate in some level of DBT training. According to DJJ's November 17, 2009 response to the MH site visit 2008-9 summary draft, DBT pilot programs are scheduled for March 2010.
e. DJJ is implementing a uniform definition of suicidal and self-harm behavior for more accurate tracking of baseline levels, trends and effectiveness of interventions.
f. DJJ reports the Suicide Prevention and Response (SPAR) Policy has been implemented in all its facilities. According to DJJ, SPAR implementation has resulted in a decrease in restrictive programming of youth, mainly as a result of only allowing mental health professionals to place youth on suicide watch levels. According to DJJ, some mental health professionals have also permitted less restrictive programming for youth on suicide watch levels, but this is reportedly not uniform. DJJ reports it is currently implementing a system for more systematic tracking all youth programming; this will provide some information on the programming of youth on suicide Risk Reduction levels.
g. The current SPAR represents an improvement over its predecessor, but it prescribes complex administrative procedures; the next iteration needs to be simplified.

2. Integrated Behavioral Treatment Model (IBTM)
    a. The Integrated Behavior Treatment Model is a rehabilitative approach required by the Safety and Welfare Remedial Plan. The IBTM will provide a central guiding vision for all DJJ staff, as well as a common language and treatment approach. The DJJ-wide cognitive-behavioral program will facilitate continuity of care as youth transfer within DJJ facilities and after care. Without such an overarching paradigm, it is inevitable, as we have observed, that various mental health professionals use different approaches, and clinical and facility staff will operate independently, resulting inconsistent and uncoordinated care. Youth describe significant variability in treatment techniques among clinicians. Just as

concerning, youth are typically unable to describe skills and goals that they are working on in treatment.

b. DJJ needs to convey a cohesive vision for rehabilitation with the IBTM. Coordination and integration of treatments, and partnership among treatment team members require considerable strengthening.
c. DJJ was to develop the IBTM by August of 2007, produce a written description and manual by November 15, 2008 and train of facility staff by August 15, 2009.
d. DJJ presented a brief written description of some IBTM values and philosophies in early 2009. These values and philosophies were expanded in March of 2009, but this description of the IBTM still lacked specifics that would guide treatment and rehabilitation services.
e. DJJ's June 2, 2009 court submission contained some confusing IBTM-related documents. Attached to Michael Brady's submission were two exhibits. One (Exhibit A) appeared to be a set of working notes from the DJJ IBTM workgroup and another (Exhibit B) was apparently developed by Orbis Partners—a DJJ-contracted company.
    i. Both appendices lacked the specificity required to guide IBTM implementation and assess the effectiveness of IBTM on reform.
    ii. The submission of two IBTM documents (Exhibit A—produced by the workgroup, and exhibit B—by Orbis Partners) was by itself baffling. It appears that there were two different groups working on the IBTM description in isolation from each other, effectively doubling the financial and human resources allocated to the endeavor. The explanation for this redundant effort was: "What the workgroup was expecting from Orbis Partners was data that would aid them in the drafting of the DJJ IBTM program description. What the workgroup got was far more than what it anticipated and far different than was communicated to them would be coming."
f. On July 2, 2009, DJJ and the plaintiffs' attorneys entered into an agreed order wherein the Farrell Safety and Welfare, Sex Behavior Treatment and Mental Health Experts, in consultation with DJJ, will draft the IBTM program description, implementation plan and manual. The drafting has been delegated to Drs. Angela Wolf and Henry Schmidt III.

3. Licensed mental beds—in 2007, the MH experts reported that DJJ appeared to have access to adequate numbers of acute and intermediate level of care licensed mental health beds. However, the distribution of the beds was not sufficient to meet the needs of all youth in DJJ custody. DJJ's initial response was to increase communication with DMH and outside psychiatric facilities with a goal of improving access for the underserved populations. There were reports of encouraging progress from these negotiations, but any progress has been insufficient to meet the all the needs of the underserved groups.

a. Males from northern California and females do not have adequate access to acute licensed mental health beds. While there is some use of contracted licensed acute mental health beds, the majority of males from northern California and females are admitted to the Stark CTC. The only acute licensed bed alternative for males in northern California is Sierra Vista, which rejects approximately 50% of DJJ selected referrals; while 75% of northern California male admissions to licensed beds are to the CTC and ICF in southern California (see 10/22/09 OSM memo to the MH experts on licensed beds). At Chaderjian, the primary mental health treatment facility in northern California, MH clinicians report that they are more hesitant and will wait longer to refer youth to the CTC, relative to a licensed acute mental health bed resource in the north if better access existed, because of concerns around moving youth away from their family support and the logistics of transferring a long distance. There is often a one-day lag in admitting youth from northern California to the CTC. When interviewed in the CTC, a number of males from northern California reported they didn't like being admitted to the CTC because it is too far from their families and support systems. All female acute licensed mental health bed admissions between July 2008 and June 2009 were to the Stark CTC (see 10/22/09 OSM memo to the MH experts on licensed beds). When females are admitted to the CTC, they are programmed separately from males, because it is DJJ policy to not program males and females together on the CTC. There are a low number of females in DJJ in need of acute licensed mental health care; unless there are two or more females on the CTC, females will program alone. The 10/22/09 OSM report also indicated that on average, compared to males, females wait a day longer for admission to the CTC.

b. Males and females with aggression, and northern California males do not have access to intermediate level of licensed mental health beds. DJJ contracts with the California Department of Mental Health (DMH) for Intermediate Care Facility (ICF) beds on the grounds of SYCRCC. There has been some improvement in the ICF's ability and willingness to accept males with a history of aggressive behavior, but there remain males who are not accepted, or even referred, to the ICF. The contract with the ICF has not been changed to include females. There were some females admitted to the DMH system but according to Ventura staff, they were returned to DJJ because of disruptive behavior. DJJ needs to develop licensed mental health bed resources to treat the under- and un-served populations. The MH experts recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for providing licensed MH beds.

4. Mental health professional peer review and quality management processes will promote more effective and uniform MH practices. Peer review processes will assess current

individual and aggregate clinician practice, and progress towards identified desired clinical behaviors. Currently, DJJ is not practicing MH peer review or quality management. A mental health peer review process was developed, but not consistent with Medical Peer Review. In general, the proposed MH peer review is more extensive and involved, which will provide more in-depth information about MH clinician functioning, and feedback to DJJ clinicians. DJJ has made the decision to harmonize the Medical and Mental Health Peer Review processes. Given the variability in psychosocial approaches, and idiosyncratic psychopharmacological prescribing practices, implementing peer review and quality management processes is one of DJJ's highest MH priorities.

5. Use of Force (UoF)—a new Use of Force policy has been written and implemented. While it is an improvement over the old policy, it still concentrates on administrative and logistical steps for using force, without sufficiently emphasizing preventative or less intrusive measures. Youth on the mental health caseload are disproportionately involved in use of force incidents, including chemical agents. On July 24, 2009, the plaintiff's attorney requested that the Farrell Safety and Welfare, Wards with Disabilities Program and Mental Health Experts investigate DJJ's Use of Force against youth with mental illness and/or mental retardation. One would expect a decrease in use of force involving youth on the mental health caseload after the implementation of DBT for suicidal and self-harm behavior and the IBTM. Use of Force should be conceptualized as being one aspect of behavior management and the Integrated Behavior Treatment Model.
6. Disciplinary Decision Making System (DDMS)—unfortunately, there are numerous examples of youth with major mental illness inappropriately given months and years of time adds because of behavior related to their mental illness. A new DDMS policy has been written, but certain mental health related elements have not been implemented because they are being grieved. Like the new Use of Force Policy, the new DDMS policy is an improvement over the old; but it remains more suitable for an adult prison system. The new policy continues to emphasize negative consequences rather than considering effective consequences in the context of a youth's treatment program. Negative consequences are just one part of an effective treatment program—DDMS should be subsumed under the Integrated Behavior Treatment Model. A positive outcome of the new DDMS policy is that all time adds for youth on the mental health caseload must be reviewed and approved by the DJJ Chief Psychiatrist. DJJ headquarters reports that one facility stopped sending time adds to headquarters for review, while another facility was using an overly narrow definition of youth on the mental health caseload; after detection by headquarters, these practices are reported to have been corrected. The MH experts will be monitoring adherence to this aspect of the policy. With these initial DDMS policy implementation problems in mind, the DJJ chief psychiatrist nonetheless reports that there has been a marked reduction in the number of time adds given to youth on the mental health caseload. In the November 17, 2009

Deputy Attorney General Letter to the MH experts, it is reported there has been an 85% reduction in time adds for youth on the mental health caseload since implementation of the DDMS policy in April 2009.

7. Family participation in mental health treatment can enhance the effectiveness of treatment, and decrease the likelihood of recidivism. Family members can provide important historical information, and encourage youth participation in MH treatment and other rehabilitative efforts. Utilizing family strengths and addressing family needs, and teaching family members about effective skills that youth have learned in DJJ custody will promote skill generalization. Effective transition planning has been shown to improve outcomes. Currently, family engagement is inconsistent throughout DJJ facilities. Some facility superintendants have gone to great lengths in engaging families, which in addition to setting a positive model and tone in their facilities, results in strong family involvement. Similarly, family engagement and involvement is second nature to some DJJ MH clinicians. However, during this round of site visits, the MH experts observed limited family involvement in mental health programming. The culture and policies of DJJ do not effectively support consistent family involvement, and instead sometimes create barriers to family participation in youth treatment. Expectations for staff to include families are limited. The current DJJ records and data systems do not provide for easy tracking of family contacts. Youth often report a desire for more family contact and family therapy, including youth who have regular visits with family. The MH experts strongly encourage increased family participation in MH treatment.
8. Training in New Programs: DJJ undertook a major training effort in the areas of Motivational Interviewing (MI), Aggression Replacement Training (ART) and suicide education. The MH experts strongly support training in these areas, and MI and ART are effective interventions.
    a. The suicide training was a generic educational training provided to all staff; when asked, most DJJ mental health staff report that it was an appropriate training for staff with no background in mental health. It is fine for DJJ to provide basic suicide training for its entire staff, but until the recent commitment to undergo a DBT pilot, there have been no trainings on effective treatments or approaches for youth with suicidal and self-harm behavior.
    b. MI is a flexible approach which has been adapted for many purposes and settings. Evidence-based treatments contain fidelity tools which measure adherence to the treatment model. DJJ's MI implementation has not included MI fidelity measures. DJJ's use of one-time training sessions or classroom trainings separated by months, without on-going monitoring of and feedback to staff is unlikely to result in effective application of MI. Successful implementation requires on-going coaching and feedback to trainees as they try to incorporate new skills. One-time trainings without on-going skills coaching are inconsistent with genuine reform.

c. Despite relatively wide-spread staff training, youth and DJJ MH clinicians consistently reported during this round of site visits that they were unaware of any provision of Aggression Replacement Training classes.
d. DJJ must plan, train and coach new treatment programs in a strategic fashion, with attention to coordinating all efforts.

Mental Health Experts' Compliance Ratings

Action Item and Audit Method / Standard	MH Plan Section/ Item		Ratings							Comments
			CO	OHC	NAC	VYCF	SR	HGS	PYCF	
3.0 ORGANIZATIONAL STRUCTURE										
Central office organizational chart - incl MH chain of command.	3	1	PC							A number of CO organization charts have been proposed, but none have incorporated an organizational and supervisory structure which will properly support the IBTM and MH treatment.
Organization chart for each facility - incl MH chain of command.	3	2		BC	BC	BC	BC	BC	BC	A number of facility organizational charts have been proposed, but none have incorporated organizational and supervisory structures which will properly support the IBTM and MH treatment. Administrative and clinical supervision must be further defined to manage the work of the YCC's and other staff who will be responsible for implementing significant portions of the IBTM and other treatments. MH staff must be in charge of MH programs.
Establish dispute resolution protocol.	3	3	BC							DJJ's current conflict resolution procedures are not adequate for resolving the wide range of recent disputes and potential disputes that may arise in DJJ's current environment. DJJ reports it is revising the previously submitted dispute resolution protocol.
4.0 SCREENING AND ASSESSMENT										

Develop tracking system for MH information and services.	4	1	B C							DJJ has not appeared to devote resources to this item recently.
Establish policy/process to receive & share MH info with counties	4	2								
Policy/process adopted.	4	2 b	B C							A process to receive information from the counties has been developed. Reception center staff report that there is significant variability in the quality and quantity of information that is received. Staff report that youth who have been adjudicated in the adult justice system consistently arrive with less information. DJJ gives information to the counties at parole or discharge, though variability in this process has also been reported by DJJ staff and observed by the experts. DJJ is developing a policy relating to this item, with a target of April 2010 for completion.
Implement policy/process to receive & share MH info with counties.	4	3	N C							Policy is not yet finalized.
Use MAYSI-2 on all youth at initial intake.	4	4		S C	S C	S C	S C	S C	SC	
Use DJJ SRSQ on all youth at intake.	4	5		S C	S C	S C	S C	S C	SC	
Use V-DISC for all youth under 18 at intake.	4	6 a		S C	S C	S C	S C	S C	SC	
Use V-DISC or validated screening instrument for youth 18 & older.	4	6 b		S C	S C	S C	S C	S C	SC	
Develop & implement structured clinical assessment for psychosis.	4	7	S C							
Analyze efficacy of screening & assessment instruments.	4	8	P C							DJJ has performed an initial analysis of its screening and assessment instruments, and is contemplating changes in assessment protocols.
5.0 LEVELS OF CARE AND PROGRAMMING										
Train direct care staff on IBTM.	5	1		N C	N C	N C	N C	N C	NC	See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. On July 2, 2009, DJJ agreed to allow the S&W, SBTP and MH experts to write the IBTM.
Develop treatment hierarchy.	5	2	B C							A Priority of Treatment Needs has been developed. It is not used in treatment plan development. A treatment hierarchy will be developed and implemented as part of the IBTM.
Develop & implement policy	5	3	P							The WIC 1800 Policy has been

regarding forensic evaluations.			C		developed and was implemented in June 2009. The MH experts are still evaluating policy implementation.
Develop and implement substance abuse/dependence program as part of IBTM.	5	4	NC		DJJ has had some very early initial discussions with the MH experts on the development and implementation of a substance abuse/dependence treatment program. As indicated by this item, the program must be consistent with the IBTM.
Adopt and implement formal criteria for each level of care	5	6			
Adopt formal criteria.	5	6a	NC		No formal criteria have been adopted. DJJ reports that Classification and Case Management Charters will also produce policy and procedures related to this item. DJJ reports that it is developing a pilot program for a single MH LOC, combining the ITP and SCP LOCs. DJJ reports that the pilot single MH LOC unit is anticipated to begin operations in 2010, and will have formal criteria.
Train staff.	5	6b	NC		No formal criteria have been adopted.
Establish centralized Mental Health Review Team / review protocol.	5	7	NC		No centralized MH review team or protocol has been developed.
Develop and implement policy & procedures for treatment planning.	5	8	NC		Aside from YASI-CA treatment planning, which in its current state is not well-integrated with other treatment plan development, DJJ has done little work in MH treatment plan development. DJJ reports that Integrated Treatment Planning has been assigned to a multidisciplinary Charter to guide development of the policy. DJJ reports that development of the policy is anticipated in 2010.
Develop and implement policy & procedures for movement between levels of care.	5	9	NC		No policy for movement between levels of care has been developed. DJJ reports that movement between levels of care is being developed as part of the Level of Care Policy, which has been assigned to a multidisciplinary Charter.
Establish and implement protocols for participation by at least one clinician not regularly involved in the treatment of the youth in treatment team reviews of longer term placements in IBTP, SCP and	5	10	BC		DJJ has the resources and organizational structure to come into substantial compliance with this item.

ITP.										
Open residential mental health treatment units. Programs staffed and operated per program design. Sufficient capacity exists to meet the needs of the population with minimal waiting time.	5	1 2								
5 Intensive Treatment Programs.	5	1 2 a			S C	S C	S C	S C		
7 Specialized Counseling Programs.	5	1 2 b		S C	S C	S C	S C	S C		SCP capacity is being monitored by the MH experts.
1 Intensive Behavior Treatment Program.	5	1 2 c			S C					
Open residential mental health treatment units	5	1 3								
1 Intensive Behavior Treatment Program.	5	1 3 b						S C		
Reduce size of MH units to level determined in conjunction with Consent Decree MH and S&W experts.	5	1 6								
Maximum unit size determined and established as DJJ policy.	5	1 6 a	S C							
Determine size of MH units in new facilities.	5	1 7	N C							DJJ has not presented the MH experts with information on the size of MH units in new facilities.
Develop Program Service Day Schedule for MH living units.	5	1 8	P C							In March 2009, the DJJ Program Service Day was implemented system-wide. Many staff report that the schedules are not usually adhered to. DJJ MH professionals identify a number of problems with accessing youth. It is reported to be difficult to schedule groups because of problems with coordinating the schedules of youth and staff. Some clinicians report that the numbers of treatment periods are not adequate. DJJ reports it is about to embark on the use of a scheduler to coordinate MH appointments and groups. DJJ reports that changes to the work hours and days of clinical staff are in development and implementation is anticipated in early 2010.
Develop p & p for youth requiring long-term care in a	5	1 9	B C							DJJ has developed a policy draft that will need revision. MH experts and

licensed facility.					DJJ MH have agreed in principle on the revisions. By report, DJJ recently began re-engaging potential partners for providing long-term licensed MH care.
Collaborate with DMH to expedite transfers and facilitate transitions.	5	20	PC		DJJ and DMH staff members have been meeting to discuss their collaboration. By report, higher level meetings are being scheduled to further develop collaboration and transition processes.
Project needs / develop tracking system for ongoing projections	5	21			
DJJ manually tracks select MH data, including wait lists, in Excel.	5	21a	SC		
In consultation with the Consent Decree MH experts DJJ identifies additional data elements to track.	5	21b	SC		
Develop timetable for tracking data elements from 5.21 not currently tracked.	5	21c	SC		
Modify manual tracking system to include data elements in 5.21b. Produce consolidated and archivable reports.	5	21d	BC		Current reports are in a raw form, and not useful for further analysis or guiding management decisions. As discussed with DJJ MH, more reliable and clinically relevant information on self-injurious behavior and more clinically relevant information on UoF with youth on the mental health caseload are needed. DJJ reports it will soon implement an electronic system for tracking youth programming.
Develop automated system to replace manual system.	5	21e	NC		DJJ has not presented any evidence of systematic and organized work in this area.
Consent decree MH experts conduct assessment of licensed bed need.	5	21f	NA		The assessment was conducted.
Plan to address deficiencies, if needed.	5	21g	BC		See narrative at beginning of report under Areas of Less than Substantial Compliance, #3. The MH experts recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for providing licensed MH beds.
Implement plan.	5	21h	BC		See narrative at beginning of report under Areas of Less than Substantial Compliance, #3. The MH experts

					recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for providing licensed MH beds.
Consent Decree MH experts conduct assessment of residential mental health program bed need. Written assessment produced.	5	21i	NA		DJJ appears to have adequate numbers of residential MH beds.
Modify current plan for residential mental health beds, if necessary.	5	21j	NA		DJJ appears to have adequate numbers of residential MH beds. DJJ reports it will be piloting a single MH level unit. Implementation of the IBTM may affect the number of residential MH beds DJJ will need.
Implement plan.	5	21k	NA		DJJ appears to have adequate numbers of residential MH beds.
Make quarterly reports comparing existing and planned resources to need.	5	21l	SC		A quarterly report was produced.
Evaluation / recommendations regarding current array of MH services	5	22			
Confer with Consent Decree MH experts.	5	22a	PC		No consultation systematically addressing the current array of MH services has taken place between DJJ and DJJ MH leadership, but the MH experts frequently communicate with DJJ MH leadership on various aspects of DJJ's MH programming.
Evaluate services, provide written summary and conclusions.	5	22b	NC		No written summary has been provided, and DJJ has not provided any evidence of a systematic evaluation of MH services.
Implement changes, if needed.	5	22c	NA		No written summary addressing the need for changes has been provided. DJJ is implementing DBT pilots on 2 of its ITPs.
Evaluate practices, make recommendations re: contract services	5	23			
Confer with Consent Decree MH experts.	5	23a	PC		See narrative at beginning of report under Areas of Less than Substantial Compliance, #3. The MH experts recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for

										providing licensed MH beds. Further conferring will clarify to what extent DJJ supports the MH expert findings, and what priority DJJ assigns to this area.
Conduct evaluation.	5	2 3 b	N A							
Assess inpatient resources for females and Northern Cal males	5	2 4								
Plan to address deficiencies, if needed.	5	2 4 a	B C							See narrative at beginning of report under Areas of Less than Substantial Compliance, #3. The MH experts recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for providing licensed MH beds.
Implement plan.	5	2 4 b	B C							See narrative at beginning of report under Areas of Less than Substantial Compliance, #3. The MH experts recommend a multi-pronged approach involving exploration of DJJ, DMH and contract provider resources to address deficiencies. By report, DJJ recently began re-engaging potential partners for providing licensed MH beds.
Develop screening and assessment policies and procedures for requirements to treat in licensed and non-licensed facilities	5	2 5								
Work with DHS to explore licensing options for new facilities, including identification of youth who require treatment in licensed facilities.	5	2 5 a	B C							DJJ reports that it conferred with DMH in October 2008 to explore options for new facilities. DJJ has not reported any further exploration with DHS in the area.
Develop screening and assessment policies & procedures.	5	2 5 b	B C							DJJ reports that it is working on a policy for youth requiring long-term care in a licensed facility. Presumably, screening and assessment policies and procedures will be included in this process.
Implementation plan to expand interventions under IBTM	5	2 6								
Confer with Consent Decree MH experts.	5	2 6 a	B C							See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order

					on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description.
Identify and prioritize new interventions.	5	2 6 b	B C		See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. DJJ has identified and prioritized a number of new interventions, though this did not occur in consultation with the MH experts.
Develop implementation plan.	5	2 6 c	B C		See narrative at the beginning of the report, under Areas of Less than Substantial Compliance, #2 and #8. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. DJJ has developed implementation plans for a number of programs. However, these plans are not well-coordinated with each other, or with the IBTM.
System to track & prioritize youth on wait lists for residential MH programs.	5	2 7	S C		
6.0 EVIDENCE BASED TREATMENT					
Develop & implement system to track attempts at family engagement, participation & notification.	6	1	P C		There is no dedicated system for tracking attempts at family engagement, participation & notification. There are some individual events that are tracked, such as youth initial contact with family after admission, family visits, and telephone calls between youth and family. However, attempts at family engagement and participation by various staff are documented in different and inconsistent areas. DJJ reports that an improved tracking system for tracking family participation and notification will be developed as part of a family engagement charter.
Conduct feasibility review of Family Engagement Model or other evidence based model of family engagement.	6	2	N C		DJJ reports that family engagement has been assigned to a charter to guide the development of a policy. A feasibility review will be part of the charter process
If feasible, implement evidence	6	3	N		Feasibility study has not been

based model for family engagement.			A							completed.
Investigate feasibility of implementing program of parent partners.	6	4	N C							DJJ reports that all family engagement programs have been assigned to a charter to guide the development of a policy.
If feasible, implement parent partner program.	6	5	N A							Feasibility study has not been completed.
Outcome analysis of FIT and Family Justice Model.	6	7	B C							The Family Justice Model pilot began in 2007. DJJ reports that Family Justice is going out o business, but the model will be expanded for state-wide use in 2010. No outcome analysis of the Family Justice model has been received, nor has DJJ indicated that one was performed. DJJ has made some initial inquiries about the FIT model and recently received some material.
Acquire professional journals & publications for each facility.	6	9		S C	S C	S C	S C	S C	SC	There was period when the Psychiatry-On-Line subscription expired. DJJ reports that the subscription was renewed for 2 years in June 2008.
Acquire or develop a mental health monitoring system. Performance indicators to monitor the quality of services and measure patient outcomes developed.	6	11								
Consult with MH experts regarding options for monitoring systems	6	11a	N C							After some early initial discussion in 2007, there has been no progress in this area recently.
Develop appropriate implementation plan including implementation schedule and interim measures, as needed.	6	11b	N C							No implementation plan has been presented to the MH experts.
Acquire/develop system	6	11c	N C							DJJ has not indicated that a system has been developed or acquired.
Train appropriate staff	6	11d	N C							No system has been acquired.
Collect data on treatment needs	6	11e	N C							No aggregated data on treatment needs has been collected.
Analyze treatment needs	6	11f	N C							DJJ has not presented an analysis on treatment needs.
Collect minimum 1 year data on treatment outcomes	6	11g	N C							DJJ has not presented 1 year data on treatment outcomes.
Analyze efficacy of interventions	6	11h	N C							DJJ has not presented an analysis of intervention efficacy.

Analyze treatment needs. Appropriate analysis conducted periodically. Analysis documented in writing.	6	11b	NC							DJJ has not presented an analysis of treatment needs.
Analyze efficacy of interventions. Appropriate analysis conducted periodically. Analysis documented in writing.	6	11c	NC							DJJ has not presented an analysis of intervention efficacy.
Modify treatment & implement training based on analysis in 6.11b.	6	12	NC							Analysis has not been performed.
7.0 STAFF QUALIFICATIONS AND TRAINING										
Pay parity with comparable CDCR adult operations MH staff.	7	1	SC							
Implement Integrated Behavior Treatment Model	7	4								
Consult with experts, re: IBTM development.	S&W 4.2		BC							See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description.
Develop treatment model.	S&W 5.2		NC							See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. Prior to this agreement, DJJ had not developed a treatment model.
Produce written description and manual.	S&W 4.3		NC							See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. Prior to this agreement, DJJ had not produced a coherent description and manual.
Convert facilities to rehabilitative model.	S&W 6.1			BC	BC	BC	BC	BC	BC	The census on core and treatment units have decreased to more manageable numbers and treatment staff positions are filled. However, there is no organized facility-wide overarching treatment or rehabilitation program as envisioned in Section 6 of the S&W Plan.
Establish training schedule -	7	5								

IBTM		a							
Develop or obtain training materials for IBTM, treatment planning, and other IBTM related interventions.	S&W 5.3		NC						See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. Prior to this agreement, DJJ had not developed a treatment model or training materials for the IBTM.
Train trainers.			NC						See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. Prior to this agreement, no trainers had been trained and DJJ had not developed a treatment model or training materials for the IBTM.
Complete training.	S&W 6.7			NC	NC	NC	NC	NC	NC	See narrative at beginning of report under Areas of Less than Substantial Compliance, #2. After years of limited progress in this area, DJJ and the plaintiffs signed an agreed order on July 2, 2009 for the S&W, SBTP and MH experts to write the IBTM program description. Prior to the agreement, no staff had been trained. DJJ had not developed a treatment model or training materials for the IBTM.
Establish training schedule - evidence based treatments	7	5 b							
Identify interventions for high frequency disorders.	7	5 b 1	NC						DJJ has completed a report on V-DISC data. DJJ reports that the V-DISC data will be further analyzed, and then interventions for high frequency disorders will be identified and developed.
Training in evidence based treatment for high frequency disorders.	7	6		NC	BC	BC	NC	NC		Select staff members at Ventura and Chad and other DJJ staff have begun participation in a DBT reading group, which precedes a DBT pilot on 1 ITP in each of those facilities. No other training on evidence-based treatments for high frequency disorders has occurred.
8.0 POLICIES AND PROCEDURES									
Develop comprehensive set of	8	1							

essential MH policies and procedures in consultation with Consent Decree MH experts		a			
Master table of contents completed for MH policies.	8	1 a 1	S C		This was completed in 2007
Master schedule completed for updating MH policies.	8	1 a 2	P C		A number of policies have been referred for completing through the charter process, and to not have a date for completion.
Policies updated per schedule. TDOs as needed.	8	1 a 3	P C		DJJ has completed all but 3 of the MH policies which are wholly contained within DJJ MH purview: schedule: the case management and reentry policies are part of a charter process. DJJ reports that the initial assessment policy is awaiting completion of the IBTM description, so it can be consistent. There are a number of other policies that haven't been written, which DJJ MH attributes in part to the need to coordinate with other parts of DJJ.
Staff trained on new policies.	8	1 a 4	P C		Training has been provided to pertinent staff on the MH policies that have been implemented.
Coordinate psychopharmacological policy with HC Services Plan.	8	1 b	S C		The psychopharmacology policy has been implemented, and staff trained. It is consistent with the HC Services Plan.
Develop/modify policies and procedures in selected areas for youth with mental health issues	8	2			
Use of force/use of restraints.	8	2 a	P C		See narrative at beginning of report, under Areas of less than Substantial Compliance, #5. Because of this item's importance in programming, achieving SC is a priority. The Use of Force Policy has been updated. Because of concerns regarding UoF on youth with disabilities and on the MH caseload, the Plaintiffs Attorney asked the S&W, WDP and MH experts to conduct an investigation on the UoF with these populations. The investigation is on-going. During the Stark site visit, it was noted that the CTC was using a helmet as a clinical intervention on an acutely agitated youth, which is outside of DJJ MH policy and community standards of MH. The DJJ Chief Psychiatrist was present during the site visit, and ordered an immediate halt to the use the helmet.

Disciplinary process.	8	2 b	P C		See narrative at beginning of report, under Areas of less than Substantial Compliance, #6. Because of this item's importance in programming, achieving SC is a priority.
9.0 MENTAL HEALTH RECORDS					
Review records system to reduce redundancy & improve info access.	9	1	P C		DJJ MH has taken an initial review of forms and removed obsolete forms. Some electronic templates are being developed for frequently used forms, and the organization of the MH section has been revised. New MH tabs have been submitted to the printing office for completion.
Identify/develop automated records system re issues in 9.1.	9	2	B C		DJJ is in the early process of modifying the WIN system to better support MH record keeping and clinical access. Forms and templates are being modified and developed. The MH progress note template is about to be implemented.
Coordinate records system with HC Services Plan.	9	3	P C		The HC Medical Records Administrator is involved in form revision and electronic template development.
10.0 QUALITY MANAGEMENT AND PEER REVIEW					
Develop internal MH audit system consistent with MH & HC Services Remedial Plans.	10	1	B C		A MH peer review tool has been developed. The MH peer review policy is reported to be in the final stages of approval.
Implement quality mgmt and peer review through HC Services Plan.	10	2	B C		DJJ reports that the MH peer review policy is in the final stages of approval, and shortly after, MH peer review will be implemented.
11.0 FACILITIES					
Plan new MH facilities to conform with principles in MH Remedial Plan.	11	3	N C		DJJ has not presented any plans for new MH facilities.
Develop technology plan for residential MH programs and staff.	11	4	N C		DJJ has not presented a technology plan for residential MH programs and staff.

EDMUND G. BROWN JR.
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DEPARTMENT OF JUSTICE

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November 17, 2009

Eric Trupin, Ph.D.
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2815 Eastlake Avenue East, Suite 200
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Terry M. Lee, M.D.
Division of Public Behavioral Health & Justice Policy
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Seattle, WA 98102

RE: Margaret Farrell v. Matthew Cate
Superior Court of California, County of Alameda, Case No. RG 03079344

Dear Drs. Trupin and Lee:

Thank you for providing the California Department of Corrections and Rehabilitation's Division of Juvenile Justice (DJJ) with the opportunity to comment upon the 2008-2009 Site Visit Summary for the first round of audits. The Mental Health staff at each of the five facilities, in addition to DJJ Headquarters staff, appreciate your efforts, comments, and professionalism. DJJ submits the following comments for your consideration. Additionally, the matrix response is attached for your review, which includes administrative comments as well as mental health comments. DJJ requests, and looks forward to, your response to these comments and recommendations.

Recognizing that its response is overdue, DJJ wishes to explain the reason for the delay. In addition to the usual clinical audit response, in which DJJ objects on a substantive basis to an audit rating, this report's audit responses were confusing and required a significant period of analysis and interpretation before DJJ could begin its clinical response. Significant DJJ staff resources were required to decipher which ratings were repeated, as well as what the experts' intended rating for a particular audit item actually was. Consequently, given the substantial confusion surrounding the majority of the experts' ratings and comments, this report was not as helpful to DJJ as DJJ would prefer it to be.

1. **Suicidal Behavior.**

(b) and (c): It is not the case that youth in DJJ are denied effective treatment for suicidal and self-harming behavior. Although Dialectical Behavioral Treatment (DBT) has not yet been trained on (see below), DJJ developed a new Suicide Prevention and Response (SPAR) Policy, presently implemented statewide, to address the management and treatment of self-harming youth. As part of the new DJJ SPAR Policy, youth who are placed on suicide risk reduction are 1) placed into the appropriate level of safety precaution; and 2) evaluated by a mental health clinician, at which time an Individualized Focal Treatment Plan (IFTP) is initiated. An IFTP is a goal-oriented, strength-based, individualized treatment plan developed by a mental health clinician with input from the treatment team when the youth is initially placed on Suicide Watch, Suicide Precaution or Follow-up Status. This Plan provides clinical and non-clinical staff with specific guidelines to address youth who have recently engaged in self-injurious behavior.

The IFTP includes a review of the following elements:

- Precipitant or stressors that may have contributed to the youth's fragile psychological state;
- A differential diagnosis;
- The treatment team's immediate goals for the youth;
- The youth's areas of strength;
- The individual, family, school, and system factors that may have influenced the youth's behavior, and contributed to his or her fragile emotional state; and
- Custody, school, clinical and system interventions recommended for the youth.

The possible clinical interventions include referral to medical; referral to psychiatry; laboratories; individual therapy; group therapy; behavioral interventions; behavioral groups; safety management plan; psychoeducation; anger management; psychological testing; behavior/reward plan; relaxation techniques; feeling sheets; general list of coping skills; sleep chart; journal and others. The FTP also indicates if the youth is part of the Wards with Disabilities Program, and specifies what the youth needs to have successfully completed to be placed in a lower level of care. The FTP is shared and discussed with the youth.

DJJ clinicians use their professional expertise to decide what interventions will be used while the youth undergoes suicide risk reduction. The clinicians use an array of treatment modalities to include Cognitive Behavioral Treatment (CBT), Psychodynamic Psychotherapy, Supportive Individual Psychotherapy, and Family Systems based Therapy. DBT is also used by a few of DJJ's clinicians, and N.A. Chaderjian currently has DBT group therapy, Behavioral Analysis and Behavioral Modification, Cognitive Restructuring, Crisis Intervention, Trauma Focused Interventions, and Systems Focus Treatment.

(c) and (f): Contrary to the information contained in the Summary, it is not true that suicidal and self-harming youth are treated in isolated confinement. The new DJJ SPAR Policy was

developed to ensure that suicidal youth are placed in a safe environment where they can receive the appropriate services during their emotional, fragile state. The intent of the new SPAR Policy is to ensure safety and to engage the youth through interventions without isolating them from peers and support groups

(d): The DBT pilot programs are scheduled for March 2010 at Ventura and N.A. Chaderjian YCFs. DJJ has a contract with Behavior Affiliates, Inc. to implement the pilot programs and train staff.

(f): The SPAR Policy is very clear that youth on suicide risk reduction, if clinically indicated, will be provided services in the less restrictive environment. With the implementation of the new policy, DJJ no longer uses clocked video observation rooms or mock gear. The SPAR Policy mandates that the youth receive services during suicide risk reduction in their living units, and are allowed to participate as much as possible in regular programming.

3. **Licensed Mental Health Beds.**

DJJ disagrees with your assertion that Northern California males "do not have adequate access to acute licensed mental health beds." Males from Northern California are placed in contracted beds at Sierra Vista Hospital, which has Correctional Treatment Center (CTC) level of care. DJJ's contract with Sierra Vista Hospital is working well; DJJ renewed its contract with Sierra Vista Hospital and continues to utilize it for Northern California youth. DJJ also transports some Northern California youth to the CTC at Heman G. Stark YCF.

Females who need a higher level of care are placed in the CTC at Stark. They may stay longer than males at the CTC, since DJJ presently does not have an Intermediate Care Facility (ICF) Level of Care for females 17 years old or younger. The travel time from Ventura to Ontario is not extensive. DJJ has entered into discussions with DMH regarding services for females in the ICF at Metropolitan State Hospital. However, DMH does not take any person under the age of 18. The only current placement option for DJJ's female youth under age 18 continues to be the CTC at Heman G. Stark YCF. However, DJJ is currently discussing alternatives for the provision of licensed psychiatric care of youth in Northern and Southern California. DJJ is actively contacting community psychiatric hospitals in Southern California to attempt to develop new contracts for acute and intermediate care.

4. **Peer Review.**

A mental health peer review process has not been implemented. A small pilot was conducted using a new Peer Review Form to examine the form's effectiveness and ease of use. The new MH Peer Policy is presently awaiting final legal review and signature. The new policy ensures that every quarter, several clinical notes are reviewed for appropriate care. In addition, the new MH Peer Review Policy creates a centralized peer review committee that keeps track of all peer reviews and corrective action plans for those clinicians showing deficiencies in the way they

provide care to the youth. In the near future, DJJ expects that the mental health and health care services peer review policies will be merged into one policy.

5. Definition of Mental Health Youth.

DJJ now has a uniform definition for Mental Health Youth:

A Mental Health Youth is a youth who has a mental health condition that impairs his or her psychological and social functioning, and/or has been diagnosed with a DSM-IV-TR Axis I diagnosis, except if the youth has only one of the following:

- Sole diagnosis of **any** Conduct Disorder;
- Sole diagnosis of **any** Sexual Disorder;
- Sole diagnosis of **any** Substance Disorder; or
- A youth receiving psychotropic medication and/or a youth that has had suicidal or homicidal ideation in the last six months.

7. DDMS.

DDMS policy is implemented throughout all five DJJ facilities even though a grievance was filed. Reviews are occurring and a process for modifying the disposition or DDMS is in place. The Chief Psychiatrist is reviewing the Level 3's and is modifying or approving them based upon his thorough review.

The policy was implemented in April 2009, and we have an 85% reduction in the number of time adds for mental health youth.

8. Family Participation.

DJJ facilities do have family therapy available, and have family events on a quarterly basis. Proofs of practice have been sent out to this effect. The charter for Family Engagement has started meeting, which includes a Mental Health Clinician as a member. All sites have begun family engagement activities and initial training has been completed.

9. Training in New Programs.

DJJ disagrees with the experts' comment that "suicide training was a generic educational training" and "inappropriate" for non-clinicians. Since the role of the MH clinicians in core units is to provide education, clinical support and coaching to non-clinicians, DJJ felt that the

clinicians needed to participate in the training so that they knew the information that was provided to non-clinical staff so that they would be able to provide better coaching and support.

DJJ looks forward to receiving your response to the foregoing comments and recommendations.

Sincerely,

TODD DARROW IRBY
Deputy Attorney General

For EDMUND G. BROWN JR.
Attorney General

Attachment: Referenced above.

cc: Michael K. Brady
Rachel Stern
Juan Carlos Arguello
Dorene Nylund
Rick Flynn
Thy Vuong
Doug Ugarkovich
Yvette Marc-Aurele

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POLICY BULLETIN (PB)			
Subject: Suicide Prevention, Assessment, and Response			
PB Number: 08-06	**Approval Date:1/9/09**		
California Department of Corrections and Rehabilitation **Division of Juvenile Justice**	Manual:	Revision #:	Section #:
	☐ Administrative (YAM)		
	☐ Education Services (ES)		
	☒ Institutions and Camps (I&C)	81	6263
	☐ Parole Services (PS)		
	☐ Special Education (SE)		

The purpose of this Policy Bulletin (PB) is to provide all Division of Juvenile Justice (DJJ) Institutions and Camps manual holders with information regarding the attached new DJJ policy for Suicide Prevention, Assessment, and Response.

The policy has been revised in response to implementation issues experienced during the pilot program at the N.A. Chaderjian Youth Correctional Facility.

Instructions

This PB contains changes to the above reference manual(s). To update your manual(s), please follow the directions below step by step.

1. Locate the correct manual(s), as marked above.

2.

Remove	Insert	Special Instructions
Suicide Prevention, Assessment, and Response (SPAR), I&C Manual, Section 6263-6272, Revision Date 03/13/08	Suicide Prevention, Assessment, and Response (SPAR), I&C Manual, Section 6263	
N/A	• Clinicians' Orders, DJJ 8.002 • Critical Factors Assessment for Determining Need for Mental Health Evaluation, DJJ 8.271 • Focal Treatment Plan: Follow-Up Status, DJJ 8.067 • Focal Treatment Plan: Suicide Precaution, DJJ 8.066 • Focal Treatment Plan: Suicide Watch, DJJ 8.068 • Focal Treatment Plan: Treatment Team Acknowledgement, DJJ 8.069 • Interdisciplinary Chronological Progress Notes, DJJ 8.003 • Intrasystem Transfer Screening, DJJ 8.023 • Mental Health Referral Form, DJJ 8.039	Insert the forms behind index in alphabetical order

	• Receiving Health Care Screening, DJJ 8.031 • Serious Incident Report, DJJ 8.036 • SPAR: 5 Minute Suicide Watch Record DJJ 8.228 • SPAR: Suicide Observation Record, DJJ 8.286 • SPAR: Suicide Risk and Screening Questionnaire, DJJ 8. 281 • Suicide Risk Response Tracking Log, DJJ 8.229 • Suicide Risk Response Status: Release Treatment Plan, DJJ 8.070	

3. Update the Revision Record Log (first page of the manual) using the revision number reference above.

This cover sheet does not need to be archived in the manual, only the attached items.

Please inform all persons concerned of the contents of this PB, which shall be maintained and the information contained in this PB utilized. Please direct any inquiries to Dolores Slaton, Policy, Procedures, Programs, and Regulations (PPP&R) Unit Manager, at (916) 262-1431.

Original Signed by

BERNARD E. WARNER
Chief Deputy Secretary

Attachments

DIVISION OF JUVENILE JUSTICE

Suicide Prevention, Assessment, and Response

Mental Health

Manual	Section #	Replace(s)
☐ Administrative (YAM)		
☐ Education Services (ES)		
☒ Institutions and Camps (I&C)	6263	6263-6272
☐ Parole Services (PS)		
☐ Special Education (SE)		

Signature/Approval Date

BERNARD E. WARNER
Chief Deputy Secretary

1/9/09
Approval Date

Policy

This policy establishes standards of training, assessment, intervention, response, and program monitoring for suicidal and self-injurious behavior to reduce the risk of injury to youth from these behaviors.

Expression of suicidal ideations, feelings, and self-injurious behaviors constitute a health care emergency which requires immediate and effective action. All Direct Care Staff in Division of Juvenile Justice (DJJ) facilities shall immediately report and respond to any communication or action indicating a youth is, or may be, thinking of suicide or self-injurious behaviors and take all necessary precautions to prevent self-harm. Any DJJ facility employee who becomes aware of a youth with current suicidal ideations, attempts at suicide, threats, or acts of self-injurious behavior shall immediately intervene with the youth, provide 1:1 staff supervision, notify a member of the Health Care Staff, and contact the Duty Lieutenant or designee.

Suicidal ideations, feelings, and self-injurious behaviors exhibited by youth are indicators of an increased level of psychological and/or psychosocial distress. Living Unit staff have the responsibility to respond to the individual's distress, resulting in decreased safety in the Living Unit (community), by confronting the precipitants of the distress and applying appropriate interventions. As soon as is clinically appropriate, and as often as necessary, following a suicidal ideation, threat, or act, the youth and Living Unit staff shall meet in large and/or small group settings to engage in guided interactions. With the guidance of staff, youth are encouraged to take accountability for their actions and to listen to the advice of their peers. The goal of these community and small group meetings is to empower the youth to make positive changes, re-establish the conditions of safety, reinforce respect for each other, and to assess, establish, and modify achievable goals.

Scope

The DJJ Suicide Prevention, Assessment and Response (SPAR) policy affects all youths, Direct Care Staff, and volunteers in DJJ facilities.

Authority

- Welfare and Institutions Code, Sections, 1000, 1004, 1712, 1751, and 5150
- California Code of Regulations, Title 15, Division 4, Section 4744

Related Standards/ References

- National Commission on Correctional Health Care: Correctional Mental Health Care Standards and Guidelines for Delivering Services: M-G-05
- Crisis Prevention and Management, I&C Manual, Section 2080
- Youth Search, I&C Manual, Section 5015
- Notice of Serious Injury, Illness or Death of a Youth, I&C Manual, Section 5515
- Medical Reception, I&C Manual, Section 6167
- Intrasystem Transfer, I&C Manual, Section 6169
- Medical and Dental Services, I&C Manual, Section 6172
- Medication Administration, I&C Manual, Section 6187
- Emergency Services, I&C Manual, Section 6209
- First Aid, I&C Manual, Section 6246
- Outpatient Housing Unit, I&C Manual, Section 6246.5
- Sentinel Events, I&C Manual, Section 6249.6
- Mortality Review, I&C Manual, Section 6249.7
- Receiving Health Care Screening, I&C Manual, Section 3271

Related Remedial Plan or Court Order

Farrell Lawsuit	**Other Lawsuits & Court Orders**
☒ Safety and Welfare	☐ L.H. Lawsuit
☐ Education Services	☐ Other: _____
☐ Wards with Disabilities Program	
☒ Mental Health	
☒ Health Care Services	
☐ Sexual Behavior Treatment Program	

Requirements

This policy has a training requirement:	☒ Yes	☐ No
This policy has an audit requirement:	☒ Yes	☐ No
This policy has restricted distribution:	☐ Yes	☒ No
This policy requires annual review:	☒ Yes	☐ No
This policy requires a local procedure:	☐ Yes	☒ No

Revision Date(s)

- Sections 6263-6266, 10/11/02
- Section 6267, 11/05
- Section 6268, 4/16/06
- Section 6269, 4/16/06

Effective Date March 10, 2009

DEFINITION(S)

1:1 Observation – Supervision of one (1) youth by one (1) Facility Staff member. 1:1 Observation is initiated by any employee identifying a youth with a risk of suicide and continues through Suicide Watch. Facility Staff shall remain as close to the youth as required to immediately respond to any attempt at self-harm and shall maintain clear visual and auditory contact with the youth.

Case Conference – A meeting involving members of the Treatment Team used to discuss treatment planning and progress of the youth.

Constant Observation – Supervision by Facility Staff providing clear, unobstructed, visual, and auditory contact with youth while on Suicide Precaution. The Facility staff shall be able to respond to any attempt at self-harm. With written approval from a mental health clinician, one (1) Facility Staff may supervise up to three (3) youth on Suicide Precaution.

Direct Care Staff – Staff members, volunteers, and contract staff who have routine contact with youth, including youth care staff, teachers, chaplains, counselors, nurses, and food care workers who supervise youth.

Facility Staff – Correctional Peace Officer staff who have been trained in the Suicide, Prevention, Assessment, and Response Program and who provide behavior management, programming, and support services to youth.

Facility Suicide, Prevention, Assessment, and Response Committee – A committee, under the direction of the Facility Superintendent and in collaboration with Chief Psychologist or Senior Psychologist, which monitors the facility's policy implementation and compliance with the statewide Suicide, Prevention, Assessment, and Response Program.

Focal Treatment Plan – A goal oriented, strength-based, individualized treatment plan developed by a psychologist or psychiatrist with input from the Treatment Team. It is developed when the youth is initially placed on Suicide Watch, Suicide Precaution, or Follow-up Status and updated as clinically indicated.

Health Care Professional Staff – Includes all Physicians, Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Technicians, Nurse Practitioners, and Physician Assistants.

Mental Health Clinician – A Psychologist or Psychiatrist.

Mental Health Professional Staff – A Psychologist, Psychiatrist, or Licensed Clinical Social Worker who, by virtue of their education, credentials, and experience, are permitted by law and scope of practice to evaluate and care for the mental health needs of youth.

Mental Health Subcommittee – A sub-committee, under the direction of a Senior Psychologist, responsible for identifying quality of care problem areas and making recommendations to the Facility Quality Management Committee and Chief Psychiatrist regarding changes in practices that will lead to improvement of patient outcome. The Mental Health Subcommittee membership shall include a Psychiatrist, Senior Psychologist, Supervising Registered Nurse, Chief of Security, and any other member as deemed necessary. The Chairperson shall be a Senior Psychologist. *See Quality Management Policy.*

Self-Injurious Behavior – Intentional, self-destructive behavior that may be accompanied by suicidal ideation and/or intent to cause death. The purpose of the behavior may be to commit suicide, experiment with the possibility of suicide,

or gain attention. Self-injurious behavior may require intervention by medical and/or Facility Staff and may indicate an increase in suicide risk.

Suicide – Intentional, self-injurious behavior that causes or leads to one's own death.

Suicidal Ideation – Thoughts of suicide or death, which can be specific or vague, and may include active thoughts of committing suicide or the passive desire to be dead. Suicidal ideation may occur with or without the intent to act upon them.

Suicide Risk Level – A HIGH, MODERATE, or LOW level of risk assigned to a youth by a Casework Specialist or other trained staff, on admission to the Division of Juvenile Justice. This determination is made following an interview with the youth, after the completion of a file review, and after the administration of a Suicide Risk and Screening Questionnaire.

Suicide Risk Reduction Status – The process in which Division of Juvenile Justice will respond and intervene when a potentially suicidal youth is identified. The Division of Juvenile Justice will attempt to normalize the youth's environment through the following four (4) levels:

- **Suicide Intervention** – 1:1 Observation initiated by any Division of Juvenile Justice employee for youth who have been identified as having a risk of suicide.
- **Suicide Watch** – Constant 1:1 Observation and mental health interventions for youth who have been determined by a mental health clinician to be in immediate and grave danger of committing suicide.
- **Suicide Precaution** – Constant Observation and mental health intervention provided for youth who are at serious risk of engaging in self-injurious behavior.
- **Follow-Up Status** – Observations and mental health interventions for youth requiring follow-up treatment for recent history of suicidal ideation or behavior.

Suicidal Threat – Verbalization of the intent to commit suicide or to harm one's self.

Treatment Team – Mental health, facility, and other staff who meet to discuss the youth's treatment plan and progress. Members of the Treatment Team include Psychologists, Psychiatrists, Casework Specialists, Parole Agents, Licensed Psychiatric Technicians, Youth Correctional Counselors, and Education staff.

TRAINING

The direct supervisor for each employee shall ensure the completion of all training requirements as described. The content of all SPAR training shall be approved by the Chief, Mental Health Services.

Direct Care Staff

The Superintendent or designee shall ensure that all Division of Juvenile Justice (DJJ) employees and volunteers who have routine contact with youth at DJJ facilities receive training in the SPAR Policy and procedures within 30 days of employment. This training shall include:

- Environmental factors in suicide and prevention
- Predisposing factors and stressors

- Suicide risk periods
- Warning signs, symptoms, and behaviors
- Common methods of suicide and self-injurious behavior
- An overview of the DJJ SPAR Program procedures including:
  - Suicide risk assessments intervention techniques for suicide ideation, threats, gestures, and attempts
  - Reporting of suicidal or self-injurious behavior
  - Appropriate emergency responses to attempts or gestures
  - Suicide reviews
- Characteristics of suicide watch and suicide precaution observation
- Liability issues associated with youth suicide
- Treatment Confidentiality

All Direct Care Staff shall receive two (2) hours of annual refresher training including:

- A review of predisposing factors, warning signs, symptoms, and behaviors
- A review of the SPAR program and all policy and procedure changes initiated within the last year
- A general discussion of any recent suicidal or significant self-injurious behavior

Health Care Professional Staff and Facility Staff

All Health Care Professional Staff and Facility Staff shall receive additional training in:

- The psychology of the suicidal or self-injurious youth
- Long term and immediate risk factors
- The use of emergency equipment located in each housing unit
- Administration and interpretation of the SPAR: Suicide Risk Screening Questionnaire (SRSQ) form

Mental Health Professional Staff

All Mental Health staff shall receive additional training in:

- A review of DJJ approved assessment tools, the appropriate use of the tools, and the procedures to initiate these assessments
- Focal Treatment Planning

Mental Health Staff and Case Work Specialists

All Mental Health and Case Work Specialists shall receive training in areas to be covered with the family of youth placed on any Suicide Risk Reduction (SRR) Level.

Additional Individuals or Groups

Additional training shall be provided to individuals or groups identified as requiring instruction.

QUALITY ASSURANCE

Facility Suicide Prevention, Assessment, and Response Committee

Each facility shall establish a Facility SPAR Committee under the direction of the Facility Superintendent.

At a minimum, the Facility SPAR Committee shall consist of: the Chief Medical Officer (CMO); a representative from Facility Administration, Religious Services, Education Services, Health and Safety Program, Health Care Services, Nursing Services, Plant Operations, Security, Support Services, and Facility Training; and one (1) clinical and one (1) non-clinical representative of the Mental Health Treatment Team.

The Facility SPAR Committee shall meet monthly in anticipation of the Mental Health Subcommittee meeting and after each episode of significant self-injurious behavior.

The Facility SPAR committee shall:

- Ensure implementation and compliance with the statewide SPAR Program policies and procedures including the use of the least restrictive housing consistent with the safety of the youth
- Plan, develop, update, and monitor local operating procedures implementing the statewide SPAR policy and required clinical services
- Collect, analyze, and submit data on self-injurious behavior and threats to the Superintendent, and to the Mental Health Subcommittee
- Review all significant self-injurious behavior requiring medical or Facility Staff intervention for the appropriateness of the response
- Annually inspect all Living Unit rooms to identify potential self-injury risk concerns
- Submit monthly Facility SPAR Meeting Minutes covering all relevant data collection, reports, findings, and recommendations to the Superintendent and the Mental Health Subcommittee
- Establish procedures to ensure training of all employees according to statewide policy and to provide additional training to groups or individuals when required
- Monitor Mental Health Quality Improvement Plans for the SPAR Policy
- Provide an annual summary of compliance with the SPAR Policy to the Superintendent, the Mental Health Subcommittee, and the Head Quarters Mental Health Management Team. The summary shall include:
    - A summary of self-injurious behavior
    - Corrective action plans completed and in progress
    - Training completed and in progress
    - Number of staff trained and not trained, and barriers to completion
    - Number of youth placed on Suicide Watch, Suicide Precaution, and Follow-Up Status
    - Total number of days youth were on each SRR Level

- Average stay on each SRR Level

- Within one (1) week of any significant self-injurious behavior, prepare and submit a report for the Mental Health Subcommittee identifying:
  - The circumstances surrounding the event
  - Facility procedures relevant to the incident
  - Pertinent Medical and Mental Health Services/reports involving the youth
- In addition to the above, a report of a successful suicide shall include:
  - All relevant training received by the involved staff
  - Possible precipitating factors leading to the suicide
  - Recommended changes, if any, in policy, training, physical plant, medical or mental health services, and operational procedures. *See Mortality Review Policy*
- Additional reports will be forwarded to the Medical Director, Chief Psychiatrist, Mental Health Services, or designee, as they become available (e.g. autopsies, ect.).
- Ensure daily tracking of all youth on each SRR Level

The Chief Psychologists shall communicate any additional concerns or difficulties regarding Mental Health Quality Management to the Head Quarters Mental Health Quality Management Team.

Mental Health Quality Improvement Indicators

Quality Improvement Indicators shall include:

- A quarterly review by the Chief Psychiatrist, Mental Health Services, or designee, of the timeliness and content of all Facility SPAR Committee minutes and reports with recommendations for corrective action
- A quarterly review by the Superintendent or designee of the timeliness of all new and annual employee SPAR training documentation
- A quarterly review of 20 randomly selected charts of youth on SRR Status to determine:
  - Compliance with mandated screening requirements
  - 1:1 Observation maintained during Suicide Intervention and Suicide Watch
  - Compliance with mandated notifications after self-injurious behavior including parents or guardian, Superintendent, Psychiatrist and/or Psychologist, and Chief Psychiatrist or Senior Supervising Psychiatrist
  - Timeliness of assessments and screenings after self-injurious behavior
  - Presence of required documentation by a Licensed Psychiatric Technicians, Psychiatrist, Psychologist, and Casework Specialist/Parole Agent (PA) I for each level of SRR Status
- A quarterly review of 20 randomly selected charts of youth placed on SRR Status that is completed by a clinician assigned by the Chief Psychologist or designee to determine:
  - Reason for placement on Suicide Intervention, Suicide Watch, Suicide Precaution, and Follow-Up Status adequately documented

- Number of hours door was closed while youth was on Suicide Watch and Suicide Precaution and adequacy of explanation provided
- Use of restrictions for privileges and programs clinically indicated and documented in the Unified Health Record (UHR) and Focal Treatment Plan for Suicide Watch and Suicide Precaution
- Focal Treatment Plans were appropriate, were implemented, and were followed

- Monthly review by a Senior Psychologist, Supervisor, or designee, of the Suicide Risk Response Tracking Logs to review the frequency of placement in SPAR Program, the appropriateness of the level of observation, and post SPAR Program placement.

Monitoring Mechanisms

The CMO, Chief Psychologist, and Senior Psychologist shall ensure timely monitoring of the Mental Health Quality Improvement Indicators. Monitoring results shall be reported to the Facility's SPAR Committee for review. Results and recommendations of the analysis shall be given to the Mental Health Subcommittee and Quality Management Committee for review and action.

PROCEDURES

Suicide Screening and Prevention

Screening for self-injurious behavior shall be completed using the Suicide, Prevention, Assessment, and Response (SPAR): Suicide Risk and Screening Questionnaire (SRSQ). Initial response to the SPAR: SRSQ form shall be determined by the youth's score:

Score	Suicide Risk Level	Response
0 – 4	LOW	Continue normal program and observe.
6	MODERATE	Immediately contact the on-site or on-call mental health clinician for discussion of placement on Suicide Intervention.
8 - 22	HIGH	Initiate Suicidal Intervention and 1:1 Observation. Refer the youth to a mental health clinician for a face-to-face evaluation

All SPAR: SRSQ form interviews for self-injurious behavior will be conducted in a confidential setting whenever possible.

If a youth refuses to participate in the administration of a SPAR: SRSQ form, Facility Staff shall make several attempts to engage the youth's cooperation.

During second (2nd) and third (3rd) Watch, if the youth remains uncooperative, a Licensed Psychiatric Technician shall be contacted for assistance whenever possible. On first (1st) Watch, a youth who refuses to cooperate with the administration of a SPAR: SRSQ form shall be placed on Suicide Intervention until seen by a mental health clinician the next morning.

The SPAR: SRSQ form may be administered to a youth identified as potentially suicidal by any Health Care or Mental Health Professional Staff, or any Facility Staff who has been trained in the administration of the form.

Suicide assessment requires on-going measurements of the youth's current risk factors. All youth shall be periodically assessed during their stay at the Division of Juvenile Justice (DJJ). Screening of every youth for potential self-injurious behavior shall occur through the following process:

- The SPAR: SRSQ form shall be administered within one (1) hour of intake into a facility.
- The SPAR: SRSQ form shall be administered to a youth upon placement in Temporary Detention and daily thereafter.
- The SPAR: SRSQ form shall be administered to a youth placed in a Behavior Treatment Program and, at a minimum, weekly thereafter.
- The SPAR: SRSQ form shall be administered to a youth placed on an Alternative Program and, at a minimum, weekly thereafter. This includes self-restrictive programs chosen by a youth.
- The SPAR: SRSQ form shall be administered after adjudication when a youth is returned to the facility from court, e.g. new charges, additional sentences, time-adds, denial of release, or parole.
- The SPAR: SRSQ form shall be administered daily to a youth placed on Suicide Watch, Suicide Precaution, or Follow-Up Status.

- The SPAR: SRSQ form shall be administered at any time a youth is suspected of or identified as potentially self-injurious.
- A Registered Nurse (RN) shall review the suicide questions on the Receiving Health Care Screening form with a youth immediately upon initial intake into the facility. *See Medical Reception Policy*
- At the time of a transfer from one DJJ facility to another or from the Department of Mental Health, a chart review and interview with the youth shall be conducted by a RN to evaluate the youth's mental health status. The mental health section of the Intrasystem Transfer Screening form shall be completed. If there is any indication of self-injurious behavior, a Mental Health Referral form shall be completed and forwarded to mental health staff. The youth shall be placed on Suicide Intervention until a face-to-face evaluation by a mental health clinician has been completed.

Information on current or past suicide risk factors and/or depression can be obtained as part of the ongoing suicide assessment. This information can be obtained from assessments or screening tools such as, but not limited to:

- Drug Experience Questionnaire
- Youth Assessment and Screening Instrument
- Voice Diagnostic Interview Schedule for Children (V-DISC): Administered and interpreted within 72 hours of initial intake into a DJJ facility
- Critical Factors Assessment for Determining Need for Mental Health Evaluation form: Completed by a Parole Agent (PA) III or designee upon initial intake into DJJ and indicates a youth's Suicide Risk Level.
- The SPAR: Suicide and Mental Health Alert form: Completed during the initial intake by the intake Casework Specialist/designee and updated as needed by Facility Staff.

Additional precautions to prevent self-injurious behavior for all youth shall include:

- The Suicide Risk Level: Evaluated and updated at each Case Conference by a mental health clinician.
- Upon intake, any youth obtaining an assigned High or Moderate Suicide Risk Level shall be placed on 1:1 Observation.
- Suicide prevention methods shall be included in individualized mental health treatment plans for youth with elevated suicide or depression assessments.
- All medications, sharp instruments, keys, cleaning agents, and other potentially self-injurious instruments shall be kept secure or under immediate staff supervision.
- Special attention shall be given to a youth on Suicide Intervention, Suicide Watch, and Suicide Precaution when the youth is showering or using the toilet.
- Special attention to medication administration procedures shall be used to prevent hoarding, overdosing, or discarding of medications.
- Communication between Health Care, Facility, Education, Religious, and Youth with Disabilities Program staff shall occur through the Individualized Treatment Plan, Case Conferences, and individual discussions.
- Routine room searches and searches of a youth by Facility Staff shall occur to locate items that may be used for self-harm.

Suicide Risk Level

A Suicide Risk Level shall be identified by an intake Casework Specialist or designee during initial intake into DJJ through a review of the Field File, an interview with the youth, completion and review of the Critical Factors Assessment for Determining Need for Mental Health Evaluation form, and completion of the SPAR: SRSQ form. A youth will remain under routine observation until a Suicide Risk Level is assigned.

A Suicide Risk Level shall be identified by a PA III or designee when a youth is transferred to a facility. The level will be determined within one (1) hour of intake and following an interview with the youth, a review of the Field File, and completion of a SPAR: SRSQ form. An additional Suicide Risk Level evaluation shall be completed within one (1) hour of placement in a room setting and within four (4) hours of placement in an open dorm setting by a member of the Treatment Team.

Modification of a youth's Suicide Risk Level can be completed by a mental health clinician.

A Casework Specialist or designee setting a youth's initial Suicide Risk Level or Mental Health Professional evaluating a youth for changes in their Suicide Risk Level shall use the following criteria to determine a youth's Suicide Risk Level:

High Suicide Risk Level

High Suicide Risk Level shall be initially set or maintained if the youth has demonstrated the following indicators:

- Self-injurious behavior within the last two (2) months
- History of suicide by a family member or close friend within the last two (2) months
- Current significant symptoms of depression
- Current significant psycho-social stressors
- A current absence of supportive resources
- At the discretion of a mental health clinician and based on clinical indications

Moderate Suicide Risk Level

A youth's Suicide Risk Level may be initially set or lowered to a Moderate Suicide Risk Level if the following indicators are present:

- Self-injurious behavior within the last six (6) months
- An absence of supportive resources within the last six (6) months
- Significant symptoms of depression within the last six (6) months
- Significant psycho-social stressors within the last six (6) months
- History of suicide by a family member or close friend within the last six (6) months
- At the discretion of a mental health clinician and based on clinical indications

Low Suicide Risk Level

A youth's Suicide Risk Level may be initially assigned or lowered to a Low Suicide Risk Level if the following indicators are present:

- Absence of self-injurious behavior within the last six (6) months
- No absence of supportive resources within the last six (6) months
- Absence of significant symptoms of depression within the last six (6) months
- Absence of significant psycho-social stressors within the last six (6) months
- Absence of history of suicide by a family member or close friend within the last six (6) months
- At the discretion of a mental health clinician and based on clinical indications

Suicide Risk Reduction Status

The purpose of Suicide Risk Reduction (SRR) status is to:

- Respond to or prevent self-injurious behavior
- Facilitate discussion of factors or events which precipitated the self-injurious behaviors
- Respond with active listening and other supportive, therapeutic interventions used by staff
- Assist a youth with emotional coping skills

Unless clinically contraindicated, youth shall remain in standard DJJ clothing while on SRR status. Youth shall be searched when placed on any level of SRR status. This search shall include the surrounding area and the removal of all clothing to ensure potentially harmful items are not available to the youth. Belts, necklaces, shoelaces, and other potentially self-injurious items shall not be permitted.

Suicide Risk Reduction Status: Suicide Intervention

Placement

Any DJJ employee aware of a youth with a risk of self-injurious behavior shall immediately place the youth on Suicide Intervention and shall remain with the youth until relieved by assigned Facility Staff.

Housing

Youth placed on Suicide Intervention shall be housed on their Living Unit unless transferred to the Out Patient Housing Unit (OHU) by a mental health clinician.

The door to the youth's room shall remain open, as much as safely possible. The door may be closed temporarily:

- To prevent injury to the youth or others as a result of the youth's agitated or out of control behavior
- For the safety and security of the unit during movement of other youth

- For the safety and security of the youth in the event of an emergency situation where there is a threat of harm to the youth

Facility Staff shall contact the on-site or on-call mental health clinician for discussion, consultation, and treatment planning. The mental health clinician shall consider the youth for transfer to an OHU, a Correctional Treatment Center (CTC), acute psychiatric hospital, or for emergency treatment if:

- The youth's door remains closed as a result of the youth's agitated or out of control behavior for a total of more than four (4) cumulative hours within a 24 hour period during 2nd, and 3rd Watch
- The door remains closed for more than 30 consecutive minutes during 2nd or 3rd Watch

The decision to transfer the youth to a CTC, acute psychiatric hospital, or for emergency treatment shall be based on the clinical condition of the youth.

1:1 Observation

Staff assigned to 1:1 Observation shall remain as close to the youth as required to immediately respond to any attempt at self-injurious behavior. Staff shall maintain clear visual and auditory contact with the youth.

1:1 Observation is the sole responsibility of staff assigned to this task.

Facility Staff shall be contacted as soon as possible to provide constant 1:1 Observation. Youth shall remain on Suicide Intervention until seen for a face-to-face evaluation by a mental health clinician and until written documentation indicates that a different level of observation is required. The youth may be placed on Suicide Watch or Suicide Precaution or may be removed from SRR if clinically indicated.

A youth who displays or threatens self-injurious behavior or ideation while in a camp setting shall be immediately transferred to a facility with Mental Health Services or to outside Emergency Services. The youth shall be maintained on Suicide Intervention while awaiting transfer.

Clinician Contacts

Face-to-Face Evaluation:

- During normal business hours during the week, a face-to-face evaluation by a mental health clinician shall begin within one (1) hour of initiation of Suicide Intervention.
- Youth placed on Suicide Intervention after 5 p.m. on weekdays, on weekends or on holidays shall be seen by a mental health clinician starting at 10 a.m. the following day.
- On weekends and holidays, the mental health clinician on-call for suicide evaluations shall contact the Duty Sergeant, or designee, by 8 a.m. to determine the need for evaluations. If contact is not initiated by 8:30 a.m., the Duty Sergeant shall contact the on-call mental health clinician. The Chief Psychologist, or designee, shall be informed by the Duty Sergeant of the need to contact the Psychologist.

A Psychologist shall meet with the youth daily to discuss the behavior initiating Suicide Intervention, current behavior, affect, mental status, degree of verbalizations, Focal Treatment Plan and progress toward release from Suicide Intervention. This discussion shall be documented in the Electronic Information System and a signed copy placed in the UHR.

A Psychiatrist shall initiate medication consultations as often as clinically indicated.

A Licensed Psychiatric Technician shall initiate contact daily with each youth and as clinically indicated.

Documentation and Notification

Facility Staff shall enter the youth's SRR status into the Alternative Program section of the Electronic Information System as soon as the situation allows and no later than two (2) hours after initiation of 1:1 Observation.

Any DJJ staff who places a youth on Suicide Intervention and who has received training in the administration of the SPAR: SRSQ form, shall complete a SPAR: SRSQ form and document the results in the Electronic Information System.

The SPAR: 15 Minute Watch Record form shall be completed a minimum of every 15 minutes by Facility Staff monitoring the youth. Facility Staff should clearly observe and document the condition of the skin on the neck and hands and movement of the youth.

Clothing

Youth shall remain in standard DJJ clothing, with the exception of belts, necklaces, shoelaces, and other potentially self-injurious items, while on Suicide Intervention. A suicide gown, mattress and blanket may be used only with the documented approval of a mental health clinician and for as short a time as clinically indicated.

Programming

The focus of programming during Suicide Intervention is to maintain the safety of the youth and to determine an appropriate treatment plan. As a result, the youth shall have restricted programming during Suicide Intervention. Individual programming opportunities may be provided when clinically appropriate and if the safety of the youth can be maintained.

Unless clinically contraindicated, the effects of the youth's behavior on other residents and on the Living Unit environment shall be addressed in the next Living Unit large group meeting. The confidentiality of the youth's history and current circumstances shall be maintained. These meetings shall be co-led by a mental health clinician. The mental health clinician co-lead should be familiar with the youth whenever possible.

Suicide Risk Reduction Status: Suicide Watch

Placement

Direct placement on Suicide Watch shall occur if a face-to-face evaluation by a mental health clinician determines that the youth is in immediate and grave danger of committing suicide. A youth requiring placement on Suicide Watch for more than 24 hours shall be considered for placement in a higher level of care.

Housing

A youth on Suicide Watch shall be housed on their Living Unit and restricted to their room. If clinically indicated, and at the direction of a medical or mental health clinician, the youth may be transferred to the OHU. Immediate transfer to the CTC, Emergency Services, or an acute psychiatric hospital shall be considered for all youth transferred to the OHU. Youth housed in an open dorm setting, shall be placed on 1:1 Observation and should be moved to alternate housing if necessary.

The assigned sleeping area of a youth placed on Suicide Watch shall be searched, and the search documented, by Facility Staff at the time of initial placement, during each shift (every eight (8) hours), and as indicated to ensure that items which may be used for self-harm are not available. These items shall be removed, placed in an area under staff control, and returned to the youth as clinically indicated.

The door to the youth's room is to remain open from 6 a.m. to 10 p.m. (2nd and 3rd Watch) and may be closed from 10 p.m. to 6 a.m. (1st Watch). The door may be closed temporarily:

- To prevent injury to the youth or others as a result of the youth's agitated or out of control behavior
- For the safety and security of the unit during movement of other youth
- For the safety and security of the youth in the event of an emergency situation where there is a threat of harm to the youth

Facility Staff shall contact the on-site or on-call mental health clinician for discussion, consultation, and treatment planning. The mental health clinician shall consider the youth for transfer to an OHU, a CTC, acute psychiatric hospital, or for emergency treatment if:

- The youth's door remains closed as a result of the youth's agitated or out of control behavior for a total of more than four (4) cumulative hours within a 24 hour period during 2nd, and 3rd Watch
- The door remains closed for more than 30 consecutive minutes during 2nd or 3rd Watch

The decision to transfer a youth to a CTC, acute psychiatric hospital, or for emergency services shall be based on the clinical condition of the youth.

If self-injurious behavior occurs while the youth is in their assigned room, Facility Staff shall intervene to prevent the self-harm. Youth may be removed from their room if required and all necessary measures shall be taken to ensure the safety of the youth. Additional Facility Staff shall be contacted to provide assistance in preventing self-harm. From 9 a.m. to 5 p.m. during the week, the youth shall be seen immediately by a mental health clinician and/or transferred to a higher level of care for consultation and/or treatment. After 5 p.m. during the week, on weekends, and on holidays, the on-call mental health clinician shall be contacted for discussion and direction.

1:1 Observation

A youth on Suicide Watch shall be placed on 1:1 Observation with supervision of one (1) youth by one (1) Facility Staff member. Staff assigned to 1:1 Observation shall remain as close to the youth as required to immediately respond to any attempt at self-harm. Staff shall maintain clear visual and auditory contact with the youth. Staff shall not participate in any other activity which distracts from their ability to directly supervise the youth.
Observations from 6 a.m. to 10 p.m. (2nd and 3rd Watch) shall occur every 15 minutes. Observations from 10 p.m. to 6 a.m. (1st Watch) shall occur every five (5) minutes.

A youth shall be monitored at all times with special attention during 'high risk' periods e.g. while sleeping, showering, toileting, and during shift change.

The mental health clinician shall contact the Chief of Mental Health Services or designee, for consultation, if a youth remains on Suicide Watch longer than 24 hours after a mental health evaluation. At the end of the consultation, the youth shall be referred to a CTC, Emergency Services, or acute psychiatric hospital, or transferred to Suicide Precaution.

Clinician Contacts

Face-to-Face Evaluation:

- During normal business hours during the week, a face-to-face evaluation by a mental health clinician shall begin within one (1) hour of initiation of Suicide Watch.
- Youth placed on Suicide Watch after 5 p.m. on weekdays, on weekends, or on holidays shall be seen by a mental health clinician starting at 10 a.m. the following day.
- On weekends and holidays, the mental health clinician on-call for suicide evaluations shall contact the Duty Sergeant, or designee, by 8 a.m. to determine the need for evaluations. If contact is not initiated by 8:30 a.m., the Duty Sergeant shall contact the on-call mental health clinician. The Chief Psychologist, or designee, shall be informed by the Duty Sergeant of the need to contact the Psychologist.

A Psychologist shall meet with the youth daily to discuss the behavior initiating Suicide Watch, current behavior, affect, mental status, degree of verbalizations, Focal Treatment Plan, and progress toward release from Suicide Watch. This discussion shall be documented in the Electronic Information System and a signed copy placed in the UHR.

A Psychiatrist shall initiate medication consultations as often as clinically indicated.

A Licensed Psychiatric Technician shall initiate contact daily with each youth and as clinically indicated.

Documentation and Notification

When a youth is placed on Suicide Watch:

- The SPAR: Suicide Observation Record form shall be completed by Facility Staff a minimum of every 15 minutes for each youth during 2nd and 3rd Watch. The SPAR: 5 Minute Suicide Watch Record form shall be completed by Facility Staff a minimum of every 5 minutes for each youth during 1st Watch. Facility Staff should clearly observe and document the condition of the skin on the neck and hands and movement of the youth
- A Focal Treatment Plan shall be completed in the Electronic Information System by the mental health clinician initiating Suicide Watch. A signed copy shall be placed in the UHR and a copy in the Living Unit Log.
- Facility Staff shall notify their supervisor of the change in the youth's SRR Level.
- The mental health clinician initiating Suicide Watch shall notify their supervisor of the change in the youth's SRR Level and of any significant change in the Focal Treatment Plan. The Chief of Mental Health Services, or designee shall be notified of any significant episode of self-injurious behavior.
- A Licensed Psychiatric Technician shall document the nature of the daily discussions, as well as the youth's affect, behavior, and other significant information in the Electronic Information System and the UHR.

- The Casework Specialist, or designee, shall notify the parents or legal guardian of a youth less than 18 years of age of the change in the youth's SRR Level as soon as possible but no later than 24 hours after the event. The parents or legal guardian of a youth over 18 years of age shall be notified only after the youth has provided written approval for this contact.
- The mental health clinician initiating Suicide Watch shall document the placement in the Electronic Information System with a signed copy placed in the UHR.

Clothing

Youth shall remain in standard DJJ clothing, with the exception of belts, necklaces, shoelaces, and other potentially self-injurious items, while on Suicide Watch. A suicide gown, mattress, and blanket may be used only with the documented approval of a mental health clinician and for as short a time as clinically indicated.

Programming

The focus of programming during Suicide Watch is to maintain the safety of the youth and to determine an appropriate treatment plan. As a result, the youth shall have restricted programming during Suicide Watch. Individual programming opportunities may be provided when clinically appropriate and if the safety of the youth can be maintained.

Unless clinically contraindicated, the effects of the youth's behavior on other residents and on the Living Unit environment shall be addressed in the next Living Unit large group meeting. The confidentiality of the youth's history and current circumstances shall be maintained. These meetings shall be co-led by a mental health clinician. The mental health clinician co-lead should be familiar with the youth whenever possible.

Suicide Precaution

Placement

Direct placement on Suicide Precaution shall be determined after a face-to-face evaluation by a mental health clinician if one of the following conditions applies:

- A youth expresses suicidal ideation, there is no history of significant self-injurious behavior, and the youth agrees to contact health care staff before any self destructive behavior occurs.
- There is clinical approval by a mental health clinician for placement on Suicide Precaution. Placement on Suicide Precaution for clinical reasons without suicidal ideation requires consultation with the Chief Psychiatrist, or designee, within one (1) business day.

Housing

The sleeping area of a youth shall be searched at the time of initial placement, during each shift (every eight (8) hours), and as often as indicated to ensure that items which may be used for self-harm are not available. These items shall be removed, placed in an area under staff control, and returned to the youth as clinically indicated.

After 72 hours on Suicide Precautions, youth assigned to a non-mental health unit shall be evaluated by a mental health clinician for placement on a Mental Health Unit.

Youth placed directly on Suicide Precaution may be transferred to Follow-Up Status as soon as clinically indicated.

Observation

A youth on Suicide Precaution shall be placed on Constant Observation. Facility Staff shall have clear, unobstructed, visual and auditory contact with the youth at all times.

The door to the youth's room is to remain open from 6 a.m. to 10 p.m. (2nd and 3rd Watch) and may be closed from 10 p.m. to 6 a.m. (1st Watch). Facility Staff should clearly observe and document the condition of the skin on the neck and hands and movement of the youth.

Observations from 6 a.m. to 10 p.m. (2nd and 3rd Watch) shall occur every 15 minutes and shall be documented by Facility Staff on a SPAR: Suicide Observation Record form. Observations from 10 p.m. to 6 a.m. (1st Watch) shall occur every five (5) minutes and shall be documented on a SPAR: 5 Minute Suicide Watch Record form.

With written clinical approval, one (1) Facility Staff member may supervise up to three (3) youth on Suicide Precaution.

A youth shall remain on Suicide Precaution for 72 hours after transfer from a Suicide Watch or for as long as clinically indicated. Youth placed directly on Suicide Precaution may be transferred to Follow-up Status or may be removed from Suicide Risk Reduction (SRR) Status if clinically indicated.

Clinician Contacts

A Psychologist shall meet with the youth daily to discuss the behavior initiating Suicide Precaution, current behavior, affect, mental status, degree of verbalizations, Focal Treatment Plan, and progress toward release from Suicide Precaution. This discussion shall be documented in the Electronic Information System and a signed copy placed in the UHR.

A Psychiatrist shall initiate medication consults as often as clinically indicated.

A Licensed Psychiatric Technician shall initiate contact daily with each youth and as clinically indicated. A SPAR: SRSQ form shall be completed daily.

Documentation and Notification

When a youth is placed on Suicide Precaution:

- The SPAR: Suicide Observation Record form shall be completed by Facility Staff a minimum of every 15 minutes for each youth.
- A Focal Treatment Plan shall be completed by the mental health clinician initiating Suicide Precaution. A signed copy shall be placed in the UHR and a copy in the Living Unit Log.
- Facility Staff shall notify their supervisor of the change in the youth's SRR Level.
- The mental health clinician initiating Suicide Precaution shall notify their supervisor of the youth's SRR Level and of any significant change in the Focal Treatment Plan.
- A Licensed Psychiatric Technician shall document the nature of the daily discussions, as well as the youth's affect, behavior, and other significant information.
- The Casework Specialist, or designee, shall notify the parents or legal guardian of a youth less than 18 years of age of the change in the youth's SRR Level as soon as possible but no later than 24 hours after the event. The parents or legal guardian of a youth over 18 years of age shall be notified only after the youth has provided written approval for a release of information. The contact shall be documented in the Electronic Information System.
- The mental health clinician initiating Suicide Precaution shall document the placement in the Electronic Information System with a signed copy placed in the UHR.

Clothing

The youth shall remain in standard DJJ clothing, with the exception of belts, necklaces, shoelaces, and other potentially self-injurious items, while on Suicide Precaution. Youth requiring clothing restrictions shall be transferred to Suicide Watch Status.

Programming

A youth on Suicide Precaution shall participate in all standard programming unless clinically contraindicated.

When clinically indicated, effects of the youth's behavior on other residents and on the Living Unit environment shall be addressed in the next Living Unit large group meeting. The confidentiality of the youth's history and current circumstances shall be maintained. These meetings shall be co-led by a mental health clinician. The mental health clinician should be familiar with the youth when possible.

Follow-Up Status

Placement

A youth may be placed on Follow-Up Status by a mental health clinician if there has been no suicidal ideation for 72 hours. If clinically indicated, the youth may be placed in Follow-Up Status at any time prior to 72 hours.

Transfer from Suicide Precaution to Follow-Up Status shall be determined after a face-to-face evaluation by a mental health clinician. A youth shall not be placed directly on Follow-Up Status.

Housing

The assigned sleeping area for youth on Follow-Up Status shall be searched as per DJJ policy. *See Youth Search Policy*

A youth shall be placed in their previously assigned housing for programming and activities unless contraindicated by clinical or security concerns.

A youth transferred from Suicide Precaution shall remain on Follow-Up Status for a minimum of seven (7) days and for as long as clinically indicated.

Observation

A youth on Follow-Up Status shall be monitored per standard DJJ observation procedures. These observations shall be documented by Facility Staff every two (2) hours.

Clinician Contacts

The clinician shall enter written instructions initiating placement on Follow-Up Status into the Electronic Information System with a signed copy placed in the UHR.

The clinician completing the face-to-face evaluation shall update the Focal Treatment Plan in the Electronic Information System and place a signed copy in the UHR. A copy shall be placed in the Living Unit Log.

At least once each week, a Psychologist or Psychiatrist shall meet with the youth and address the reason for the Follow-Up Status as well as the youth's current behavior, affect, mental status, degree of verbalizations, Focal Treatment Plan, and progress toward release from SRR Status. The discussion shall be documented in the Electronic Information System and a signed copy placed in the UHR. Any change in the Focal Treatment Plan shall be discussed with the youth immediately and with the Treatment Team as soon as possible.

A Licensed Psychiatric Technician shall initiate contact weekly with each youth and as clinically indicated. A SPAR: SRSQ form shall be completed daily.

Documentation and Notification

When a youth is placed on Follow-Up Status:

- The SPAR: Suicide Observation Record form shall be completed by Facility Staff a minimum of every two (2) hours for each youth.
- A Focal Treatment Plan shall be completed by the mental health clinician initiating Follow-Up Status. A signed copy shall be placed in the UHR and a copy in the Living Unit Log.
- Facility Staff shall notify their chain of command of a change in the SRR Level of the youth.
- The mental health clinician shall notify their supervisor of a change in the SRR Level of the youth and of any significant change in the Focal Treatment Plan.

- The Casework Specialist, or designee, shall notify the parents or legal guardian of a youth less than 18 years of age of the change in the SRR Level of the youth as soon as possible but no later than 24 hours after the event. The parents or legal guardian of a youth over 18 years of age shall be notified only after the youth has provided written approval for a release of information. The contact shall be documented in the Electronic Information System.
- The mental health clinician initiating Follow-Up Status shall document the placement in the Electronic Information System with a signed copy placed in the UHR.

Clothing

A youth is expected to wear standard DJJ clothing with no restrictions.

Programming

A youth is expected to participate in all programming. Youth shall be considered for placement on a Mental Health Unit when clinically indicated.

If clinically indicated, the effects of the youth's behavior on other residents and on the Living Unit environment shall be addressed in the next Living Unit large group meeting. The confidentiality of the youth's history and current circumstances shall be maintained. These meetings shall be co-led by a mental health clinician. The mental health clinician should be familiar with the youth when possible.

Suicide Risk Reduction Status: Transfer Criteria

After a thorough and documented evaluation by a mental health clinician, a youth on Suicide Intervention may be placed on Suicide Watch or Suicide Precaution or may be returned to their Living Unit without a SRR Level. If clinically appropriate, a youth may be placed in a higher level of care from any SRR status.

Transfer to Suicide Watch from Suicide Precaution or Follow-Up Status

A youth on Suicide Precaution or Follow-Up Status shall be transferred to Suicide Watch based on evaluation by a mental health clinician if one of the following occurs:

- A youth makes significant or continuing suicide threats, exhibits significant self-injurious behavior, or expresses significant suicidal ideation.
- A youth is unable to cooperate with the requirements of Suicide Precaution.
- A youth is awaiting transfer to a Correctional Treatment Center (CTC), Emergency Services, or an acute psychiatric hospital for self-injurious behavior, intent, or ideation.
- Approval for transfer for clinical reasons is given by a mental health clinician. Placement on Suicide Watch for clinical reasons without self-injurious behavior, intent, or ideation requires consultation with the Chief of Mental Health Services, or designee, within one (1) business day.

Transfer to a CTC, Emergency Services, or an acute psychiatric hospital may be ordered by a physician if there is significant self-injurious behavior or continuing suicidal ideation.

Transfer from Suicide Watch to Suicide Precaution

A youth shall be placed on Suicide Precaution when Suicide Watch is no longer clinically indicated.

A youth may be transferred from Suicide Watch to Suicide Precaution if documentation indicates all of the following:

- There have been no incidents of self-harm, threats, or ideation with the intent of self-harm for 24 hours
- The clinician has assessed that the youth will be safe to be transferred to a lower level of care
- There is documented approval by a mental health clinician

Transfer to Suicide Precaution from Follow-Up Status

A youth shall be transferred from Follow-Up Status to Suicide Precaution if one (1) of the following applies:

- Significant suicidal ideation without the intent to self-harm
- If there is clinical approval by a mental health clinician for placement on Suicide Precaution. Placement on Suicide Precaution for clinical reasons without suicidal ideation requires consultation with a Chief of Mental Health Services, or designee, within one (1) business day.

Transfer to a CTC, Emergency Services, or an acute psychiatric hospital may be ordered by a physician if there is significant self-injurious behavior or continuing suicidal ideation that cannot be controlled in the facility.

A youth shall be placed on Suicide Watch while awaiting transfer to a CTC, Emergency Services, or an acute psychiatric hospital.

Transfer from Suicide Precaution to Follow-Up Status

A youth on Suicide Precaution may be transferred to Follow-Up Status if documentation indicates all of the following:

- There have been no incidents of self-harm, threats, or ideation with the intent of self-harm for 72 hours
- The clinician has assessed that the youth will be safe to be transferred to a lower level of care
- There is documented approval by a mental health clinician

Transfer from Follow-Up Status to Suicide Precaution or Suicide Watch

A youth on Follow-Up Status shall be transferred to Suicide Precaution or Suicide Watch if one (1) of the following applies:

- The youth expresses significant suicidal ideation without the intent to self-harm
- If there is documented approval by a mental health clinician for placement

Placement on Suicide Precaution for suicide ideation without intent requires consultation with a Chief Psychiatrist or designee within one (1) business day.

Transfer to a CTC, Emergency Services, or an acute psychiatric hospital may be ordered by a physician if there is significant self-injurious behavior or continuing suicidal ideation that cannot be controlled in the facility.

A youth shall be placed on Suicide Watch while awaiting transfer to a CTC, Emergency Services, or an acute psychiatric hospital.

Release from Follow-Up Status

A youth on Follow-Up Status may be removed from observations if documentation indicates all of the following:

- A youth has remained on Follow-Up Status for a minimum of seven (7) days
- There has been no episodes of self-injurious behavior or ideation in the past seven (7) days
- There is documented approval by a mental health clinician

General Suicide Risk Reduction Guidelines

The Treatment Team shall be consulted for treatment decisions when possible.

Facility Staff shall be consulted and input encouraged for security concerns when initiating a transfer, an increase or decrease in Suicide Risk Response (SRR) Levels, or a change in the Focal Treatment Plan.

The Chief Psychologist, or designee, shall ensure that documentation indicates that youth on any SRR Level has been seen by required mental health staff.

Unless clinically contraindicated, youth shall remain in standard DJJ clothing while on SRR status. Youth shall be searched when placed on any level of SRR status. This search shall include the surrounding area and the removal of all clothing to ensure potentially harmful items are not available to the youth. Belts, necklaces, shoelaces, and other potentially self-injurious items shall not be permitted.

Documentation and Communication

All clinical contacts with the youth shall be documented in the Electronic Information System and a signed copy placed in the UHR. This documentation is for the purpose of communicating treatment information to the Treatment Team. Sensitive mental health information shall be documented in the UHR. Documentation shall consist of an evaluation of the youth, the circumstances surrounding treatment decisions, and the plan of care.

Documentation by Facility Staff shall be placed in the appropriate section of the Electronic Information System.

Documentation shall be completed at the time of the occurrence whenever possible, but no more than two (2) hours following the occurrence. On-call clinicians shall document their interactions on the day of their return to the facility. Documentation shall include an explanation of the reason for a late entry. If the Electronic Information System is unavailable, documentation shall be placed in the UHR and a "late entry" placed into the Electronic Information System.

At the time of an evaluation, the clinician shall document the circumstances of any change in the SRR Level of the youth in the Electronic Information System and place a signed copy in the UHR. Verbal directions for a reduction in the SRR Level shall not be accepted, but shall be accepted for an increase in the required status.

Sensitive mental health information shall be documented in the UHR. Descriptions of specific behaviors and quotes of significant statements should be documented when relevant.

Urgent information shall be communicated directly to Facility Staff, medical staff, or mental health staff as well as documented in the UHR and/or Electronic Information System.

A mental health clinician shall document specific clinical restrictions for clothing and programming and the length of time for the restriction. Facility Staff shall document specific security restrictions and the length of time for the restriction.

All successful or unsuccessful attempts to contact the family shall be documented in the Electronic Information System. Documentation shall include the contact method and content of the discussion. Contacts made by Health Care Professional Staff will be documented in UHR.

For any episode of self-injurious behavior requiring medical attention, Facility Staff shall complete a Serious Incident Report form.

Focal Treatment Plan

A Focal Treatment Plan shall be completed by a mental health clinician at the time of placement on Suicide Watch, Suicide Precaution, or Follow-up Status and shall be updated as clinically indicated. The signed Focal Treatment Plan shall be placed in the UHR and a copy placed in the Living Unit Log. The Focal Treatment Plan and the youth's progress shall be discussed with the youth at designated intervals and when clinically indicated. These discussions, along with the condition of the youth, shall be documented by the mental health clinician in the UHR and Electronic Information System.

The Focal Treatment Plan shall consist of:

- Relevant history with the immediate and on-going suicide risk factors
- Current SRR status level including expected program participation and activities
- Documentation of an initial discussion with the youth

The Focal Treatment Plan shall ensure that transfer planning is included and completed before the SRR Level is changed and shall include:

- The level of observation to be maintained
- Program and activity expectations
- Focus of staff and youth interactions, discussions, and activities

All treatment plan information shall be available to the Treatment Team and other Facility Staff on a need to know basis. Confidentiality of the youth's treatment shall be maintained.

A Suicide Risk Response Tracking Log shall be updated each time the SRR Level or housing assignment of a youth is changed. The Suicide Risk Response Tracking Log shall be reviewed and signed each day by a Senior Psychologist, or designee, to ensure completion of the log, compliance with the policy, and appropriate clinical treatment for the youth.

A Mental Health Referral form requesting services beyond those required by the SPAR policy shall be completed by any DJJ staff member. The referral shall be completed in the Electronic Information System and shall include the specific reason for the referral and the urgency of the request. If the referral is urgent, a mental health clinician shall be notified directly.

Housing, Clothing, Hygiene, and Meals

A youth who is actively self-destructive and whose behavior cannot be controlled at the facility shall be immediately transferred to the CTC, for Emergency Services, or to an acute psychiatric hospital for medical or mental health treatment after clinical evaluation by a Mental Health Professional.

A youth shall be housed in the least restrictive housing, consistent with safety, security, and clinical judgment.

Individuals shall be searched when they are placed on any level of SRR status. This search shall include the removal of all clothing to ensure that potentially harmful items are not available to the youth.

Paperback books, educational materials, papers without staples, writing materials, and all other non-injurious items beneficial to the welfare of the youth shall be provided at all times. Items may be withheld for clinical reasons with accompanying documentation by a mental health clinician. The reasoning for the restrictions shall be documented in the UHR.

Programming and Peer Contact

A youth on Suicide Precaution or Follow-Up Status shall be integrated into all programming activities. A youth **shall not** be isolated or restricted more than required by safety, security, and clinical concerns and shall be offered the opportunity to participate in on-unit or individual programming as soon as clinically appropriate.

The need for restrictions on contact with peers shall be determined by a mental health clinician and based on clinical indications. The circumstances surrounding the clinician's order for restrictions shall be documented in the UHR. Restrictions for safety reasons shall be determined by the Treatment Team, shall be documented in the Electronic Information System, and communicated to mental health staff.

Youth on any SRR Level shall be transported using the least restrictive means that the safety and security of the youth permits and as clinically appropriate.

Medications

A medication review for each youth while on SRR shall be completed and documented by a Psychiatrist when clinically indicated.

Crushed, liquid, or rapidly dissolving medications shall be administered to a youth only upon order of a Psychiatrist. Documentation of the circumstances surrounding the order shall be documented in the UHR.

To prevent a youth from discarding or hoarding medications, mouth checks for youth receiving medications while on SRR status shall be performed by health care staff administering the medications. Facility Staff shall be present during medication administration as per the Medication Administration policy.

Clinical Decisions, Consultations and Disagreement

The on-site mental health clinician most knowledgeable about the youth's condition shall be contacted for clinical decisions whenever possible.

A mental health on-call schedule shall be utilized during non-business hours whenever a clinical consultation or a report of change in condition is required.

A review by a Senior Psychologist, Chief Psychologist, Senior Supervising Psychiatrist, or a designee shall be requested for complicated or ambiguous cases.

In the event of a clinical disagreement, or a complicated and ambiguous case concerning the mental health of the youth, current suicide risk, or appropriate level of observation required, the youth shall be maintained on the higher level of observation until the clinical picture has been reviewed. The review will be made by the Senior Psychologist or Chief Psychologist with input from the Treatment Team when possible. The higher level of observation shall be maintained until a plan of treatment has been determined.

Any continuing conflict in a clinical assessment or treatment plan shall be referred to the Chief of Mental Health Services, or designee, for resolution before action is taken. Based on clinical indications, the Chief of Mental Health Services, or designee, may independently determine the level of observation and treatment required.

Notification

An on-site or on-call mental health clinician shall be notified immediately for any significant change in the youth's SRR Level. The notification shall be documented in the UHR and in the Electronic Information System.

The Casework Specialist, Case Manager, or designee, shall contact the family of youth less than 18 years of age as soon as possible but no longer than 24 hours after a self-injurious event. The contact shall be documented in the Electronic Information System.

Family notification for a youth 18 years of age or over may occur after discussion with the youth has occurred and a signed consent for release of medical information has been obtained.

This notification shall occur when a youth is:

- Placed on Suicide Watch, Suicide Precaution, Follow-Up Status, or released from SRR Status
- Requires medical care beyond first aid

The discussion with the family shall consist of:

- The reason for the current SRR Level
- A brief outline of the Focal Treatment Plan
- Identification of recent communication or changes in communications with the family; e.g., refuse to talk, refuse to cooperate
- The current effect of family contact on the clinical condition of the youth
- Methods for facilitating contact if appropriate

The frequency of contact between a youth on SRR Status and his family shall be based on the clinical condition of the youth and shall not be determined by facility policy. Safety and security concerns will be addressed by the Treatment Team and mental health clinicians.

Response to Self-Injurious Behavior and Medical Emergencies

Medical Response

Any employee aware of a life-threatening medical situation shall call 911 to activate outside Emergency Medical Services (EMS), in accordance with facility procedures. Immediately after contacting EMS, staff shall notify the Facility Control Center of the impending arrival of an ambulance, as well as the circumstances and location of the emergency. Each facility shall maintain local operating procedures defining the facility response to a medical emergency and the pending arrival of EMS. *See Emergency Services Policy.*

In an attempt to normalize their environment, every effort shall be made to obtain medical evaluation and treatment for injuries to the youth while the youth remains on the Living Unit. Transportation to the OHU shall be considered if, in the opinion of medical staff, the severity of the youth's injuries are such that they cannot be treated on the Living Unit or there are insufficient nurses to allow a nurse to come to the youth's Living Unit because of other events taking place in the facility such as a group disturbance that requires a nurse's attention or if the medical facilities on the Living Unit are inadequate to provide care.

Youth requiring medical attention in the OHU shall be maintained on 1:1 Observation while awaiting treatment. Youth may be evaluated in the OHU by a mental health clinician to determine their SRR status or may return to the Living Unit to await assessment.

A youth requiring medical attention beyond that which can be supplied at DJJ shall be referred to the on-site or on-call physician or to Emergency Services. The circumstances of the injury or condition shall be documented in the UHR. In cases of significant injury or possible injury such as hanging, 911 shall be activated immediately. *See Emergency Services Policy.*

Post Suicide Response

A Senior Psychologist and/or Psychiatrist shall schedule a meeting of the Treatment Team staff and other staff involved in the incident. This discussion shall occur as soon as possible after the event and no longer than one (1) week from the incident. Mental health clinicians shall be available to the Superintendent for assistance in implementing established DJJ post suicide response protocols.

The purpose of this response is to discuss:

- The circumstances surrounding the incident
- Possible precipitating factors leading to the incident
- Health care and facility procedures relevant to the incident
- Recommendations for any changes in policy, training, physical plant, healthcare services, and/or facility procedures

The Superintendent and the Chief, Mental Health Services or designee, shall be notified immediately of any significant issues or recommended changes discussed during the meetings.

A youth involved in or affected by the incident shall be evaluated by the assigned Psychologist and/or Psychiatrist. A plan of care shall be developed when indicated.

A Sentinel Event Report shall be prepared by the CMO and forwarded to the Chief Medical Office when indicated. *See Sentinel Event policy.*

FORM(S)

1. Clinicians' Orders, DJJ 8.002
2. Critical Factors Assessment for Determining Need for Mental Health Evaluation, DJJ 8.271
3. Focal Treatment Plan: Follow-Up Status, DJJ 8.067
4. Focal Treatment Plan: Suicide Precaution, DJJ 8.066
5. Focal Treatment Plan: Suicide Watch, DJJ 8.068
6. Focal Treatment Plan: Treatment Team Acknowledgement, DJJ 8.069
7. Interdisciplinary Chronological Progress Notes, DJJ 8.003
8. Intrasystem Transfer Screening, DJJ 8.023
9. Mental Health Referral Form, DJJ 8.039
10. Receiving Health Care Screening, DJJ 8.031
11. Serious Incident Report, DJJ 8.036
12. SPAR: 5 Minute Suicide Watch Record DJJ 8.228
13. SPAR: Suicide Observation Record, DJJ 8.286
14. SPAR: Suicide Risk and Screening Questionnaire, DJJ 8. 281
15. Suicide Risk Response Tracking Log, DJJ 8.229
16. Suicide Risk Response Status: Release Treatment Plan, DJJ 8.070

DJJ use of force data
Chaderjian, August 1, 2008 to October 17, 2008
Summarized by Zack Schwartz and Aubra Fletcher

The tables below represent our compilation of use of force information from Chaderjian spanning August 1 through October 17, 2008. The tables' contents are based on use of force documents we received at Chaderjian in October 2008. These documents do not appear to be WIN-generated, and our office has not seen such records at any other facility, though it is possible they are in statewide use. We sent an unredacted version of these tables to the safety and welfare and mental health experts on November 10, 2008. In December, we forwarded the information to DJJ's director of facilities.

Each document describes a separate incident and indicates whether the relevant youth is on the mental health case load (indicated by an "X" in the "MH" column). For many reported incidents, no force was used; these records were marked as "potential" use of force incidents. We also refer to potential use of force incidents as "crises resolved without force."

The "cause of incident" categories that appear in these tables are a product of our office, but the "type of force" categories are from the use of force documents.

A number of individual youth were involved in multiple incidents, sometimes within a period of minutes or hours. But because this document is redacted, the tables cannot be sorted by youth name.

In our November 10, 2008 e-mail to the experts, we highlighted the use of chemical force in response to self-harm behavior. Of 45 incidents of self harm or attempted self harm, 14 resulted in the use of force. Six of these 14 incidents involved chemical agents. As an example, the description of one of these incidents reads: "Ward [] maced for self-injurious behavior, attempting to bite himself." During OSM's visit to Chaderjian on October 17, 2009, an interviewed youth told us that he had been maced in his cell for wrapping a sheet around his neck. His name appeared in multiple UoF records, and a summary of information we have about him is also attached. On multiple occasions, staff sprayed him with chemical agents for attempting to harm himself.

The Z505 Cap Stun Crowd Control was used in 23 incidents, or 44% of the chemical uses of force, usually for one-on-one youth fights or in response to self-harm behavior. By contrast, according to the manufacturer's web site, the Z505 Crowd Control is recommended for "saturation of an indoor barricaded area where innocent individuals might be exposed to injury or death if traditional ordinance is used. Z-505 has a devastating heavy burst of spray with a visible range of 20 feet (7 meters). With proper training and deployment the airborne particulate will carry well beyond 200 feet (60 Meters)."[*]

Youth identified as "mental health youth" were disproportionately represented in records of actual or potential uses of force. As of October 16, 2008, about 40% of youth at Chaderjian were mental health youth. However, 78% of uses of force involved MH youth, and 83% of incidents involving chemical force involved mental health youth.

We also identified various questions that emerged from our reading of the documents and shared these questions with the experts. Among our questions were the following:

1. Why are "potential" use of force incidents recorded at all? Routinely logging this information *in use of force records* might encourage staff to think of force first in situations involving failure to follow instructions or other non-physical resistance.

[*] See http://www.zarc.com/english/productline/z505.html.

2. Similarly, why are the watch commander, security, and search and escort teams called to the unit for most incidents involving failure to follow instructions or posting up?

3. Many instances in which security and the watch commander respond are resolved through dialogue. Is it the mere fact of security presence that contributes to resolution? Or do staff refrain from engaging in dialogue until security arrives? Or, do security staff bring special dialogue skills to the situation that could just as easily be applied by living unit staff?

4. Why does the primary response come from the watch commander and security when the matter appears to be a mental health issue? For example, on August 22, 2008 in the medical outpatient housing unit (OHU), a youth covered his window with his suicide mattress and stood on the sink. The narrative indicates only that the watch commander responded, and not mental health staff.

5. What exactly constitutes a "takedown?" Why is this form of physical force used rather than holds in situations in which the youth is not running away, etc. (such as resistance to being cuffed)?

Table 1

Causes of Crises and Uses of Force at Chad, 8/1/08 to 10/17/08										
Cause	**All Recorded Crises**		**All Resolved w/o Force**		**All UOFs**		**Chemical UOFs**		**Physical UOFs**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Y/Y Fight	51	17%	20	9%	31	39%	30	58%	5	14%
Y/S Fight	3	1%	0	0%	3	4%	1	2%	2	6%
Self-Harm	45	15%	31	14%	14	18%	6	12%	9	26%
P. Damage	10	3%	9	4%	1	1%	1	2%	0	0%
Resistance	159	54%	130	60%	29	36%	13	25%	18	51%
Other	28	9%	26	12%	2	3%	1	2%	1	3%
Total	296		216		80		52		35	

Table 2

Involvement of MH Youth in Crises and UOFs at Chad, 8/1/08 to 10/17/08										
	All Recorded Crises		**Resolved w/o Force**		**UOFs**		**Chemical UOFs**		**Physical UOFs**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**

MH	224	76%	162	75%	62	78%	43	83%	25	71%
Not MH	72	24%	54	25%	18	23%	9	17%	10	29%
Total	296		216		80		52		35	

Table 3

Proportion of MH Youth at Chad		
Date:	**Youth Population**	
10/16/08	**n**	**%**
MH	94	39%
Not MH	148	61%
Total	242	

Table 4: August 2008

Date	Time	Location	MH	Cause of Incident						Type of Force					Description	UoF details
				Y/Y Fight	Y/S Fight	Self-Harm	Property Damage	Resistance	Other	Phys.	Mech.	Chem.	Less Lethal	None		
8/1/08	720	Smith						X						X	Comm. Center notified that youth left hall without permission. Security picked him up and escorted him to hall.	None listed
8/1/08	820	outdoors	X					X						X	Lying down on track in front of Comm. Center. Security dispatched. Was escorted back to MTA (where he had come from), then transported to OPHU for more evaluation.	None listed
8/1/08	1000	Merced (ITP)	X			X		X						X	Was being placed on Suicide Watch but refused to take it to his room. Security responded. Youth went to upper tier. Psychologist in building was notified.	None listed
8/1/08	1210	Merced (ITP)	X		X			X		X					(OSM interviewed this youth.) Returned from OPHU to be placed on Suicide Watch per psychologist. Became very argumentative and aggravated once back in his room. Became "physical with" security and had to be restrained.	Lock; leg. Takedown.
8/1/08	1512	McCloud	X	X								X			1:1 fight in dayroom. Watch commander and security responded. Chemical force was used "to gain compliance." RN did medical assessment. Youth was taken to OHU for further assessment.	Z505 Cap Stun Crowd Control
8/2/08	1215	Owens						X						X	Not following instructions. Security responded and resolved with dialogue.	None listed
8/2/08	1625	Pajaro		X					X			X			1:1 fight and chemical force used "to gain compliance. Both youth seen by RN.	Z505 Cap Stun Crowd Control

Table 4: August 2008

8/3/08	1013	American							X				X	Was seen hiding contraband on his person in dayroom. Security searched and processed youth through the metal detector "with negative results."	None listed
8/3/08	1228	American							X				X	"[A]cting suspicious, possible drug activity." Watch commander and security responded. Transported youth to receiving for search and metal detector.	None listed
8/3/08	1400	Receiving	X					X					X	Returned from Sierra Vista Hospital. Back on unit, refused to strip down and go into a smock. Resolved through dialogue.	None listed
8/3/08	1940	Admin Control - pill call	X		X			X		X				Not following instructions to exit dispensary during pill call. Refused security instructions to cuff up. Became combative; had to be physically restrained. Was seen by RN.	Takedown
8/4/08	920	Merced (ITP)	X			X				X		X		On SW. Banging head on door; wrapped t-shirt around neck. Watch commander, security, clinician responded. "Chemical agents were utilized to gain compliance." During escort from shower, youth "became resistive and had to be physically restrained."	9000 Fogger/MK9. Takedown.
8/4/08	1100	Merced (ITP)	X			X						X		On SW. Covering face with plastic bag. Chemical force used "to gain compliance."	Z505 Cap Stun Crowd Control
8/4/08	1134	Merced (ITP)	X			X							X	On SW. Attempted to swallow "a plastic" from his lunch tray. Watch commander, security, and a clinician responded. Transported to OHU.	None listed
8/5/08	1740	Merced (ITP)	X					X					X	Posting up in room. Staff couldn't use safety chain. Could see youth pacing inside. Security, watch commander, and psych responded. Resolved with	None listed

Table 4: August 2008

															dialogue.	
8/6/08	625	American	X					X						X	Posting up and refusing to respond. Chain used to gain visual. Security and watch commander responded. Youth refused to follow instructions and was placed on Merced (ITP) until further evaluation.	None listed
8/6/08	2030	Merced (ITP)	X						X					X	Youth verbally threatened the staff watching him. Per watch commander, staff on the watch was switched.	None listed
8/6/08	2120	Merced (ITP)	X					X						X	Posting up on top tier; mattresses placed on ground. Security and watch commander responded. Resolved with dialogue.	None listed
8/7/08	1040	American	X					X						X	Refusal to go to room. Security and watch commander responding. Youth complied before security arrived.	None listed
8/7/08	2202	Merced (ITP)	X					X						X	Posted up and stated that staff would have to "spray" him out. Dialogue begun by "SW [Suicide Watch] staff." Watch commander responded. Resolved with dialogue.	None listed
8/8/08	2055	Kern (SMP)	X					X		X					Held food slot open. Security responded. Youth moved back when chemical agent was pulled and verbal instructions were given. Staff quickly closed the slot, though youth tried to stop it from closing with his arm.	Unspecified physical force
8/9/08	1210	Kern (SMP)	X		X			X				X			Youth covering windows with toothpaste and refused to respond to instructions. Security chain was used, and door opened to gain a visual. Youth charged toward staff as they attempted to "clear the window."	9000 Fogger/MK9. Z505 Cap Stun Crowd Control.
8/10/08	916	Kern (SMP)	X					X						X	Posted up. Cleared window when security arrived.	None listed

Table 4: August 2008

8/11/08	1303	school area		X									X	1:1 fight. Both transported to medical for assessment by RN.	None listed
8/12/08	1721	school area	X	X								X		Two youth initiated 1:1 fight in gym; A third joined in on attack on youth 2. All ignored instructions to stop.	4000 OC/MK4
8/12/08	1800	Merced (ITP)	X					X						X	Refused to give up cuffs. Watch commander and security responding. Complied through dialogue.	None listed
8/12/08	1920	Merced (ITP)	X					X						X	Youth was placed on temporary detention after earlier altercation and covering up in temporary detention cell. Watch commander responding. Dialogue effective.	None listed
8/13/08	1136	Sacramento (IBTP)	X					X						X	Refused to take it down from the recreation yard. Watch commander, search and escort units, psychologist, and intervention crew dispatched. Resolved with dialogue.	None listed
8/13/08	1248	American						X						X	Refusal to take it down to his room. Watch commander and security dispatched. As security arrived, youth followed instructions.	None listed
8/13/08	1325	American						X						X	Posted up in room. Watch commander and search and escort units dispatched. Resolved through dialogue.	None listed
8/13/08	2125	American						X						X	Refusal to take it down. Watch commander and security responding. Dialogue effective.	None listed
8/13/08	2200	Merced (ITP)	X					X						X	Covering window with mattress; refusal to respond. Watch commander and security resolved with dialogue.	None listed
8/14/08	1028	McCloud		X										X	1:1 fight. Youth followed instructions to stop fighting as security arrived. Duty nurses dispatched to hall.	None listed

Table 4: August 2008

8/14/08	1500	Merced (ITP)	X					X						X	Refusal to take it down. Watch commander and security responding. Dialogue effective.	None listed
8/14/08	2010	Merced (ITP)	X	X										X	1:1 fight. Watch commander and security responding. Complied with verbal directions.	None listed
8/14/08	2126	Merced (ITP)	X					X						X	Refusal to take it down. Watch commander and security responding. Youth complied.	None listed
8/15/08	1338	Merced (ITP)		X										X	1:1 fight. Complied with staff directives and were escorted back to halls. "To be CI'd at a later date per SYCC."	None listed
8/15/08	1603	Smith						X						X	Refusal to take it down. Watch commander and security responding. Youth responded to dialogue.	None listed
8/15/08	1615	Pajaro	X			X			X					X	Placed on temporary detention per hall staff for threatening his interpreter. Then made suicidal threats. Watch commander responding. Psychologist notified.	None listed
8/15/08	2217	Merced (ITP)	X					X						X	Posting up, blocking window, and not following instructions. Duty lieutenant and security responded. Youth responded to dialogue.	None listed
8/15/08	2303	Merced (ITP)	X					X						X	Posting up. Security responded. Dialogue resolved the issue.	None listed
8/16/08	1115	Mojave	X					X	X					X	Attempting to incite other youth to take it to their rooms as count was approaching. Watch commander and search and escort units were dispatched. Resolved with dialogue.	None listed
8/16/08	1250	Smith	X						X					X	Youth was "out of control" in dayroom. Watch commander and search and escort units dispatched. Resolved through dialogue.	None listed

Table 4: August 2008

8/16/08	1930	American	X					X						X	Posting up in dayroom. Security and watch commander responding. Resolved with dialogue.	None listed
8/16/08	2108	American	X					X						X	Posting up in room and jammed his door. Security and watch commander responding. At 2122 hours security unjammed the door, "and dialogue is in place now . . . seems to be effective at this time."	None listed
8/17/08	740	Feather	X					X						X	Refused to follow instructions to take it down to his room. Watch commander and search and escort units dispatched. Issues resolved through dialogue.	None listed
8/17/08	1500	Merced (ITP)	X					X						X	Refusal to follow instructions. Watch commander and security responded and resolved with dialogue. Youth was visited by psych tech, and a psychologist was notified.	None listed
8/17/08	2042	Sacramento (IBTP)	X			X								X	(We interviewed this youth.) Placed on Suicide Intervention status due to uncontrolled crying and unspecified self-destructive behavior. RN responded and provided medical assessment. An ADA staff assistant visited the youth. Psychologist was notified by phone.	None listed
8/18/08	1744	Tuolumne		X				X				X			2:1 fight in dayroom. MK-4 was used "to gain compliance." "Security arrived and observed twenty wards in the dayroom. [Redacted youth name] refused to follow instructions and was maced with MK-9."	4000 OC/MK4. 9000 Fogger/MK9.
8/18/08	1826	Feather		X										X	1:1 fight in dayroom. RN did medical assessments.	None listed

Table 4: August 2008

8/19/08	926	school area	X	X										X	1:1 fight in gym locker room. Security resolved incident with dialogue. RN provided medical assessments.	None listed
8/19/08	1510	McCloud	X	X						X		X			1:1 fight. Watch commander and security responded. "Wards refused to stop fighting." Both seen by RN and showered. Chemical force "effectively used." (No mention of the physical force that was apparently used.)	4000 OC/MK4. Z505 Cap Stun Crowd Control. Lock; arm/wrist. Takedown.
8/19/08	1515	Feather	X	X								X			1:1 fight. Watch commander and security responded. "Wards refused to follow directions and stop fighting." Chemical agents were effective. Youth were cuffed and escorted to rooms.	4000 OC/MK4.
8/19/08	1710	Feather	X	X								X			1:1 fight. Watch commander and security responded. Failed to follow staff directives to stop fighting. Chemical force effective. Seen by RN and showered.	4000 OC/MK4.
8/19/08	1838	American						X						X	Covering up window. Security obtained visual. Complied with staff directives.	None listed
8/20/08	1640	Kern (SMP)						X						X	Covered his window. Dialogue initiated by staff. Watch commander and TTS en route. Resolved through dialogue.	None listed
8/21/08	907	school area	X					X						X	Refused to return to his hall. Search and escort units dispatched. Was escorted to hall without incident.	None listed
8/21/08	1636	Sacramento (IBTP)	X			X								X	Threatened to jump from top tier. Watch commander and security responded. Dialogue initiated by hall staff: psychologist and SCWS. Dialogue effective. Youth escorted to room and placed on Suicide Prevention status by psychologist.	None listed

Table 4: August 2008

8/21/08	1915	San Joaquin County Hospital	X					X		X	X				Youth "became resistive at the hospital and had to be physically restrained."	Takedown. Handcuff. Leg iron.
8/22/08	1415	OHU	X					X				X			Covering window and "non-responsive to staff." "Chemical agents were used when staff attempted to push mat[t]ress away from the door and ward became resistive."	Z505 Cap Stun Crowd Control
8/22/08	2210	Sacramento (IBTP)	X					X						X	Covering room window. Security responded; resolved through dialogue.	None listed
8/22/08	2230	OHU	X			X		X						X	Covered window with his suicide mattress and stood on sink. Watch commander responded. Dialogue effective, and youth was given his medication.	None listed
8/23/08	1754	Feather	X	X										X	1:1 fight in kitchen. Watch commander and search and escort units dispatched. Were seen by duty nurse.	None listed
8/23/08	2135	Pajaro	X					X		X					Youth "became resistive when security staff attempted to cuff ward. Physical strength and holds became necessary to gain compliance of the ward."	Takedown.
8/24/08	1515	Merced (ITP)	X					X						X	Posted up in room. Watch commander and search and escort units dispatched. Resolved through dialogue.	None listed
8/24/08	1521	Mojave							X					X	"Multiple wards grouping in the dayroom, mostly North." Watch commander and search and escort units dispatched. Issues resolved through dialogue.	None listed
8/25/08	2050	Mojave	X					X				X			Posted up in room and not responding. "Chemical agent became necessary when ward approached door as it was opened."	Z505 Cap Stun Crowd Control
8/26/08	1130	Tuolumne	X	X								X			1:1 fight. Chemical agent used. Seen by duty nurse.	4000 OC/MK4

Table 4: August 2008

8/26/08	1518	Feather	X			X		X	X					X	Holding contraband (package of beads found in new shoes) "hostage in his hand" and attempting to swallow them. Security and Watch Commander responding. Resolved through dialogue.	None listed
8/26/08	1635	Administration Control						X						X	Refusing to follow instructions. Security responding. Resolved with dialogue.	None listed
8/26/08	1640	Pajaro						X						X	Refusing to follow instructions. Security and watch commander responded. Resolved with dialogue.	None listed
8/26/08	2105	Mojave	X					X				X			Posting up in room. Safety chain utilized. Security and watch commander responded. Youth refused to comply with staff instructions, and chemical force was used.	Unspecified chemical force
8/26/08	2130	Mojave	X					X						X	Posting up in room. Safety chain utilized. Security and watch commander responded. Before they arrived, hall staff resolved with dialogue.	None listed
8/26/08	2345	Sacramento (IBTP)	X				X							X	Staff called security to report youth was being "disruptive" and had smashed his TV on the floor. Youth claimed it fell. Security and duty lieutenant responded. Resolved with dialogue.	None listed
8/27/08	1507	Sacramento (IBTP)	X						X					X	Hiding under table in his room covered with a blanket. Initially would not respond to dialogue. Security responded. SCWS used dialogue to resolve.	None listed
8/27/08	1655	Administration Control	X					X						X	Refused to return to hall. Resolved through dialogue with "S&E 18 and Program Administrator." Escorted back to Kern (SMP).	None listed

Table 4: August 2008

8/27/08	1733	Sacramento (IBTP)	X			X							X	On tier. Security, watch commander and MH staff responding. Dialogue initiated. Youth came off rail at 1811 and was escorted to room. A clinician ordered him transferred to OHU and placed on SW. Transferred at 1832.	None listed
8/27/08	1841	Pajaro	X					X		X				Refused to go down. Dialogue initiated. Security and watch commander responded. When attempting to cuff youth, he pulled away and was then physically restrained by security. Was then escorted to dispensary to be seen by RN.	Lock; arm/wrist. Takedown. Figure 4 leg lock.
8/27/08	1958	Mojave	X					X					X	Refused to go down to his room. Security and watch commander responding. Resolved through dialogue.	None listed
8/28/08	741	Sacramento (IBTP)	X					X					X	Covering his windows and refusing to respond. Safety chain utilized. Watch commander, security units responded and resolved with dialogue.	None listed
8/29/08	649	Sacramento (IBTP)	X					X					X	Posting up in room. Security responded, and youth cooperated. A clinician spoke to youth, and he agreed to contract.	None listed
8/29/08	1230	Smith						X	X				X	"Red light [redacted youth name] ward [redacted youth name] . . . Threatening staff with bodily harm. Ward placed on alternative program on Kern [SMP]. Ward refusing to be searched and to spar. Sgt. [redacted] enroute [sic] to counsel, and ward complied."	None listed
8/29/08	1715	Mojave	X					X					X	Refusing to take it down. Security responding. Resolved through dialogue.	None listed

Table 4: August 2008

8/29/08	1744	Kern (SMP)						X						X	Refusing to take it down. Security responding. Resolved through dialogue.	None listed
8/29/08	1801	Sacramento (IBTP)	X					X						X	Covering window. Dialogue initiated. Security and MH staff responding. Dialogue effective.	None listed
8/29/08	1855	American	X						X					X	Youth to be placed on temporary detention for threatening staff. Security responding to transport youth to Kern (SMP).	None listed
8/29/08	1904	American	X			X		X		X					Several Norteno youth refusing to take it to their rooms. One youth climbed onto the TV stand and threatened to jump. Two other youth had to be physically restrained "when they became resistive while being handcuffed."	Lock; arm/wrist. Lock; leg. Takedown.
8/29/08	1940	Sacramento (IBTP)	X					X						X	On SW. Refusing to be transferred to Merced (ITP). Security and watch commander responding. Dialogue initiated. Per captain, youth to remain on Suicide Watch on Sacramento hall.	None listed
8/29/08	2016	McCloud	X					X						X	Security response. Refused to go down. Resolved through dialogue.	None listed
8/29/08	2045	Kern (SMP)					X							X	"Wards from American flooding. Security responding. First watch Lieutenant en route."	None listed
8/29/08	2220	Kern (SMP)						X				X			Posting up and covering in their rooms. Watch commander responding. Two youth allowed staff to remove the covering with chain. A third youth advanced toward door when staff attempted to remove the covering, and chemical force was used.	Z505 Cap Stun Crowd Control
8/30/08	720	McCloud						X						X	Youth was upset with hall staff and ran into kitchen and hid in the closet. Watch	None listed

Table 4: August 2008

															commander and search and escort units were dispatched. Youth followed security instructions and was placed in his room.	
8/30/08	1106	Owens		X										X	1:1 fight. Both youth complied with staff instructions.	None listed
8/30/08	2135	Merced (ITP)	X			X				X					Youth attempted to run upstairs to the second tier and was physically restrained.	Lock; arm/wrist. Lock; leg. Takedown.
8/30/08	2135	Merced (ITP)	X			X		X		X					Youth "was non-compliant, refusing to return to his room." He ran away from staff and attempted to run up to second tier.	Takedown.
8/31/08	1110	Owens						X						X	Refused to take it down to his room. Continued not to follow staff instructions.	None listed
8/31/08	2139	Mojave	X					X				X			1:1 fight. "Chemical agent utilized to gain compliance." Watch commander and security responded. RN performed medical assessments.	4000 OC/MK4
8/31/08	2212	Merced (ITP)	X					X				X			Covering windows, refusing to follow orders. "Chemical agents used when wards approached the door. Both were seen by the MTA.	Z505 Cap Stun Crowd Control
Total	**98**		**72**	**16**	**3**	**13**	**2**	**66**	**12**	**11**	**1**	**17**	**0**	**72**		

Cause	n	n No Force	n UOFs	n Chemical	n Physical
Y/Y Fight	**16**	**8**	**8**	**8**	**1**
Y/S Fight	**3**	**0**	**3**	**1**	**2**
Self-Harm	**13**	**8**	**5**	**2**	**4**
P. Damage	**2**	**2**	**0**	**0**	**0**
Resistance	**66**	**50**	**16**	**8**	**8**
Other	**12**	**11**	**1**	**1**	**0**

MH Youth Only:	
All Crises	72
No Force	49
UOFs	23
Chemical	14
Physical	11

Table 5: September 2008

Date	Time	Location	MH	Cause of Incident						Type of Force					Description	UoF details
				Y/Y Fight	Y/S Fight	Self-Harm	Property Damage	Resistance	Other	Phys.	Mech.	Chem.	Less Lethal	None		
9/1/08	1540	school area	X	X										X	Fighting	None listed
9/1/08	1941	Mojave	X					X						X	Posting up “on lockers” in dayroom.	None listed
9/2/08	850	Merced (ITP)	X			X				X	X				On SP. Ran toward top tier. Spit mask requested. Watch Commander and search and escort units dispatched.	Takedown, handcuff, leg iron.
9/2/08	920	American	X					X						X	Posted up in room. Watch commander and search and escort units dispatched. Safety chain was utilized to clear his door. Youth followed instructions once security arrived. Youth’s “issues being resolved by staff.”	None listed
9/2/08	1035	McCloud	X						X					X	Threatening classroom teacher with bodily harm. Search and escort units dispatched. Followed instructions and escorted back to living unit.	None listed
9/2/08	1210	Sacramento (IBTP)	X					X						X	(In other records, this youth appears to have been on Merced as of this date.) On Suicide Prevention status. Refused to give up clothing upon duty psychologist’s request. Watch commander and search and escort units dispatched. Refused to follow security instructions. A psychologist was able to get the ward to comply.	None listed
9/2/08	1729	Merced (ITP)	X					X				X			Was “covering up.” “Dialogue initiated by hall staff.” Security and watch commander en route. “Ward refused to uncover.” Chain utilized.	Z505 Cap Stun Crowd Control

Table 5: September 2008

9/2/08	1740	Merced (ITP)	X					X						X	(OSM interviewed this youth.) "Covering up." "Dialogue initiated." Security and watch commander en route. Dialogue effective.	None listed
9/2/08	1905	Merced (ITP)	X					X						X	"Covering up." "Dialogue initiated." Security and watch commander en route. Dialogue effective.	None listed
9/3/08	748	Feather	X					X						X	Refused to be searched after returning from pill call. Watch commander and search and escort units dispatched. Both were searched by security.	None listed
9/3/08	841	Merced (ITP)	X			X				X					Both on SP. Ran toward top tier.	Takedown
9/3/08	1000	gym	X	X										X	Fighting. No injuries. Both seen by nurse.	None listed
9/3/08	1055	Merced (ITP)	X			X						X			Tied cloth around neck and wouldn't remove it when instructed. Wouldn't open door when instructed. Staff opened door and used unspecified chem. agent. Youth seen by duty nurse and psychologist.	Chem. agent (unspecified)
9/3/08	1647	Merced (ITP)	X					X						X	"Red light Merced ward" refused to go to room. Security responded, and he complied.	None listed
9/3/08	1652	OHU / medical area	X					X						X	Lieutenant en route to dispensary, you refused to leave MTA's office.	None listed
9/3/08	1703	Merced (ITP)	X			X						X			Wrapped t-shirt around neck. Security dispatched. Chemical agents "became necessary" to prevent youth from injuring self. (OSM interviewed this youth, who said staff sprayed the large mace can at him and implied it wasn't necessary – "When they see you" attempting/gesturing suicide, "they spray you.")	Z505 Cap Stun Crowd Control
9/3/08	1850	Merced (ITP)	X					X		X					Posted up on top tier. Lieutenant and security responded.	Takedown

Table 5: September 2008

9/3/08	1940	Feather	X					X						X	Covering room window. Staff dialogue "and were going to utilize the safety chain."	None listed
9/3/08	1947	Mojave	X					X						X	"Red light staff" report youth refused instructions. Lieutenant and security en route, and youth placed in his room without incident.	None listed
9/3/08	2202	Merced (ITP)	X			X						X			On SP. Tried to hang self with sheets. Sheets removed. Shortly thereafter he tried to hang himself with t-shirt. Chemical agents "were required to stop ward from injuring himself."	Z505 Cap Stun Crowd Control
9/3/08	2238	Sacramento (IBTP)	X			X								X	Youth was returned from CTC on 9/3, on SW, and began smearing and consuming feces and scratching his wrist with his fingernails to the point of bleeding. "Lieutenant and Medical staff respon [sic]"	None listed
9/4/08	948	Merced (ITP)	X			X								X	Threatening to jump off his sink. A psychologist spoke with the youth, who agreed to contract.	None listed
9/5/08	1128	outside Sacramento (IBTP)	X	X								X			Fighting. Both were maced, seen by nurse, showered by hall staff.	4000 OC/MK4
9/5/08	1714	Merced (ITP)	X						X					X	"Security Response Ward [redacted name] out of control."	None listed
9/5/08	2123	Merced (ITP)	X					X						X	"Security Response Ward [redacted name] posting up."	None listed
9/6/08	815	Merced (ITP)	X					X						X	Refusal to "take it down to his room." Watch commander and search and escort units dispatched. Issues resolved through dialogue.	None listed
9/6/08	855	Merced (ITP)	X				X							X	Busted sprinkler head in his room after threatening to do so. Watch commander and search and escort units dispatched. "Removed from his room for clean up."	None listed

Table 5: September 2008

9/6/08	950	Merced (ITP)	X				X							X	Threatening to start fire in his room. Watch commander and search and escort units dispatched. Issues resolved through dialogue. (Less than 2 hours later, youth placed on Suicide Prevention status – this may be better classified as self-harm behavior.)	None listed
9/6/08	1130	Merced (ITP)	X			X								X	Threatening to jump off table in his room. Placed on Suicide Prevention status on Sacramento hall by duty psychologist.	None listed
9/6/08	1345	Sacramento (IBTP)	X	X										X	1:1 fight. Security response.	None listed
9/6/08	1400	Merced (ITP)	X				X							X	Broke fire sprinkler in his room (second time in one day). Maintenance notified.	None listed
9/6/08	2045	Feather	X					X						X	Security response. Youth "refusing to go down."	None listed
9/7/08	1000	Chapel							X					X	Was taken from chapel and placed on Kern hall (SMP) for threatening staff during services.	None listed
9/7/08	1400	Merced (ITP)	X					X						X	Security response –not following instructions	None listed
9/7/08	1620	Merced (ITP)	X					X						X	Security response – "refusing to take it down." Given verbal counseling and cooperated.	None listed
9/8/08	1755	Pajaro (SBTP)	X	X								X			Fighting	4000 OC/MK4
9/8/08	1808	Feather	X					X						X	Refusing to "take it down." Security response.	None listed
9/8/08	1945	Mojave	X					X						X	Posting up. Security response.	None listed
9/8/08	2220	Merced (ITP)	X				X							X	Destroying state property – tampering with fire sprinkler. Security and watch commander responded. Broke fire sprinkler causing water to flow continuously. Was moved to another room. Behavior report written. (Posted up in new room a few minutes later.)	None listed
9/8/08	2247	Merced (ITP)	X					X						X	Posted up in room. Security and watch commander responded. Resolved with dialogue.	None listed

Table 5: September 2008

9/9/08	920	Feather	X					X						X	Refused to “take it down to his room” after approached by hall staff who saw him with a bloody nose. When asked about his nose, began yelling and screaming at staff to mind their own business. Watch commander and security responded. Was placed in room with no further incident.	None listed
9/9/08	1625	Smith	X					X						X	Refused to “take it down.” Security response.	None listed
9/10/08	905	Merced (ITP)	X					X						X	On Suicide Prevention status (we interviewed this youth). Posted up and refused to uncover. Safety chain utilized. Watch commander and search and escort units dispatched. Youth continues to ignore security instructions. TTS and psychologist being notified. (This may be better classified as self-harm behavior.)	None listed
9/10/08	1030	Sacramento (IBTP)	X			X								X	Threatening to “hand” himself. Watch commander, TTS, and duty psychologist dispatched. Continued to make threats to hurt himself. Search and escort units dispatched to assist hall staff.	None listed
9/11/08	900	Merced (ITP)	X					X						X	“Posted on basketball hoop” outside. Security and watch commander responded. Came down with dialogue. Transported to “(SAC)” [possibly Sacramento] temporarily. “Ward causing a disruption on the hall.”	None listed
9/11/08	1655	Merced (ITP)	X				X					X			Trying to break sprinklers in “their room.”	Unspecified mace
9/11/08	2035	Mojave	X					X						X	Refused to “take it down” to his room. Security responded. Placed in room without further incident, using dialogue.	None listed
9/11/08	2355	Merced (ITP)	X					X						X	Covered window. Duty lieutenant and security responded. Dialogue resolved the issue.	None listed

Table 5: September 2008

9/12/08	735	McCloud	X				X							X	Trying to break sprinkler in room.	None listed
9/12/08	936	school area	X					X						X	Refusal to return to living unit. Lieutenant and security responded. SCWS spoke to youth and resolved through dialogue.	None listed
9/12/08	954	McCloud	X			X								X	Hall staff requested security assistance; youth refused to wear a smock.	None listed
9/12/08	2005	McCloud	X			X								X	Ran out of room up to top tier. Staff were able to convince him to cooperate and escorted him back to his room.	None listed
9/12/08	2007	McCloud	X					X						X	Posting up. Youth "seems to be feeding off, (responding to)" another youth's behavior.	None listed
9/12/08	2030	Smith						X						X	Posting up. Says he wants to go to lock-up.	None listed
9/13/08	830	Mojave	X	X								X			Fighting. Youth was maced because he was the aggressor. Security responded with lieutenant Both youth were seen by nurse and cleared.	Unspecified mace
9/13/08	1145	McCloud	X					X				X			(Youth was also at Merced.) Posted up in room on his sink, refused to come down.	Unspecified mace
9/13/08	1450	Merced (ITP)	X			X								X	(OSM interviewed this youth.) On top tier. Secured in room. On-call psychologist was called.	None listed
9/13/08	1545	McCloud	X	X								X			Fighting	Z505 Cap Stun Crowd Control
9/13/08	2015	McCloud	X					X						X	Refusal to "give up his handcuffs."	None listed (handcuffs not noted)
9/13/08	2115	American							X					X	Upset in his room, refused to talk to staff and just wanted door closed.	None listed
9/14/08	1128	McCloud	X	X								X			Fighting. Both maced by hall staff, seen by nurse, and cleared. Both were given a shower.	Unspecified mace
9/14/08	1825	McCloud	X					X						X	Refusal to go to room. Verbal counseling.	None listed

Table 5: September 2008

9/15/08	1115	school area						X						X	Not following instructions in school area. Departed school without permission. Once on unit, threatened staff. Placed on temporary detention status on Kern.	None listed
9/15/08	1815	McCloud	X						X					X	Spit out door onto staff. Security and watch commander responded. Placed on temporary detention with notifications to superintendent, captain, and TTS.	None listed
9/15/08	2030	Merced (ITP)	X			X								X	Posted up on top tier railing. Security and watch commander responded. Resolved with dialogue. Came down but said he wanted to kill himself. Psychologist (on grounds) was notified.	None listed
9/15/08	2040	American						X						X	Refused to “take it to this room - Approximately 18 wards in hard back chairs.” Security and watch commander responded. Resolved with dialogue.	None listed
9/15/08	2100	Mojave	X					X						X	Not following instructions, “running his own [program] in the day room.” Security responded. Resolved with dialogue.	None listed
9/15/08	2110	Mojave	X			X								X	Posted up in shower and ingesting unknown liquid. Security already on scene. MTA responded. Youth examined and placed in room. Resolved with dialogue.	None listed
9/16/08	645	Owens		X										X	1:1 fight. No injuries. No chemicals.	None listed
9/16/08	1230	Mojave	X					X						X	Covered up room window. Watch commander and security responded. Safety chain used to clear window.	None listed

Table 5: September 2008

9/16/08	1442	Merced (ITP)	X			X								X	(OSM reviewed this youth's chart.) On Suicide Prevention status. Cutting on wrists. Security and watch commander responded. Seen by nurse and clinician. Will continue on Suicide Prevention status per a second clinician.	None listed
9/16/08	1458	Mojave	X					X						X	Not following instructions, causing disruption on the unit. Security and watch commander responding. Resolved with dialogue. Youth was seen by hall psychologist.	None listed
9/16/08	1510	Mojave	X					X						X	Not following staff instructions, disrupting program. Security and watch commander on the hall. Resolved with dialogue.	None listed
9/16/08	1700	Feather	X					X						X	Posted up in room. Safety chain utilized. All youth out on the floor, "advised them to move their wards to the outside recreation area." Security and watch commander responded. Resolved with dialogue.	None listed
9/16/08	1804	Feather	X					X						X	Refusing "to take it to their rooms." Seated in hardback chairs and refusing to move. Security and watch commander responded. Resolved with dialogue.	None listed
9/16/08	1850	Mojave	X			X								X	Youth stated he needed to be on a watch. SPAR score = 12. Security and watch commander responded. Per a psychologist, youth to be placed on Suicide Watch with 1:1 observation, in a smock with a suicide blanket. A second clinician was also informed.	None listed
9/16/08	2000	Mojave	X					X						X	Refusal to follow instructions. Security and watch commander responded. Resolved with dialogue.	None listed

Table 5: September 2008

9/16/08	2050	Feather	X			X								X	Put sheet around his neck and stated wanted to kill himself. Two clinicians were notified. Youth to be placed in smock with suicide blanket "per the Dr.'s on S[uicide] W[atch] one on one observation." SPAR score = 18.	None listed
9/16/08	2100	Mojave	X					X						X	Refusal to follow instructions, pacing around dayroom. Security and watch commander responded. Resolved with dialogue.	None listed
9/17/08	805	school area	X	X						X		X			Physical altercation. Watch commander and security responded. Both seen by MTA and showered.	Z505 Cap Stun Crowd Control. Lock; arm/wrist.
9/17/08	900	Kern (SMP)		X								X			Mutual physical altercation in classroom on Kern hall. Watch commander and security responded. Chemical agents. Both youth seen by MTA and showered.	4000 OC/MK4
9/17/08	1340	McCloud	X	X								X			Physical altercation in dayroom. Watch commander and security responded. Chemical agents used. Both youth received showers and were seen by RN.	4000 OC/MK4
9/17/08	1350	school area	X					X						X	Refused to exit classroom. Security responded. Youth was taken to Receiving, put through the metal detector, and strip-searched. Prison-made tattoo motor and fresh tattoos found on the youth.	None listed [Strip-search]
9/17/08	1505	Feather	X					X						X	Not following instructions in dayroom. Security and watch commander responded. Resolved with dialogue.	None listed
9/17/08	1530	Smith							X					X	Threatening staff. Security and watch commander responded. Placed in room on temporary detention. Resolved with dialogue.	None listed

Table 5: September 2008

9/17/08	1620	Mojave	X					X						X	Disrupting program in dayroom. In possession of contraband (prison made tattoo motor). Security and watch commander responded. Resolved with dialogue. Motor confiscated.	None listed
9/17/08	1905	Kern (SMP)		X								X			Physical altercation. Chemical agents used to gain control. Both youth seen by MTA and showered.	4000 OC/MK4
9/18/08	1310	McCloud	X	X								X			1:1 fight. Chemical agent used to stop fighting. All were seen by nurse.	Z505 Cap Stun Crowd Control
9/18/08	1442	McCloud	X					X						X	Staff used panic alarm. Youth resistive toward staff returning from shower area to his room. Was placed back into the shower until security arrived to assist.	None listed
9/19/08	823	Kern (SMP)	X					X	X					X	Was not following instructions and out of control. Security responded. Resolved with dialogue.	None listed
9/19/08	1049	Merced (ITP)	X					X						X	Duty lieutenant radioed to report that youth refused to "go down" after school movement. Security responded and resolved with dialogue.	None listed
9/19/08	1245	Administra-tion Control						X						X	Not following instructions. Security responded, and youth was escorted to Kern (SMP).	None listed
9/19/08	1300	school area						X		X	X				Not following instructions in classroom. Security responded, and physical strength and holds became necessary. Youth was placed on Kern (SMP).	Lock; arm/wrist. Handcuff.
9/19/08	1815	Feather	X	X								X			2:1 fight. Refused to comply with direct order to stop.	Z505 Cap Stun Crowd Control
9/20/08	1901	Feather							X					X	Asked to speak to the duty lieutenant. Threatened to post up.	None listed
9/20/08	2343	Merced (ITP)	X					X						X	(OSM interviewed this youth.) Covered room window, refused to respond. Watch commander and security unit responded and resolved with dialogue.	None listed

Table 5: September 2008

9/21/08	1326	McCloud	X					X						X	Refusal to return to room. Security and lieutenant responded and resolved through dialogue.	None listed
9/21/08	1444	McCloud	X	X										X	1:1 fight. No mace or injuries.	None listed
9/22/08	1843	Merced (ITP)	X					X		X	X	X			Refused to go down. Chemical agents and restraint "necessary."	4000 OC/MK4. Lock; arm/wrist. Handcuff.
9/22/08	2130	Merced (ITP)	X			X								X	Posting up. Contacted on-call psychologist. Youth placed on Suicide Watch.	None listed
9/22/08	2206	Merced (ITP)	X			X								X	"Staff called to report that [youth], who is on Watch, was posting up and covering the door (window)." Duty lieutenant and security responded and used dialogue to resolve.	None listed
9/23/08	1552	Merced (ITP)	X						X					X	(OSM reviewed this youth's chart.) Spit on YCC. ("Staff assault") Secured in his room.	None listed
9/23/08	1804	pill call						X						X	Running from security during pill call. Ran on track toward unit IV. Could not get into Smith front door. Was "secured." "Central on fence line. Post 132 inside."	None listed
9/23/08	2127	McCloud	X			X								X	Refusal to be placed in smock per psychologist's orders. Security assisted staff.	None listed
9/23/08	2205	Merced (ITP)	X					X						X	Covering window. Security and lieutenant responded; resolved through dialogue.	None listed
9/24/08	1040	school area						X						X	"[K]icked out of class for being disruptive." Security dispatched after alarm was activated to classroom. Escorted back to his hall.	None listed
9/24/08	1410	McCloud	X					X		X	X				Not following instructions. Attempting to climb fence and standing on table.	Rear wrist lock. Handcuff.
9/24/08	1643	McCloud	X				X							X	Trying to pop sprinkler in room. Security response.	None listed

Table 5: September 2008

9/24/08	1730	Merced (ITP)	X			X				X	X				On top tier. Was secured to rail while psychologist was talking to him. An hour later was secured in his room with the psychologist still talking to him. "Physical strength and holds necessary to prevent ward from possibly injuring himself."	Lock; arm/wrist. Lock; leg. Figure 4 leg lock. Handcuff. Leg iron.
9/25/08	930	Merced (ITP)	X					X				X			(Note: youth was suicidal the previous day.) Posted up, "safety chain utilized." "Chemical agent used as ward was at the door when it was opened." Watch commander and search and escort units dispatched. Seen by nurse and showered.	Z505 Cap Stun Crowd Control
9/25/08	1735	McCloud	X	X								X			2:1 fight. No injuries.	Z505 Cap Stun Crowd Control
9/26/08	705	Merced (ITP)	X			X								X	Attempting to cut self with plastic utensil with breakfast. Watch commander and search and escort units dispatched. Resolved through dialogue.	None listed
9/26/08	807	Merced (ITP)	X				X							X	Attempting to break his tray slot. Watch commander dispatched. Resolved through dialogue.	None listed
9/26/08	1414	McCloud	X					X						X	Posting up in room. Security en route and youth uncovered through use of dialogue.	None listed
9/26/08	1451	American	X					X						X	Refusal to follow instructions. Security and lieutenant en route. Youth complied through dialogue.	None listed
9/26/08	1635	McCloud	X			X								X	Placed t-shirt around neck in dayroom. Staff "confronted the ward," and he removed the shirt. Placed on suicide intervention status per psychologist.	None listed
9/26/08	1743	field area	X	X								X			Youth 1 rushed into field and attacked youth 2. Youth 1 was seen by nurse and cleared. Showered.	Z505 Cap Stun Crowd Control

Table 5: September 2008

9/26/08	2206	Merced (ITP)	X						X					X	Covering window and smearing feces. Security and watch commander responded. Dialogue initiated. Youth threatened to continue "to act out" unless moved to OHU and watched by a certain female staff. The on-call psychologist was notified.	None listed
9/27/08	1446	Feather	X	X								X			Hall staff maced while security and lieutenant en route. Both seen by nurse and had shower.	Z505 Cap Stun Crowd Control
9/27/08	1545	Merced (ITP)	X	X						X					Fighting. Physical strength and holds had to be used on one of the youth because he refused to allow security to uncuff him and place him in his room. (Does not indicate why cuffs were necessary.)	Lock; arm/wrist. Figure 4 leg lock. (Handcuffs/ mechanical not checked on form.)
9/27/08	1625	Merced (ITP)	X			X								X	"[P]osting up covering his window." Security and lieutenant en route. Tying items to sprinkler, placed a shirt around neck, and banging head against wall. Psychologist was notified.	None listed
9/27/08	1720	Merced (ITP)	X			X						X			Was "maced for self-injurious behavior, attempting to bite himself."	Z505 Cap Stun Crowd Control
9/27/08	2052	Merced (ITP)	X	X								X			Fighting. Both maced, seen by nurse, and showered.	4000 OC/MK4
9/28/08	1436	McCloud	X	X										X	1:1 fight. No mace used. Both complied with verbal instructions. Both seen by MTA and cleared.	None listed
9/29/08	932	school area	X	X										X	1:1 fight in gym.	None listed
9/30/08	934	Merced (ITP)	X			X								X	Posting up on top tier rail. "Staff were informed to use dialogue and to contact their unit psychologist."	None listed
9/30/08	1034	Merced (ITP)	X					X						X	Refusal to return to room from kitchen. Security and lieutenant responded. Youth complied with dialogue.	None listed

Table 5: September 2008

9/30/08	1340	school area	X	X								X			2:1 fight.	4000 OC/MK4 and 9000 Fogger/MK9.
9/30/08	1835	Mojave	X					X						X	Refusal to take down. Security responding. "Psych tec. requested."	None listed
9/30/08	1930	Mojave	X					X						X	Not following instructions: "refusing to take it down."	None listed
130	**130**		**116**	**24**	**0**	**26**	**8**	**63**	**10**	**9**	**5**	**25**	**0**	**98**		

Cause	n	n No Force	n UOFs	n Chemical	n Physical
Y/Y Fight	**24**	**7**	**17**	**16**	**2**
Y/S Fight	**0**	**0**	**0**	**0**	**0**
Self-Harm	**26**	**19**	**7**	**4**	**3**
P. Damage	**8**	**7**	**1**	**1**	**0**
Resistance	**63**	**56**	**7**	**4**	**4**
Other	**10**	**10**	**0**	**0**	**0**

MH Wards Only:	
All Crises	116
No Force	87
UOFs	29
Chemical	23
Physical	8

Table 6: October 1, 2008 to October 17, 2008

Date	Time	Location	MH	Type of Incident						Type of Force					Description	UoF details
				Y/Y Fight	Y/S Fight	Self-Harm	Property Damage	Resistance	Other	Phys.	Mech.	Chem.	Less Lethal	None		
10/1/08	843	Feather	X			X		X						X	Refused to come out of room to be transferred to Preston. Posted up in room, "forcing staff to utilize the safety chain." Watch commander and search and escort units dispatched. Was placed on Suicide Watch per hall psychologist. Move to Preston was canceled.	None listed
10/1/08	1030	McCloud	X			X		X		X	X				Refused to follow staff instructions. Watch commander and search and escort units dispatched. Had to be physically restrained by security and placed in room. Duty psychologist placed him on Suicide Watch.	Lock; arm/wrist. Figure 4 leg lock. Handcuff.
10/1/08	1150	Kern (SMP)	X					X						X	Refusing to take it to their rooms after rec time. TTS, program administrator, and watch commander dispatched. All youth followed instructions after some time and took it to their rooms.	None listed
10/1/08	1815	Mojave	X					X						X	Refusing to follow instructions; refusing to go down. "Lt. [redacted] on unit."	None listed
10/1/08	2037	Feather	X					X						X	Refusing to follow instructions, take it down. Security responding. At 2045 youth was secured in room.	None listed
10/2/08	1115	Merced (ITP)	X	X										X	1:1 fight. Watch commander and search and escort units dispatched. Youth complied with instructions to stop. Both were seen	None listed

Table 6: October 1, 2008 to October 17, 2008

															by duty nurse.	
10/2/08	1325	Merced (ITP)	X					X		X					Refusal to follow instructions, running from staff, "creating a ruckus." Ran to top tier and sat on top rail. Watch commander and search and escort units dispatched. "[H]ad to be physically restrained."	Lock; arm/wrist. Lock; leg. Takedown
10/2/08	1430	school area	X					X	X	X					Walked away from school when metal detector went off. Youth was "resistive" when security approached. "Ward taken to ground extra security requested." Had unspecified contraband on his person and was taken to Kern hall (SMP) potty watch. Incomplete narrative: "Ward refused t".	Lock; leg. Takedown
10/2/08	1452	American						X						X	Refused to go to room. Security response.	None listed
10/2/08	1740	Tuolumne	X					X						X	Not following instructions. Youth upset he got a disciplinary “check.” Security response.	None listed
10/3/08	1510	Merced (ITP)	X	X								X			1:1 incident.	Z505 Cap Stun Crowd Control
10/3/08	1810	Smith		X										X	One youth struck another, who then struck him back. Both youth then went to their rooms.	None listed
10/4/08	1809	Feather	X					X						X	Refused to take it down to his room. Security and lieutenant responded.	None listed
10/5/08	853	Tuolumne	X					X						X	Refused to be searched "when confronted by hall staff." Security dispatched. Was escorted to receiving to be searched.	None listed

Table 6: October 1, 2008 to October 17, 2008

10/5/08	1020	Owens						X						X	Refusing to take it down to his room. Watch commander and search and escort units dispatched. Youth eventually followed instructions and was placed back in his room.	None listed
10/5/08	1621	Merced (ITP)	X	X										X	1:1 fight. Watch commander and search and escort units dispatched. Youth complied with instructions to stop. Both were seen by duty nurse.	None listed
10/6/08	905	school area	X						X					X	Youth was escorted from classroom back to his hall and placed on temporary detention for threatening teacher.	None listed
10/6/08	1010	McCloud	X					X						X	Refused to take it down to his room. Watch commander and search and escort units dispatched. Resolved through dialogue. Was placed in his room.	None listed
10/6/08	1626	Tuolumne						X						X	Posted up in room, covering window. Security and lieutenant responded. Resolved through dialogue.	None listed
10/6/08	2224	Kern (SMP)						X	X					X	Listed youth posted up on doors. Other youth yelling and banging on doors. Youth were upset because first watch staff turned off music. [An unfinished sentence beginning "Se" ends the description.]	None listed
10/6/08	2238	Kern (SMP)						X						X	Covered door. Resolved verbally.	None listed
10/6/08	2242	Kern (SMP)						X						X	Not responding to staff; door covered. Watch commander and security responding. Resolved verbally.	None listed

Table 6: October 1, 2008 to October 17, 2008

10/7/08	1608	Mojave	X					X						X	Not following instructions. Youth upset he got a check. Security and watch commander responded. Was placed in his room, and staff continued dialogue.	None listed
10/7/08	2118	Merced (ITP)	X	X										X	YCC activated personal alarm. 1:1 fight. Security and watch commander responding. Youth complied with instructions to stop fighting. Were cuffed and escorted to shower.	None listed
10/8/08	1906	McCloud	X					X						X	Refused to be searched by staff. Were suspected of holding contraband. Watch commander and security responding. Youth were searched by security staff "with negative results."	None listed
10/9/08	1301	Kern (SMP)	X					X						X	Security response. Youth "would not give up the restraints." Hall staff resolved the issue.	None listed
10/9/08	1630	McCloud	X	X				X		X		X			1:1 altercation. Security and watch commander responding. Youth failed to follow instructions to stop fighting. Chemical agents effective in obtaining compliance. Afterward, one of the youth failed to prone out, refused to follow orders, and had to be physically restrained.	4000 OC/MK 4. Takedown
10/10/08	1130	McCloud	X					X	X					X	Being disruptive. As security was dispatched, hall staff convinced youth to comply with instructions and placed him back in his room.	None listed
10/10/08	1505	Owens						X		X					While being escorted off hall, youth attempted to pull away from YCO. "Physical strength and	Takedown [no holds listed]

Table 6: October 1, 2008 to October 17, 2008

															holds became necessary to gain compliance."	
10/13/08	1424	Feather						X						X	Refused to take it down to his room. Security and lieutenant responded. Complied with security based on dialogue.	None listed
10/13/08	1618	outdoor	X	X										X	1:1 fight. Both examined by RN and cleared.	None listed
10/13/08	2000	Pajaro	X			X		X		X					Became "resistive" with security and had to be physically restrained. A psychologist placed him on Suicide Intervention status at the OHU.	Multi Person take-down
10/15/08	1335	Sacramento (IBTP)	X						X					X	"Sacramento classroom Panic alarm staff [redacted staff name]. Ward … removed from the classroom." Security response.	None listed
10/15/08	1530	Feather	X	X								X			1:1 physical altercation. Chemical agents used. Both seen by the MTA and were given a decontamination shower.	Unspecified chemical force.
10/15/08	1730	Tuolumne						X						X	Refusing to transfer to American hall. Posting up in dayroom. Watch commander responding. Was taken to Kern (SMP) on temporary detention "and transferred in the computer."	None listed
10/15/08	1813	Mojave	X	X								X			1:1 physical altercation. Chemical agents used. Both seen by the MTA and were given a decontamination shower.	Unspecified chemical force.
10/16/08	714	Movement	X	X						X		X	X		Pill call - 1:1 fight in front of unit 1. Pepperball, mace, and physical force used to separate the youth. Both were seen by RN and cleared.	Z505 Cap Stun Crowd Control. Takedown. Pepperball Water.

Table 6: October 1, 2008 to October 17, 2008

10/16/08	1312	McCloud	X			X								X	Security response. Youth banging his head against cement wall and punching wall with his fists. A psychologist was called to speak with the youth. Security responded to assist hall staff.	None listed
10/16/08	1500	Merced (ITP)	X					X						X	Blocking window. Resolved verbally.	None listed
10/16/08	1730	Feather	X	X								X			1:1 fight between two youth, and a third jumped into the fight. Chemicals used.	4000 OC/MK 4.
10/16/08	2025	Sacramento (IBTP)	X			X								X	Youth "threatening to cut himself or jump off the sink he was spared [sic] by [redacted] and scored a 22" on SRSQ. Dr. [redacted] was called and placed him on S[uicide] I[ntervention]; ordered staff to search his room for sharp objects. "If he was found to have a sharp object then we sho" [sic].	None listed
10/17/08	755	McCloud	X					X						X	Security response. Youth refused to be searched. Resolved verbally.	None listed
10/17/08	1158	McCloud	X			X								X	Banging head on wall and floor. "Dr. responded and will give medication."	None listed
10/17/08	1221	McCloud	X					X						X	Posting up on window. Treatment team had visual and made verbal contact. Security "responded again for ward [redacted] acting out of control in his room they have verbal contact at this time"	None listed
10/17/08	1546	McCloud	X					X						X	Refusing to take it down to his room. Security responded. Resolved through dialogue.	None listed

Table 6: October 1, 2008 to October 17, 2008

10/17/08	2027	McCloud	X						X					X	Youth spit on staff, "making contact with his facial area." Security and lieutenant responded. Staff was seen by RN and sent to St. Joseph's urgent care.	None listed

Cause	n	n No Force	n UOFs	n Chemical	n Physical
Y/Y Fight	**11**	**5**	**6**	**6**	**2**
Y/S Fight	**0**	**0**	**0**	**0**	**0**
Self-Harm	**6**	**4**	**2**	**0**	**2**
P. Damage	**0**	**0**	**0**	**0**	**0**
Resistance	**30**	**24**	**6**	**1**	**6**
Other	**6**	**5**	**1**	**0**	**1**

MH Youth Only:	
All Crises	36
No Force	26
UOFs	10
Chemical	6
Physical	6

To: Donna Brorby
From: Zack Schwartz
Re: Licensed Bed Usage Data
Date: October 22, 2009

I. Introduction

The mental health experts' 2008-9 formal report revisits the issue of licensed bed care.[1] As they did in May 2007,[2] the experts find that two populations at DJJ lack adequate access to licensed beds: youth housed in northern California and women.[3] DJJ has argued that utilization data shows that it is meeting the youth need for licensed mental health care beds.[4] The mental health experts had reviewed data concerning Chaderjian referrals for licensed bed care, but had not reviewed complete utilization data.[5] We have since collected such data from DJJ.

DJJ has provided its "Trackable Mental Health List" as of October 2009.[6] This Excel chart lists all referrals to licensed beds and inpatient psychiatric programs, and includes data on the identity of the referred youth, referring facility, reason for referral, whether the referral was rejected, the days pending transfer, length of stay, diagnosis at referral and discharge, and the program to which the youth was

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[1] Farrell Mental Health Experts' 2008-9 Site Visit Summary (draft), August 2009, pp. 7- 8 [hereinafter "Lee/Trupin 2009 Report"]; *compare* Fourth Report of the Special Master (July 2007), Appendix B (Farrell Mental Health Experts' Report on Licensed Mental Health Beds in the California Division of Juvenile Justice) [hereinafter "Lee/Trupin 2007 Licensed Bed Report"].

[2] Lee/Trupin 2007 Licensed Bed Report, p. 7.

[3] Lee/Trupin 2009 Report, pp. 7- 8. They note that DJJ primarily uses the CTC to treat males from the north and that logistical concerns and a desire to keep youth closer to their families make clinicians hesitant to transfer youth there from northern California. *Id*. A similar finding appears in the experts' 2007 licensed bed report. Lee/Trupin Licensed Bed Report, p. 6. Informal reports indicate that the source for these statements in 2009 include interviews with the chief psychologist at Chaderjian, a review of the transfer list from Chaderjian and an "Acute Bed Response document," and interviews and chart reviews of three youth at the CTC. Lee/Trupin Informal Report on Chaderjian, October 2008, p. 18; Lee/Trupin informal report on DJJ central office, January 2009, p. 30; Lee/Trupin informal report on Stark, May 2009, pp. 20-21. The experts report that DMH rejected two female youth for aggressiveness with instructions that DJJ should not refer them again and that females are isolated at the CTC where they usually are the lone female patient. Lee/Trupin 2009 Report, pp. 7- 8.

[4] At the August 22, 2009 mental health summit, Director Doug McKeever and psychiatrist Dr. Arguello noted that DJJ does not generally exceed 50% of its licensed bed capacity.

[5] *See* Lee/Trupin Informal Report on Chaderjian, October 2008, p. 18.

[6] Included in MH Data CD, PoP #534 (October 13, 2009).

discharged. In order to compare rates of referrals among facilities, I drew population averages from the Quarterly Statistical Report and OBITS.[7] DJJ has also provided data on the CTC, SVH and ICF census.[8]

During the 2008-9 fiscal year, DJJ used four types of licensed beds[9]:

- Correctional Treatment Center (CTC). DJJ's 10-bed Correctional Treatment Center is used for acute and crisis stabilization care. The CTC is located at Stark.
- Sierra Vista Hospital (SVH). DJJ contracts for access to acute and crisis stabilization beds at Sierra Vista Hospital, a private hospital in or near Stockton, California.
- Intermediate Care Facility (ICF). The Department of Mental Health operates a 20-bed Intermediate Care Facility at the SYCRCC facility.
- Department of Mental Health (DMH). By agreement, DJJ has access to 10 acute or intermediate care beds at DMH facilities, where appropriate beds are available. During the 2008-9 fiscal, DJJ admitted youth to three DMH hospitals: Metro State, Napa State, and Patton State.

The CTC and ICF are located in southern California, as are Metro State Hospital and Patton State Hospital. SVH and Napa State Hospital are located in northern California. As a result of a conflict between hospital rules and CCPOA contract provisions, DJJ no longer contracts for access to acute-care beds at Aurora Vista Del Mar Hospital, as it did at the time of the experts' 2007 report on licensed beds.[10]

II. Summary of the Data

In fiscal year 2008-9, youth were admitted to licensed beds at a higher rate than they were at the time of the experts' first report. Self-injurious or suicidal behavior is by far the most frequent reason for

[7] OSM has received the past four Quarterly Statistical Reports as a Proofs of Practice. *See also* e-mail of Tammie McGuire to Zack Schwartz, October 6, 2009 (reporting OBITS figures on population of women at DJJ from July 2008 to June 2009); Third Report of the Special Master (September/November 2006), Appendix A, Attachment C (OBITS Monthly Population Reports, January to June 2006); CDCR, "DJJ Research and Statistics," available at http://www.cdcr.ca.gov/Juvenile_Justice/Research_and_Statistics/index.html (last accessed October 20, 2009) (OBITS Monthly Population Reports, July to September 2006).
[8] Included in "MH Data" CD, PoP #534 (October 13, 2009).
[9] This paragraph is based on Lee/Trupin 2007 Licensed Bed Report, p. 1.
[10] E-mail of Juan Carlos Arguello to the special master, September 24, 2009; Lee/Trupin Licensed Bed Report, p. 3.

admission to licensed beds. Most licensed bed care was provided to DJJ youth at the CTC at Stark, an acute/crisis care facility. This was true for male youth in northern and southern California and for female youth. A minority of northern California male youth referred for licensed bed care received acute/crisis treatment at the private Sierra Vista hospital in Stockton. A minority of male youth from southern California facilities, but few from northern California facilities and no female youth, received treatment at the DMH-operated intermediate care facility at SYCRCC. Relatively few youth were treated in the 10 DMH hospital beds to which DJJ has access, and most of them were males from southern California facilities. Eighteen referrals were rejected by licensed bed facilities, ten of which were accepted within a week in an alternate licensed bed facilities. Most often, Sierra Vista was the rejecting facility and the CTC was the licensed bed of last resort. The CTC and ICF were generally at 50% capacity, the 10 beds available to DJJ at DMH hospitals were generally filled, and two or fewer DJJ youth were generally at Sierra Vista hospital. Nine youth were identified an unusually high rate of admissions to licensed beds from facilities (4.4 admissions per youth, as compared to 1.3 among other admits).[11]

II. System-Wide Patterns

During fiscal year 2008-9, there were 171 admissions to licensed beds, including 22 admissions from the CTC and ICF to other licensed beds (i.e., the patient was referred for continuing licensed bed care instead of sent back to his/her facility). Unless otherwise noted, the tables below refer to the set of 171 referrals. An additional 18 referrals resulted in rejection, although ten of the 18 quickly found placement at another licensed bed. Appendix A details the rejections and alternate placements.

The overall rate of admissions has increased approximately three times since the experts' first report on licensed beds. At that time – the first nine months of 2006 – DJJ logged 62 admissions to licensed mental health beds, for a rate of 0.8 admissions per 10,000 youth-days.[12]

[11] We selected the nine because each had been admitted to inpatient care from facilities three or more times in a six month period.
[12] During the first nine months of 2009, DJJ logged 103 admissions involving 65 youth.

By the period studied, the rate of admissions had risen to 2.9 admissions per 10,000 youth-days. A direct comparison with the first nine months of 2009 shows a similar trend: a rate of 2.2 admissions per 100 youth in the first nine months of 2006 increases to 6.3 admissions per 100 youth in the first nine months of 2009.[13] It is not clear if the increase is due to the changing composition of DJJ's population, improved access to licensed beds, or both.

Rate of Admissions Over Time

Time Period	Average Daily Population	Days	Youth-Days	Admissions	Admissions per 10,000 Youth-Days
1/1/06 to 9/30/06	2872	273	784056	62	0.79
7/1/08 to 6/30/09	1623	365	592395	171	2.89

Referrals to the CTC accounted for 72% of admissions to licensed beds during the 2008-09 fiscal year. The CTC had the highest average admissions per youth admitted, indicating that it had the highest proportion of youth admitted more than once. SVH, the other acute-care facility open to DJJ youth, had the second highest such rate.[14]

Admissions to Licensed Beds by Bed Type

Bed Type	# of Admissions	# of Youth Admitted	Average Admissions per Youth
CTC	117	75	1.6
ICF	32	29	1.1
DMH	9	9	1.0
SVH	13	10	1.3
All Bed Types	171	91	1.9

[13] QSR population data for the third quarter of 2009 was not available when writing this report. The admissions rate for the first nine months of 2009 is based on the average daily population for the first two quarters of that year.
[14] All admissions were counted, whether the youth came from a DJJ facility or from another licensed bed facility. Youth admitted to more than one bed type were counted separately in each category. For this reason, the number of youth admitted (91) is less than the total of the number s in the "# of Youth Admitted" column (123). There were 32 repeat admissions to the same category of licensed bed.

Chaderjian had the highest rate of referrals resulting in admissions in fiscal year 2008-9, followed by Stark.

Admissions to Licensed Beds by Referring Facility

Referring Facility	# of Admissions	Average Daily Population	Admissions per 100 Youth
Chaderjian	51	219	23.3
OH Close	2	172	1.2
Preston	7	348	2.0
Stark	56	493	11.4
SYCRCC	19	219	8.7
Ventura	14	173	8.1
CTC	17	n/a	n/a
ICF	5	n/a	n/a

Most DJJ patients admitted to licensed care beds were referred for suicidal and self-injurious behavior. Suicidal and self-injurious behavior was the stated reason for 66% of all referrals that led to admissions to licensed beds, followed by psychotic or bizarre behavior (10%), mania/hypomania (8%), and depression (5%). Self-injurious and suicidal behavior was also the most frequent reason for admission to both acute-care beds and intermediate care beds at the ICF. Depression and grave disability were the most frequent reasons for admission to DMH intermediate-care beds.

Reasons for Referral to Licensed Beds by Bed Type

Reason for Referral	Relative Frequency (%)			
	CTC	ICF	DMH	SVH
Current or recent suicidal/self-injurious behavior	78	38	11	69
Psychotic or bizarre behavior	9	16	11	8
Gravely disabled	2	0	33	0
Depression	2	9	33	8
Mania/hypomania	6	13	0	15
Medication adjustment	0	3	0	0
Clarify diagnosis	0	13	0	0
Aggression paired with mental disorder	3	0	0	0
Anxiety/panic	1	6	0	0
Other	1	3	11	0

Patients generally are admitted to acute/crisis stabilization beds (CTC, SVH) faster than intermediate-care beds (ICF, DMH). Half of all admits to the CTC and SVH waited less than a day, and the longest wait time for either facility was two days. A wait time of approximately a week was standard for admission to the ICF.[15] DMH beds showed the greatest variability in wait times, ranging from one day to over two months.

Days Pending Transfer by Bed Type

Licensed Bed Type	Days Pending Transfer			
	Median	Interquartile Range	Shortest	Longest
CTC	0	1	0	2
ICF	6	3	1	20
SVH	0	1	0	1
DMH	12	26	1	67
All Bed Types	1	1	0	67

Patients also generally stay longer at intermediate-care beds ICF and DMH beds than at the CTC or SVH.[16] For example, while half of all admits to the CTC were discharged within ten days, 75% of admits to the ICF stayed longer than a month.[17] The ICF showed the greatest variability in length of stay.

Length of Stay by Bed Type

Licensed Bed Type	Length of Stay (in Days)			
	Median	Interquartile Range	Shortest	Longest
CTC	10	8	2	117
ICF	59	86	3	255
DMH	48	31	13	155
SVH	6	1	2	10

[15] Twenty-five percent of admits to the CTC waited less than five days. Half of all admits to the ICF waited less than a week. Seventy-five percent of admits to the ICF waited less than eight days.

[16] Eight admissions to licensed beds, mainly admissions to the ICF, were still pending discharge as of October 2009. Those eight cases are excluded from all calculations concerning LOS.

[17] One youth remained at the CTC for 117 days. This appears to be an unusual case, as the next-longest LOS was 49 days. The youth ([redacted], #[redacted]) was diagnosed with paranoid schizophrenia and referred from the Chaderjian IBTP to the CTC for aggression paired with mental disorder. He remained at the CTC from March 2009 through July 2009, when he was paroled.

During the 2007-8 and 2008-9 fiscal years, the CTC and ICF were most commonly at half capacity. SVH was most commonly empty of DJJ youth. The DMH beds available to DJJ were frequently at 40% capacity, but also spent a substantial number of days at close to or over capacity. For example, there were 34 days when DJJ had over 10 youth staying at DMH beds. The CTC was over capacity for four days, all of them in May 2008.

CTC Beds Filled (out of 10)

Census (Beds Filled)	Days at This Census	
	#	%
1	20	5
2	47	13
3	46	13
4	40	11
5	59	16
6	63	17
7	49	13
8	28	8
9	8	2
10	1	0
11	4	1

DMH Beds Filled (out of 10)

Census (Beds Filled)	Days at This Census	
	#	%
3	47	13
4	85	23
5	17	5
6	22	6
7	65	18
8	54	15
9	26	7
10	15	4
11	27	7
12	7	2

SVH Beds Filled

Census (Beds Filled)	Days at This Census	
	#	%
0	291	80
1	68	19
2	6	2

ICF Beds Filled (out of 20)

Census (Beds Filled)	Days at This Census	
	#	%
9	6	2
10	120	33
11	108	30
12	41	11
13	32	9
14	51	14
15	7	2

III. Regional Differences

During the 2008-9 fiscal year, most youth from both regions who were admitted to licensed bed facilities were treated at the CTC at Stark. Youth from northern California facilities were rarely admitted to intermediate care beds compared to youth from southern California facilities.

Admissions by Region and Bed Type
(Excluding Admissions from CTC and ICF)

Bed Type	North		South	
	# of Admissions from Region	% of Admissions from Region	# of Admissions from Region	% of Admissions from Region
CTC	40	67	75	84
SVH	13	22	0	0
ICF	5	8	11	12
DMH: Metro	0	0	1	1
DMH: Napa	2	3	1	1
DMH: Patton	0	0	1	1
All Bed Types	60	100	89	100

Like the overall rate of admissions, the rate of admissions from northern California facilities has increased about three times since the time of the experts' last report (0.7 admissions per 10,000 youth-days to 2.2 admissions per 10,000 youth days).

Rate of Admissions from Northern California Facilities Over Time

Time Period	Average Daily Population	Days	Youth-Days	Admissions	Admissions per 10,000 Youth-Days
1/1/06 to 9/30/06	1336	273	364728	26	0.7
7/1/08 to 6/30/09	739	365	269735	60	2.2

Northern California facilities referred youth to Sierra Vista hospital in northern California, but that facility had almost a 50% rejection rate for DJJ referrals. Of eighteen rejected referrals during the fiscal year, eleven (61%) were rejected by SVH. Of those 11 rejected referrals, nine resulted in placement at the CTC within a day of the rejection. In one case, a youth referred to the SVH for chronic care was placed at the ICF. One youth rejected by SVH did not gain an alternate licensed bed placement (this was one of 8 rejected referrals where there was no alternate placement).

Rejections By Region and Bed Type

Bed Type	Number of Rejections	
	North	South
CTC	1	1
SVH	11	0
ICF	2	1
DMH: Metro	0	2
DMH: Napa	0	0

Overall, southern facilities successfully refer youth to licensed beds at a 25% higher rate than northern facilities (ten versus eight admissions per 100 youth). The average number of admissions per youth is almost the same for the two regions. Southern facilities admit proportionally more youth to licensed beds than northern facilities, rather than admitting the same youth more time.

Rate of Admissions By Region
(Excluding Admissions from CTC and ICF)

Region	# of Admissions	Average Daily Population	Admissions per 100 Youth
North	60	739	8
South	89	885	10

Admissions per Youth by Region
(Excluding Admissions from CTC and ICF)

Region	# of Admissions	# of Youth	Average Admissions per Youth
North	60	41	1.5
South	89	60	1.5

As the mental health experts observed, youth from northern California tend to wait a day for admission to acute/crisis licensed beds and youth from southern California do not. For CTC admissions, the median wait time was less than a day from southern California and one day from northern California. In both regions, the longest anyone waited for admission to the CTC was two days.

Days Pending Transfer by Region

Region	Days Pending Transfer			
	All Admissions		CTC Admissions	
	Median	Interquartile Range	Median	Interquartile Range
North	1.0	0.3	1.0	0.3
South	0.0	2.0	0.0	0.0

No meaningful regional differences were observed for LOS or reasons for referrals.

Length of Stay by Region

Region	Length of Stay (in Days)			
	All Admissions		CTC Admissions	
	Median	Interquartile Range	Median	Interquartile Range
North	10	7	10	6
South	12	24	12	10

Reasons for Referral to Licensed Beds by Region of Referring Facility

Reason for Referral	Relative Frequency (%)	
	North	South
Current or recent suicidal/self-injurious behavior	77	60
Psychotic or bizarre behavior	5	13
Gravely disabled	5	2
Depression	2	7
Mania/hypomania	7	8
Medication adjustment	0	1
Clarify diagnosis	0	4
Aggression paired with mental disorder	3	1
Anxiety/panic	0	3
Other	2	2

III. Availability of Licensed Beds to Women

Women are admitted to licensed beds at a higher rate than men. However, the average rate of admissions per youth is virtually the same for men and women, which means that a higher proportion of female youth than male youth are referred to and admitted at licensed bed facilities.

Like men from northern California facilities, women generally are not gaining access to intermediate care beds. From July 2008 through June 2009, women were admitted the CTC 13 times and to Metro State Hospital once. No women were admitted to any other licensed bed facility. This is a change from 2007 when the mental health experts filed their first report on licensed beds, when DJJ generally used the private hospital Aurora Vista Del Mar for licensed beds for women, and not the CTC.[18]

Admissions by Gender

Gender	# of Admissions	# of Youth Admitted	Average Admissions per Youth
Females	14	8	1.8
Males	157	83	1.9

[18] Lee/Trupin Licensed Bed Report, pp. 1-3. The experts reported that DJJ sent one female to the CTC in late 2006 or early 2007, but used Aurora Vista del Mar for other acute/crisis stabilization care for females.

Rate of Admissions by Gender

Bed Type	Admissions per 100 Youth	
	Females	Males
CTC	16.3	6.7
ICF	0.0	2.1
DMH	1.3	0.5
SVH	0.0	0.8
All	17.5	10.2

Women tend to be referred to licensed beds for a narrower range of reasons than men. All admissions to licensed beds among women involved suicidal/self-injurious or psychotic/bizarre behavior. None involved mania/hypomania, depression, grave disability, or other relatively infrequent reasons for admissions among men. It is possible that these differences in reasons for referral mean that, for women, only the most serious crises are referred to mental health beds. Other explanations are possible, however: the two populations may have different incidences of mania/hypomania, depression, etc., or clinicians at Ventura may tend to characterize admissions to licensed bed in an idiosyncratic way.

Reasons for Referral to Licensed Beds by Gender of Referred Youth

Reason for Referral	Relative Frequency (%)	
	Females	Males
Current or recent suicidal/self-injurious behavior	86	64
Psychotic or bizarre behavior	14	10
Gravely disabled	0	3
Depression	0	6
Mania/hypomania	0	8
Medication adjustment	0	1
Clarify diagnosis	0	3
Aggression paired with mental disorder	0	2
Anxiety/panic	0	2
Other	0	2

Women tend to wait a day longer for admission to the CTC than men. The median wait time for women was one day for women, compared to less than a day for men. The longest wait time for CTC admission in both groups was two days. Women and men showed no notable differences in LOS.

Days Pending Transfer by Gender

Gender	Days Pending Transfer			
	All Admissions		CTC Admissions	
	Median	Interquartile Range	Median	Interquartile Range
Female	1.0	0.8	1.0	1.0
Male	1.0	2.0	0.0	1.0

Length of Stay by Gender

Gender	Length of Stay (in Days)			
	All Admissions		CTC Admissions	
	Median	Interquartile Range	Median	Interquartile Range
Female	11	7	11	6
Male	12	20	10	9

IV. Youth With Repeat Admissions

Nine youth were admitted to licensed beds from DJJ facilities three times or more within six months. These nine youth were admitted to licensed bed from DJJ facilities 40 times during the year, for an average of 4.4 admissions per youth (as compared to 1.3 admissions per youth among the remaining youth admitted to licensed beds). Thirty-three of the 40 admissions were to the CTC at Stark. Of the nine youth, five came from facilities in northern California, three came from facilities in southern California, and one was female. The most frequent reason for these 40 admissions was suicidal or self-injurious behavior (82% of admissions, as compared to 71% of admissions among the remaining youth admitted to licensed beds from DJJ facilities). The identities, region from which referred, and current location of the nine youth are listed in Appendix B.

Appendix A: Rejected Referrals

Eighteen referrals to licensed beds resulted in rejection. In 10 cases, the youth was placed in a licensed bed at a different location within a week. The table below lists details on these incidents. Reasons for referrals reproduce the code used in DJJ's tracking list, in which a "1" designates "current/recent suicidal behavior of self-injurious behavior, a "3" designates grave disability, a "4" designates depression, and a "5" designates mania or hypomania.

Name	Referring Facility & Program	Level of Care Needed	Dx Upon Referral	Reason for Referral	Rejection		Placement	
					Date	Place	Date	Place
[redacted]	NAC-IBTP	Acute	296.90	1	10/20/2008	SVH	10/20/2008	HGS-CTC
[redacted]	NAC-IBTP	Acute	309.28	1	1/6/2009	SVH	1/6/2009	HGS-CTC
[redacted]	NAC-IBTP	Acute	296.63	1	11/25/2008	SVH	11/25/2008	HGS-CTC
[redacted]	NAC-IBTP	Acute	296.63	1	1/6/2009	SVH	1/6/2009	HGS-CTC
[redacted]	NAC-O-ITP	Acute	309.81	1	10/29/2008	SVH	10/29/2008	HGS-CTC
[redacted]	NAC-O-ITP	Acute	296.22	1	9/5/2008	SVH	None	None
[redacted]	SRCC-GP	Acute	296.90	1	7/9/2008	HGS-CTC	None	None
[redacted]	PYCF-GP	Acute	314.01	1	9/17/2008	SVH	9/17/2008	HGS-CTC
[redacted]	PYCF-IBTP	Acute	V61.21	1	7/4/2008	SVH	7/5/2008	HGS-CTC
[redacted]	NAC-Y-ITP	Acute	314.01	1	9/5/2008	HGS-CTC	None	None
[redacted]	NAC-Y-SCP	Acute	296.44	1	8/27/2008	SVH	8/28/2008	HGS-CTC
[redacted]	NAC-Y-ITP	Chronic	296.90	1	5/19/2009	SVH	5/19/2009	SRCC-ICF
[redacted]	NAC-Y-SCP	Acute	296.34	3	1/28/2009	SVH	1/28/2009	HGS-CTC
[redacted]	HGS-IBTP	Chronic	296.30	4	11/26/2008	DMH-MSH	None	None
[redacted]	HGS-ITP	Chronic	296.34	4	5/27/2009	DMH-MSH	None	None
[redacted]	PYCF-IBTP	Intermed	296.90	4	7/24/2008	SRCC-ICF	None	None
[redacted]	OHC-GP	Intermed	309.81	5	8/4/2008	SRCC-ICF	None	None
[redacted]	HGS-CTC	Intermed	309.90	5	9/22/2008	SRCC-ICF	None	None

Three of the youth who were rejected and who did not have alternate referrals/admissions at the time later were admitted to the intermediate level of care, [redacted], [redacted] and [redacted] (compare above list of rejections with below list showing that these three youth are in intermediate care now).

Appendix B: Youth With Unusually Frequent Admissions to Licensed Beds

Ten youth had three or more admissions from DJJ facilities to licensed beds within six months. Their names, YA numbers, region from which referred, and current locations (as of September 2009) are listed below. Asterisks mark those who also were rejected by a licensed bed facility.

Name	YA#	Region	Current Location
[redacted]	[redacted]	South	Stark ITP
[redacted]	[redacted]	North	Stark ITP
* [redacted]	[redacted]	South	DMH-PSH
[redacted]	[redacted]	North	SYCRCC ICF
* [redacted]	[redacted]	North	Chaderjian IBTP
[redacted]	[redacted]	South	Paroled
[redacted]	[redacted]	North	Paroled
[redacted]	[redacted]	n/a	Ventura ITP
* [redacted]	[redacted]	North	SYCRCC ICF