SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. JEFFREY A. BEARD, PH.D. Defendant.	))))))))))	CASE NO. RG03079344

TWENTY-NINTH REPORT OF THE SPECIAL MASTER

Nancy M. Campbell, Special Master
John Chen, Deputy Special Master
Virginia L. Morrison, Deputy Special Master
56 East Road
Tacoma, WA 98406
253-503-0684
nancy@nmcampbell.com

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Appendix A: Gage, *Mental Health Audit Comprehensive Summary,* (May 25, 2014).

Appendix B: Kishimoto, *Observations and Recommendation following the Site Visit to Department of Juvenile Justice, State of California,* (March 2014).

I. INTRODUCTION

The Special Master submits for filing the Twenty-Ninth Report of the Special Master. This report reviews the *Farrell* Mental Health Expert Dr. Bruce Gage's first Mental Health comprehensive report for his 2013-2014 round of audits (site visits, March and April 2014) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justice's (DJJ) compliance with the *Farrell* remedial plans. The Mental Health comprehensive report is attached to this report as Appendix A. The Special Master's report, consistent with an agreement by the parties, limits the summarization of the expert's report and instead identifies the major areas of improvement as well as areas of concern.

The report begins with a brief overview of youth, programs and staff census data. An update on the implementation of the Integrated Behavioral Treatment Model (IBTM) followed by an analysis of progress in implementing the Mental Health Program is provided as well as an update on the status of the few remaining Safety and Welfare items. The Special Master affirms her recommendation from her twenty-eighth report to transfer monitoring of the *Safety and Welfare Remedial Plan* to Defendant.

II. YOUTH POPULATION, PROGRAMS AND STAFFING

A. Overview

At the March 2014 Case Management Conference, the Court asked the Special Master to include in her future reports youth demographic trends and pertinent program information. The Court desires greater understanding of Defendant's programs and operations in order to place the reform measures and Defendant's progress into proper context. Accordingly, the Special Master prepared this overview section for the Court's

information. In general, the information and factual data contained in this section should remain fairly constant from reporting period to reporting period. Significant fluctuations, deviations, and program changes will be reflected in future reports.

B. Youth Population

The youth population recently has remained very constant after years of steady, and sometimes steep, decline. Over the first four months, Defendant's youth population hardly changed in terms of youth committed and youth's facility assignment as depicted in Table 1.

Table 1
Youth Committed and Assigned to DJJ
January through April 2014[1]

	Committed	Physical Count
January 31, 2014	694	679
February 28,2014	694	680
March 31, 2014	694	679
April 30, 2014	693	672

In contrast, the youth population declined drastically in prior years. During the initial phase of *Farrell* reform (December 31, 2005) Defendant's youth population was 2,915. Four years later on December 31, 2009, the youth population had declined to 1,527, which necessitated several rounds of facility closures. Even as recent as 2013, Defendant experienced a 15% decline in its youth population, which resulted in closure of some living units.

[1] Compiled by the Office of the Special Master (OSM) based on data in the "Monthly Facility Population Table" in DJJ's website.
[2] *Ibid*.

Table 2
Quarterly Comparison of Youth Population at DJJ[2]
December 31, 2012 through December 31, 2013

	Committed	Physical Count
December 31, 2012	811	790
March 31, 2013	764	744
June 30, 2013	733	716
September 30, 2013	726	715
December 31, 2013	693	679

Significant fluctuation in youth population, particularly during declines, hampers Defendant's efforts to deliver meaningful treatment and services to youth. It creates uncertainty among youth and staff and diverts management and staff's focus and attention from treatment and services.

Youth are assigned to three facilities and a fire camp. Consistent with the recent trend in population, there has been little change in each facility's overall youth population during 2014.

Table 3
Comparison of Youth Population by Facility[3]
Between December 31, 2013 and April 30, 2014[4]

	O.H. Close Youth Correctional Facility (OHCYCF)	N.A. Chaderjian Youth Correctional Facility (NACYCF)	Ventura Youth Correctional Facility (VYCF)	Pine Grove	Total
April 30, 2014	186	199	231	56	672
December 31, 2013	177	214	231	57	679

[2] *Ibid*.
[3] Based on the physical count of the youth population at the facility. The number of youth each facility is responsible for could vary (usually higher) by factors such as youth being sent to Court or youth housed at adult institutions.
[4] Compiled by the OSM based on data in the "Monthly Facility Population Table" in DJJ's website.

C. Programs

Defendant's programs are broadly classified into core and specialized programs. Housing unit assignment is determined by the nature of the program. Core programs serve youth in the general population and are divided into high core and low core units in accordance with the risk level of the youth. Specialized programs are designed to meet the individualized needs of a certain segment of youth. They include the Mental Health Program, the Sexual Behavior Treatment Program (SBTP), and the Behavior Treatment Program (BTP). The Mental Health Program is further divided into Mental Health Residential Unit (MHRU) and the Intensive Behavior Treatment Program (IBTP). The capacity of the living units that operates the program ranges from 24 to 38, depending on the treatment needs and risk level, as previously agreed to by the parties.

The following table provides a breakdown of the programs at each facility. NACYCF also operates an intake unit for male youth newly assigned to DJJ.

Table 4
Living Unit Breakdown by Programs

	OHCYCF	NACYCF	VYCF[5]
Specialized Programs			
SBTP	El Dorado, Humboldt	Mojave	None
BTP	Inyo	Kern	Monte Vista
IBTP	None	Sacramento	None
MHRU	None	Merced	Alborado, El Toyan (Female)
Core Programs			
High Core	Butte, Amador	San Joaquin, Tuolumne	Casa de Los Caballeros (CLC), Mirmar
Low Core	Glenn	Feather	Alta Vista, Montecito, El Toyan (Female) Mira Loma
Intake	None	McCloud	El Toyan (Female)

[5] Because of the limited number of female youth, the female unit at VYCF houses youth in core programs and specialized programs as well as functioning as an intake unit.

As previously noted, Defendant's average daily youth population changed little during 2014 and the same trend is evidenced in specialized programs. The total number of youth in specialized programs was 208 as of May 31, 2014 in comparison to 195 as of December 31, 2013. With the exception of VYCF's BTP unit and its female unit, all specialized units have ample capacity to accommodate additional youth in the program.

Table 5
Comparison of Youth Population by Specialized Units at Each Facility[6]
December 31, 2013 and May 31, 2014

	OHCYCF		**NACYCF**				**VYCF**		
	BTP	SBTP[7]	BTP	SBTP	IBTP	MH	BTP	Female[8]	MH
Dec. 31, 13	12	58	15	34	11	14	23	25	17
May 31, 14	13[9]	64[10]	14[11]	25[12]	11[13]	15[14]	24[15]	22[16]	20[17]

D. Staffing

The staffing levels at the facilities are prescribed under a set of "Business Rules" that were reviewed and approved by Plaintiff. The Business Rules describe, in detail, the positions that must be staffed at each type of living units.

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[6] Compiled by the OSM based on the data in the "Living Unit Breakdown" on DJJ's website.
[7] OHCYCF operates two SBTP units.
[8] The female unit houses youth with a mental health designation as well as youth without such designation. As of May 31, 2014, 12 youth in the unit were designated as mental health youth.
[9] Based on email of June 9, 2014 from Superintendent Erin Brock to Deputy Special Master John Chen.
[10] Based on email of Dr. Heather Bowlds, SBTP Program Coordinator, to Deputy Special Master John Chen.
[11] Based on email of June 9, 2014 from Superintendent Erin Brock to Deputy Special Master John Chen.
[12] Based on email of Dr. Heather Bowlds, SBTP Program Coordinator, to Deputy Special Master John Chen.
[13] Based on email of June 9, 2014 from Superintendent Erin Brock to Deputy Special Master John Chen.
[14] Based on email of June 9, 2014 from Yvette Marc-Aurele to Deputy Special Master John Chen.
[15] Based on listing of youth assigned to Monte Vista BTP as of May 31, 2014.
[16]Based on email of June 9, 2014 from Yvette Marc-Aurele to Deputy Special Master John Chen.
[17] *Ibid.*

Table 6
Living Unit Staff Allocation under Business Rules[18]

	IBTP	BTP	MH	SBTP	Core Unit
Senior Youth Correctional Counselor	1	1	1	1	1
Youth Correctional Counselor	14.73	14.73	12.31	8.93	8.93
Casework Specialist	2	1	2	2	
Case Manager/Parole Agent (PA)					2
Case Records Technician	1	.5	1	1	.5
Psychologists	1.5	1	1.5	2	.5
Youth Correctional Officer (Third Watch)	1.24	1.24	1.24	1.24	1.24
Totals	21.47	19.47	19.05	16.17	14.17

III. INTEGRATED BEHAVIORAL TREATMENT MODEL

A. Current Progress

The Mental Health Expert, Dr. Bruce Gage, completed a second IBTM audit of OHCYCF. While the final audit results have not been released as of the time of this writing, Dr. Gage indicated in his exit interview that he believes there has been significant progress in the implementation of the IBTM at OHCYCF. Similarly, a consultant, Orbis Partners, who had not been on-site for several years, described the change in the IBTM as one of staff moving from resisting the reform direction to being actively engaged in wanting to understand how to implement the IBTM model elements well.[19] Finally, the University of Cincinnati Corrections Institute (UCCI) consultant notes in her most recent report, attached as Appendix B, several areas of improvement. The

[18] Business Rules effective as of January 14, 2014.

[19] Drs. David Robinson and Marilyn Van Dieten from Orbis Partners were at the Northern Complex from May 20 to 22nd, 2014 to assess what changes might be needed in the California Youth Assessment Screening Instrument process to increase tool reliability and validity. The Special Master participated in a conference call with Defendant and the consultant team on May 22nd. The consultants noted the cultural shift during this debrief.

Special Master concurs with these observations and provides the following assessment of Defendant's current implementation status.

In contrast to the last reporting period, progress in implementation of the IBTM has been consistent and focused. Dr. Gage noted movement from acceptance of the IBTM to enthusiasm for the IBTM among the OHCYF facility staff. The most noted improvement has been in the timely delivery of the cognitive-based therapies (CBT). Similarly, there is clear evidence from staff and youth that the Reinforcement System (RS) is being actively experimented with. The development of a behavioral level system continues. Most importantly, senior facility leaders are holding their staff accountable for producing quality assurance data and beginning to take responsibility for IBTM implementation activities.

It appears that the mandate given to the facility Superintendents from the Court to demonstrate ownership of and leadership in the implementation of the IBTM in the March 2014 case management conference was heard and is being acted upon. Director Minor continues to model his commitment through his consistent efforts to engage managers in the change process.[20] Defendant's senior leaders demonstrate commitment to the IBTM in where they are dedicating resources, how they reward staff and where they focus their time. Progress in implementing the following model elements will be reviewed:

- Valid and reliable evidence-based risk and needs assessment.
- Case planning, the process by which targets for change are recorded and progress is evaluated.
- CBT resource groups, the approach used to teach skills.
- The behavioral management system (BMS), which includes the RS, level system (currently the Youth Incentive Program (YIP) and the Disciplinary

[20] Director Minor is sponsoring a two-day workshop in June 2014 for all managers to foster understanding and commitment to the principles of the IBTM.

Decision-Making System (DDMS), is the system through which youth are encouraged to practice skills and receive feedback.

- Quality assurance (QA) systems provide data to assess if the system is maintaining fidelity to the model and where more support or change might be needed.

Defendant has conferred with Orbis Partners, the company that designed the California Youth Assessment and Screening Instrument (CA-YASI), regarding issues relating to reliability and validity of the tool as well as case planning. Senior consultants from Orbis Partners conducted focus groups with line and management staff and met with the executive and IBTM Central Team staff in the Northern Complex to assess the current status of the CA-YASI and case management implementation. Defendant included the Special Master in a telephonic debrief with the Orbis Partners following their site visit and a follow-up report and proposal has been submitted to Defendant.[21]

The Orbis Partners' staff members saw evidence of substantial transfer of learning regarding the first three elements of the model, assessment, case planning and CBT resource groups. The consultants noted consistent use of the assessment tool to measure risk as evidenced by unit placement and needs as evidenced by use of case plans. Also noted was the knowledge base and continued commitment of the IBTM Central Team. Staff members at all levels displayed an increased use and understanding of the model elements.

Not surprisingly in such a long-term change endeavor, the consultants also noted areas where staff members are asking for clarification or help and/or where the consultants saw opportunities to assist in the following areas:

- Integration of the CA-YASI report into Defendant's technology.
- Understanding of how to use the monthly aggregate data.

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[21] Orbis Partners was on site at the Northern Complex from May 20-22nd and the Special Master participated in a visit debrief on May 22nd.

- Modification of administrative options that determine who has authorization to modify reports.
- Identifying a reasonable level of system overrides.
- Clarification regarding how the re-assessment process should work.
- Increasing tool reliability by ensuring that all staff administer and score the report in the same way.
- Reducing the number of items in the CA-YASI.
- Creating an accurate and effective case conceptualization.
- Ensuring that the three elements of a case plan (targets, goals and action steps) are understood and used accurately.
- Developing training for Youth Correctional Counselors (YCCs) to ensure their understanding and ability to use the assessment and case planning tools.
- Clarification and development of quality assurance systems.

The consultant team has proposed an array of strategies including training, coaching, curriculum development, and the development of protocols to address these issues. Defendant is considering options to address several of the identified issues.

The Assessment Process

As noted above, the Orbis Partners consultants noted consistent use of the assessment tool to measure risk and needs as evidenced by unit placement and the use of CA-YASI domains in case planning.[22] In the focus groups with staff, the level and type of questions asked about the tool demonstrates a basic understanding of the instrument if not a full understanding of how to use it accurately. The Special Master has shared with the consultants the data regarding the reliability and validity of the tool.[23] The consultants identified a series of possible issues that are impacting the reliability of the tool (is the tool applied accurately by and across raters) and possible problems with the assessment

[22] The consultants did not review case files so their understanding about the level of use of the CA-YASI is based on conversations with staff. It has been the experience of the Special Master that staff often describe their abilities as being greater than they actually are and this is seen when reviewing the actual written case plans. That said, it appears the staff were open and interested in discussing challenges and problems they are having understanding and administering the tool.

[23] Defendant undertook a validation study of the CA-YASI. The study was completed by Dr. Jennifer Skeem, a notable expert in the field of juvenile risk and needs assessment, at the University of California at Irvine. *See* Phase I, II and III UCI Studies.

process. Defendant is engaging in a thoughtful process with Orbis Partners to increase the reliability and validity of the CA-YASI.

Case Management Process

Challenges with the case management process documented in the twenty-eighth report of the Special Master are evidenced in the reports from UCCI and Orbis Partners as well as the recent exit conference feedback from the Mental Health Expert.[24] This report focuses largely on areas of progress in case management and will not review the details of the problem areas.[25]

Some progress has been made in addressing the structural problems with case management. These problems include: what document is used to manage and execute the case plan, where it is stored, what are the expectations regarding who and how progress is input into the case plan and how and when is the plan updated. The file review at the OHCYCF IBTM audit indicated that files are better organized and there is greater consistency in documentation. The case conference report now serves less frequently as the case plan, is clearly labeled as the Individual Change Plan (ICP), and is an addendum to the case conference notes. Plan updates are typically falling within proscribed timeframes. Who provides input into the actual written case plan and how progress is communicated about plan goals is less than ideal. There is evidence of a clearer progression in case planning goals from one case conference to the next.

The Special Master observed several case conferences as did the Mental Health Expert during the OHCYCF audit. Both found the tone of the conferences to be more supportive than in the past and the team members to be more engaged. The conferences

[24] OSM 28, pp. 14-28.

[25] For a thorough discussion of the problems, *see* OSM 28, pp. 14-19.

observed by the Special Master were well organized. The PA observed by the Special Master is highly skilled and could serve as a coach and mentor regarding how to facilitate an effective and responsive case conference. He quickly put the youth at ease, spoke directly to the youth, solicited the youth's ideas and commitment and ensured that the youth had copies of his revised individual change plan.[26]

The Special Master was particularly impressed with the improved contribution made by the education staff. They were prepared with detailed reports of student progress from all teachers and aides. Teachers provided progress reports that identified both grades and behavior in class. Of great significance was that the YCC who supervised the youth was in the conferences and when a youth was not on his caseload he presented information from the youth's supervising YCC.

There is also some improvement in the content issues. Content issues include: is the plan based upon risk and needs data, are behavioral targets individualized for each youth, are standards for input for progress into the case plan by various unit staff members defined and are quality assurance measures sufficient and used.

An effective case plan begins with a robust case conceptualization that draws on risk and need data from several sources. Robust case conceptualizations are rarely seen in the case plans of youth in the core units.[27] That said, this is a skill that requires training, coaching, mentoring and good quality assurance measures. A thorough case conceptualization requires access to multiple data sources and the ability to analyze and interpret these sources to integrate them into a framework for understanding a youth. It

[26] Unlike the PA, other conference participants tended to refer to the youth in the third person and used their last name only. Only the PA consistently spoke directly to the youth using his first name.

[27] This is one of the issues noted in the Orbis Partners report as a possible topic for further assistance. Again the Special Master opines that Defendant has internal capacity that can help with this issue. Dr. Heather Bowlds, Senior Psychologist, has demonstrated a high level of skill and understanding in this area.

requires an understanding of not just behavioral principles but social and psychological variables as well. This is a skill set that will take time for many PAs and some Casework Specialists (CWS) to develop. This should be an area that Psychologists who are trained in assessment could make a valuable contribution.

One of the key risk and needs tools relied upon for the case conceptualization is also the tool that drives the targets for the case plan and that is the CA-YASI. There is evidence that staff members are developing an understanding of the CA-YASI. Some CWSs and PAs understand the tool well and use it with a high degree of accuracy. Others appear to not understand how to implement it accurately. The CA-YASI domains are referenced on a regular basis by staff and the graphic representation called the "wheel" can be found in case files. Youth also are beginning to be able to identify their CA-YASI domains. Of great importance is that the YCCs are beginning to understand the high-level target areas for a youth.

Defendant is reviewing feedback and data from all the consultants groups to determine how to address issues raised by the Orbis Partners. Defendant should develop a plan to increase the reliability of the CA-YASI through training, coaching and tool modifications.

As staff noted in their focus groups with the Orbis Partners, it is unclear for some staff what the three elements of a case plan are. Targets, goals and action steps are typically not well differentiated or accurately defined. Often goals and action steps do not address primary criminogenic needs.[28] Many of the PAs and CWSs who are tasked with creating the case plan struggle to develop meaningful goals and action steps that identify

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[28] Primary criminogenic needs are behaviors that research has shown are linked to recidivism. If the primary goal of the IBTM is to reduce recidivism, then the youth must identify and modify the behaviors that are linked to criminal behavior.

what behavioral changes a youth needs to make. Rarely is the concept of responsivity fully understood resulting in goals that youth do not understand and/or are not invested in addressing. One of the strategies chosen by Defendant to increase responsivity on the part of staff is a strategy called Motivational Interviewing (MI). Case planning would benefit greatly from using the stages of change model used in MI.

The goals and action steps lack specificity and therefore make it difficult for a youth to understand what he or she should be attempting to change in his or her behavior. That said, there is slight improvement in the case plans reviewed during the OHCYCF audit. The UCCI consultant is working with Defendant to create a methodology to assist staff with goal and action step development that is responsive to the youth and identifies primary criminogenic needs. Case notes continue to be sporadic, not informative and too often unrelated to case plan goals and action steps.

CBT Resource Group Delivery

Defendant has done an excellent job of rectifying the problem of cancelled groups and failure by management to capture and review aggregate data about group delivery. In the last reporting period, the Special Master worked with the IBTM Central Team staff to attempt to identify if groups were being held, how many youth were completing groups and if groups were cancelled, were they rescheduled timely to ensure continuity of treatment. Data turned in by facility unit management was so poor as to be unintelligible in some cases except to note that groups were being cancelled with regularity, not rescheduled timely and in too many cases, it frankly was impossible to tell what was happening with the delivery of the CBT resource groups.[29] The only conclusion that could be reached was that the line staff did not understand that the CBT resource groups

[29] *See* OSM 28, p. 21.

are a key treatment intervention and not optional programming. It also appeared that many first-line managers did not feel responsible for group data collection and the second-level managers and above were not reviewing the group data in any systemic or meaningful way.[30] In this reporting period, there are clear records of group attendance and a monthly report that captures group data.[31]

Group reporting data from February through May 2014 indicate that few groups are being cancelled in OHCYCF and NACYCF. The high number of group cancellations at VYCF is almost all the result of the BTP. This is an artifact of a serious group disturbance and the fact that there are so many program groups in this unit.[32]

Of equal importance is the data that shows how often groups are being rescheduled. The data from OHCYCF looks accurate.[33] It shows a fairly regular rate of re-scheduling of some groups. This is consistent with the experience of the Mental Health Expert and the Special Master while on site. There appears to be a fairly consistent pattern of re-scheduling at both OHCYCF and NACYCF. The data from NACYCF does not show as many groups being rescheduled which does not appear accurate. The Special Master encourages senior leaders to use the data reporting system to monitor such issues.

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[30] As noted in OSM 28, it appears many staff members feel resource groups are similar to those of the past where there was no approved curriculum; staff basically delivered whatever they believed appropriate and groups were in a sense a privilege not a requirement. Staff members do not understand that the groups are at the heart of the recidivism reduction strategy. *See* discussion at pp. 25-26.
[31] It should be noted that the Special Master has not audited the reports in any way and is taking the data at face value at this time.
[32] The VYCF Behavior Treatment Program, Monte Vista, had a serious staff assault that involved eight youth in March of 2014. This accounts for the high number of group cancellations. The number is also inflated because due to the short length of stay in the BTPs, the full CBT curricula is not delivered but shorter modules targeted on aggression. There are many more modules delivered than in the regular CBT resource groups. In short, the goal on the BTP is to provide more treatment with shorter modules. The unit staff is to be commended for how quickly they resumed normal programming in light of the seriousness of the staff assault.
[33] For an example of reporting that shows the level and type of rescheduling that experts and the Special Master commonly experience while on site, *see* OHC Amador Group Summary May-14.xls.

Table 7
Group Cancellations for 2014

Month	February	March	April	May
OHCYCF	0	1	4	0
NACYCF	1	2	3	3
VYCF	7	44	5	17
Total	8	47	12	20

The following units are to be congratulated for the significant improvement in both data capture and group delivery:[34]

OHCYCF: BTP Inyo unit
NACYCF: Low core unit, Feather; the BTP, Kern; high core units San Joaquin and Tuolumne
VYCF: High core units, Mira Mar and CLC

Of equal concern to the groups being held is having data to understand the trends in each unit and across units. For example, despite the high number of cancelled groups, 34 in the VYCF BTP in March, the unit managed to reduce the number to five in April. The number of cancellations increased to 11 in May because as a result of the series of serious staff assault incidents, eight of 10 regular BTP staff members, including the Senior Youth Correctional Counselor (SYCC) who generally has an excellent rapport with youth in the unit,[35] were on Industrial Disability Leave (IDL) as of May 30, 2014. The influx of new staff with insufficient training and the high number of program groups led to the facility having to temporarily curtail the number of resource groups at the living unit.

This indicates the high number of cancellations was likely an aberration due to the serious staff assault incident and not the norm. Facility managers should observe these trends on a regular basis to ensure youth are receiving the primary intervention of the

[34] Units not listed were not having any or significant problems with group cancellations.
[35] Based on discussion between Superintendent Mark Blaser and Deputy Special Master John Chen on May 29, 2014. Seven of eight staff members on IDL were a direct result from staff assault incidents.

CBT resource groups. Another valuable tool that is in the process of being refined is the monthly unit report.

This report gathers critical management information regarding youth treatment goal progression, group attendance, and adherence to case plan and conference requirements. The report is being modified but an iteration of it is in use. The report, if used by the first and second-level managers, provides a high-level overview of key indicators of how a unit is doing with IBTM implementation and should help managers ensure consistent delivery of IBTM elements such as CBT resource groups. Senior managers are using the data to review CBT group delivery on a monthly basis.[36] Group cancellations are now reviewed at each facility at the Superintendent's weekly meetings as well as by the Central Office (CO) executive staff on a monthly basis.[37]

An effort is underway that will provide greater support to unit staff to enhance their ability to deliver the CBT resource groups with fidelity. The IBTM Central Team has been engaged in many activities to help staff understand the curriculum and to develop better facilitation skills. Activities have included observations and feedback, coaching and training first and second-level managers to perform the same functions.[38] Group facilitation observations indicate that there is still a wide variation in staff ability. Some staff are highly skilled, enjoy the work and seek new learning opportunities while others are insecure about their facilitation skills and do not understand the curriculum content.[39] The Special Master again opines that a system to support the unskilled

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[36] *See* Core CW Monthly Report Revised 4-30-14.doc

[37] The executive staff is the senior leadership of the division. The executive staff is led by Director Minor. *See* Appendix B, First Quarter 2014UCCI.doc, p. 3.

[38] Past OSM reports including OSM 25, pp.4-6 and OSM 26, pp.5-8 have gone into detail discussing the nature and quantity of the observations.

[39] The Special Master's recent observations of groups included staff who should not be allowed to facilitate by themselves. They do not understand the material and do not know how to facilitate. Other staff are adept

facilitators by using the highly skilled facilitators as peer mentors would complement the limited resources of the IBTM Central Team and the first and second-line managers.

Behavioral Management System (RS and Level System)

Defendant continues to make steady progress in implementing the RS and developing a new level system (Youth Incentive Program). As noted in Table 8, with the exception of education staff at OHCYCF, the number of staff trained in the RS system increased from the last reporting period. Notably VYCF has done a good job of increasing the number of YCCs and Youth Correctional Officers (YCOs) trained. VYCF that was significantly behind other facilities in training now exceeds other facilities for several job classifications.

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at facilitation and thoroughly understand the curriculum materials. These staff can serve as mentors and coaches.

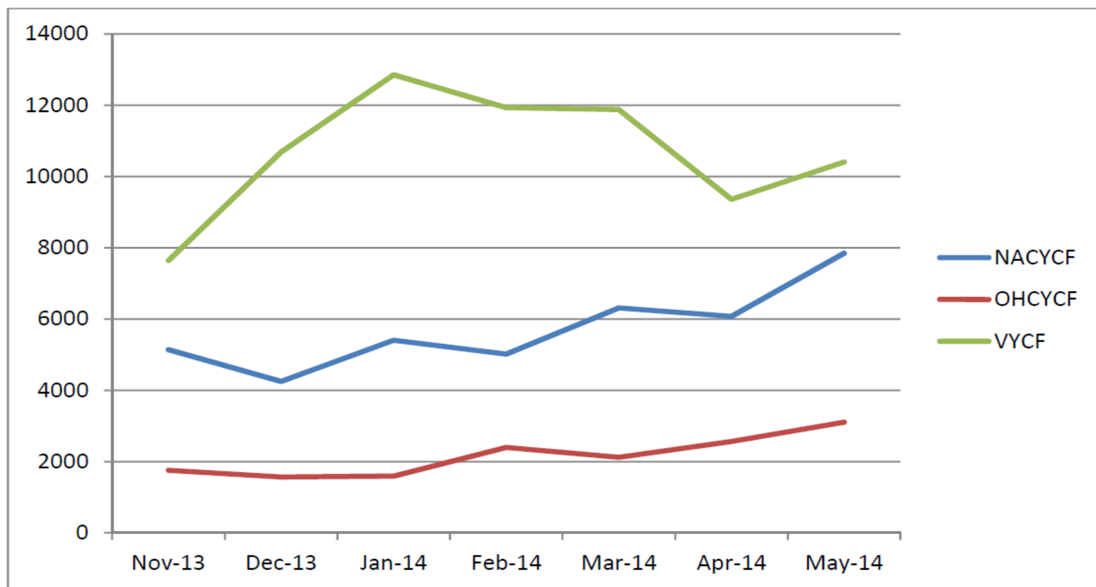
Table 8
Reinforcement System Training
Comparison of Increase (Decrease) between February 2014 and May 2014[40]

	OHCYCF			NACYCF			VYCF		
	Feb 14	May 14	Increase (decrease)	Feb 14	May14	Increase (Decrease)	Feb 14	May14	Increase (Decrease)
Casework Specialist	100%	100%	0%	64%	91%	27%	100%	100%	0%
Parole Agent 1	100%	100%	0%	64%	80%	16%	93%	93%	0%
Youth Correctional Counselor	71%	87%	16%	77%	88%	11%	58%	89%	31%
Senior Youth Correctional Counselor	80%	100%	20%	63%	100%	37%	75%	100%	25%
Treatment Team Supervisor	100%	100%	0%	100%	100%	0%	100%	100%	0%
Supervising Casework Specialist	NA[41]	NA	NA	100%	100%	0%	100%	100%	0%
Youth Correctional Officer	62%	87%	25%	60%	63%	3%	66%	100%	34%
Education	100%	78%	(22%)	87%	84%	(3%)	41%	91%	50%
Sub-Totals	**77%**	**87%**	**10%**	**75%**	**79%**	**4%**			
Staff who may be assigned to OHCYCF or NACYCF									
Lieutenant	33%	89%	56%				63%	75%	37%
Sergeant	30%	70%	40%				100%	100%	0%
Psychologist	60%	67%	7%					100%	
Senior Psychologist	25%	67%	42%					100%	
Psychological Technician	0%	100%	100%					67%	
Clinical Psychiatrist								100%	
Sub-Totals	**36%**	**76%**	**40%**						
Totals[42]							**54%**	**93%**	**39%**

[40] OSM made the comparison using percentages reported in OSM 28 for September 2014 and calculated the percentages for May 2014 using data provided by the IBTM Program Administrator.
[41] OHCYCF has no Supervising Casework Specialist.
[42] Totals are not reported for OHCYCF and NACYCF because some staff members are assigned to both facilities and it is not possible to segregate them by facility.

The use of positive checks is seen in the sheer number of checks being documented and in the response of staff and youth to the system. At this stage of implementation, the number of checks given may vary significantly by unit and facility. The way in which checks are being rewarded also may vary from unit to unit. While Defendant may want to ensure greater continuity between units in the future, at this stage, this is a learning process to experiment and to see what works best. In addition, Defendant will need to shift staff over time from using the RS to reward only generic behaviors for youth (for example, picking up garbage) to reinforcing skill utilization (a youth used words not fists to express anger).

Table 9
Positive Checks November 2013 through May 2014[43]



[43] This graph was provided by the IBTM CO Team.

What is most encouraging is seeing the change in staff response to the RS. Once thought to be providing "candy bars" to youth for behavior they are "supposed" to engage in, staff members are beginning to understand the concept of behavioral shaping and how rewards work to reinforce desired behavior. As one staff member said to the Mental Health Expert, "when I used to say you are getting a check, kids thought they were getting a DDMS (disciplinary action) and now they know it means they have done something good." When staff members were queried about the RS in interviews at OHCYCF conducted by the Mental Health Expert and the Special Master at the recent IBTM audit, there was uniform support for the system. Staff indicated it is changing the environment by focusing on what youth do right not just what they do wrong.

Defendant continues to make progress on finalizing a revised model for the YIP. The committee tasked with the development of a new YIP has continued to meet and to report to Defendant leadership, the Mental Health Expert and the Special Master. Understanding that this system is used to both shape behavior and to manage risk is a new concept for many staff. The idea that providing positive incentives increases the likelihood of behavioral change is in many ways a difficult concept for correctional staff to embrace because the belief that demanding accountability through the threat of negative sanctions is embedded in all criminal justice systems. Defendant is doing a good job of educating staff how to use both positive and negative reinforcers to shape youth behavior.

The revised system should provide substantial enough privileges that youth will want to modify their behavior to receive them. An effective system provides gradual and consistent opportunities for youth to test new skills. Key among the skills is the ability to

manage their own behavior. Opportunities for increased freedom from the structures of institutional rules are a way staff can test the capacity and ability of youth to "self manage." Hopefully youth will internalize values and behaviors that allow them to function effectively in less structured settings and activities where they are allowed more freedom to make choices. The committee is exploring what type of privileges they believe will motivate youth to change their behavior and how to apply the system across the different type of facility units.

Training

Underlying all activities in the behavioral management realm is the way in which staff interacts with youth. As discussed in the twenty-eighth report of the Special Master, despite constant references in policy to motivational interviewing, a technique designed to engage youth in the change process, the majority of staff do not employ this strategy consistently or in many cases at all.

In the evidenced-based practice literature, strategies such as motivational interviewing are tools to align with the "responsivity principle." The responsivity principle indicates that to effectively engage youth, staff must use intervention methods that are aligned with the learning style and individual characteristics of the youth.[44] Motivational interviewing is a technique to elicit engagement from clients.

Training data on motivational interviewing indicates while a high percentage of staff completed the first stage of training, few completed the critical second stage. Most staff was trained in 2008 and 2009.

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[44] The three principles of effective interventions, risk, needs and responsivity are described in Joplin, L., Bogue, B., Woodward, W., Campbell, N., Clawson, E., and Faust, D 2004. "Implementing Evidence-Based Principles in Community Corrections: The Principles of Effective Intervention." National Institute of Corrections, Washington DC. http://www.nicic.org/Library/019342

Table 10
Motivational Interviewing[45]

	OHCYCF Staff	OHCYCF Trained	OHCYCF %	NACYCF Staff	NACYCF Trained	NACYCF %	VYCF Staff	VYCF Trained	VYCF %
Staff assigned directly to facility									
Phase One – 3 Days	127	102	80%	165	144	87%	167	133	80%
Phase Two – 2 Days	127	62	49%	165	46	28%	167	57	34%
Staff who may be assigned to OHCYCF or NACYCF									
Phase One – 3 Days	20	10	50%						
Phase Two – 2 Days	20	6	30%						

The failure to understand MI is seen in many ways but in short, it is demonstrated by telling youth what to do more than attempting to engage them in participating.[46] Examples of small but important gestures that do not align with the responsivity principle include: calling youth by their last names only, speaking about youth in the third person rather than speaking directly to them, ordering youth to engage in activities, telling youth what their goals are rather than eliciting information regarding what the youth believes need to change, and threatening youth with disciplinary action before attempting engagement. Defendant continues to make efforts to teach staff how to engage and motivate youth.

As seen in Table 11, small gains have been made in the number of line staff trained in the CBT resource group curricula and the IBTM overview training courses.

[45] Compiled by OSM based on data provided by the IBTM Program via email on May 30, 2014.
[46] The use of MI does eliminate the use of appropriate negative reinforcement or punishment.

With one exception, VYCF shows consistent progress in increasing the number of staff trained and is closing the gap with the other facilities regarding the number of staff trained.

Table 11
Comparison of Percentages[47] of Staff Completed IBTM Training
Between February 2014 and May 2014
Direct Care Staff

	OHCYCF		NACYCF		VYCF[48]	
	Feb. 2014	May 2014	Feb. 2014	May 2014	Feb. 2014	May 2014
IBTM Overview[49]	83%	85%	57%	67%	29%	32%
Introduction to Treatment[50]	13%	13%	23%	32%	93%	36%[51]
Aggression Interruption Training	94%	97%	72%	91%	45%	65%
CounterPoint	88%	93%	60%	75%	46%	65%
Skill of the Week	64%	74%	79%	83%	46%	63%
Advance Practice[52]	30%	32%	91%	94%	64%	78%
Substance Abuse[53]		45%		37%		52%

In the twenty-eighth report of the Special Master, recommendations were made to ensure supervisors and managers are trained in the overview of the IBTM and, as soon as possible, the full CBT resource group curricula. As seen in Table 12, Defendant has not provided all SYCCs and Treatment Team Supervisors (TTSs) the IBTM overview.

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[47] OSM made the comparison using percentages reported in OSM 28 for February 2014 and calculated the percentages for May 2014 using data provided by the IBTM Program Administrator.
[48] Training data for VYCF may be under-represented as data for some staff members were excluded due to inadequate documentation even though they attended training.
[49] Data excludes staff members who may be assigned to either OHCYCF or NACYCF (Lieutenants, Sergeants, Senior Psychologists, Psychologists, and Psychological Technicians). As of May 28, 2014, 24 of 49 (49%) of staff members in these classifications completed the IBTM overview training.
[50] The percentage for this module is low because only intake staff at NACYCF is required to be trained in this module. At VYCF, only the El Toyan Hall (female unit) conducts groups on Introduction to Treatment and is required to attend such training. OHCYCF does not have an intake unit. Each facility has enough staff trained in this module to ensure that any youth who did not complete the modules in intake will receive them in the living units. The facilities have chosen different strategies to address this. *See* Intro to Treatment e-mail from Tammy McGuire.
[51] Significant decline likely caused by staff turnover at the El Toyan Hall.
[52] It is not possible to make a valid comparison between facilities as OHCYCF included all YCCs as staff members required to attend training whereas NACYCF and VYCF excluded all YCCs in their February 2014 data.
[53] Percentages for Substance Abuse training for Feb 2014 are not available.

Given this, it is not surprising that the quality of the observations of facilitators (a critical quality assurance measure) is less than adequate as the staff assigned to provide quality assurance services have not been trained in the fundamentals of the IBTM.[54]

One important activity Defendant is engaging in to assist all supervisors and managers to better understand the IBTM is an all management staff meeting scheduled for June 25-26th 2014. The meeting is designed to assist first-line supervisors and managers to better understand the IBTM and to elicit from them what support or help they might need to enhance their knowledge base. Having all facility managers together to focus on the IBTM demonstrates the high level of investment in the reform effort by senior level leaders. Initial feedback from attendees is that Director Minor and senior leaders inspired staff to engage more actively in the IBTM. The training provided a forum for supervisors and managers to develop a deeper understanding of the IBTM and their role in leading its implementation.

[54] Defendant may feel awkward about asking supervisors and managers to go back and take a class that their subordinates have already taken. It may be wise to create a supervisory overview.

Table 12
IBTM Overview Training[55]

	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Casework Specialist	4	4	100%	11	10	91%	4	4	100%
Parole Agent 1	9	9	100%	10	10	100%	15	7	47%
Youth Correctional Counselor	53	45	85%	88	42	50%	82	38	45%
Senior Youth Correctional Counselor	6	6	100%	7	5	71%	8	5	63%
Treatment Team Supervisor	4	3	75%	4	4	100%	3	2	67%
Supervising Casework Specialist	0	0		1	0	0%	3	3	100%
Youth Correctional Officer	45	38	84%	93	67	72%	77	0	0%
Education	51	41	80%	44	36	82%	46	22	48%
Sub-Totals	**172**	**146**	**85%**	**258**	**174**	**67%**	**238**	**81**	**34%**
Staff who may be assigned to OHCYCF or NACYCF									
Lieutenant	9	6	67%				8	0	0%
Sergeant	20	7	35%				6	0	0%
Psychologist	12	9	75%				6	1	17%
Senior Psychologist	3	2	67%				1	0	0%
Psychological Technician	5	0	0%						
Sub-Totals	**49**	**24**	**49%**				**21**	**1**	**5%**
Totals[56]							**259**	**82**	**32%**

[55] Compiled by OSM based on data provided by the IBTM Program via email on May 30, 2014.
[56] Totals are not reported for OHCYCF and NACYCF because some staff members are assigned to both facilities and it is not possible to segregate them by facility.

Quality Assurance Activities

Director Minor has now appointed a staff member to develop a quality assurance plan for the major IBTM elements. The UCCI consultant and the Orbis Partners consultants as well as the Mental Health Expert have all opined regarding the elements they believe should be part of a QA plan. This element of the IBTM is in the initial planning stages.

The plan will address issues such as fidelity monitoring of both groups and units, ensuring appropriate dosage based on risk levels is being provided, and case planning is performed with the level of specificity and quality needed for efficacy.[57] The UCCI consultant will work with Defendant on this plan. The Mental Health Expert and Orbis Partners should provide feedback and guidance as well.

Over a year ago, a position was created to assist Superintendents with quality assurance activities. The staff members holding these positions have provided valuable support during *Farrell* audits. At this time, it is unclear how these staff integrate in the IBTM quality assurance efforts. These staff members may provide much needed resources in supporting IBTM quality assurance activities.

B. Next Steps

Defendant is to be congratulated for the efforts made to address some of the concerns raised in the twenty-eighth report of the Special Master. Of particular note is moving swiftly to correct the problem of inconsistent CBT resource group delivery. Defendant has approached the issue of CBT resource group delivery and the implementation of the revised RS in the same thoughtful manner used to address the issue of use of force.

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[57] *See* Appendix B, First Quarter 2014UCCI.doc, p. 5.

Director Minor has set clear expectations for superintendents and managers regarding CBT resource group delivery and timing. Systems have been put in place to document outcomes and there are multiple levels of review to ensure expectations are met. Facility managers understand that they will be held accountable if CBT resource groups are not delivered. Another issue that must be addressed is the consistent pattern by some facilitators to deliver truncated, short versions of the sessions.

It is unclear at this time what follow-up occurs when a line staff member fails to facilitate a scheduled group. In the recent IBTM audit of OHCYCF, there was the same trend the Mental Health Expert and Special Master have experienced in all facilities and that is the failure of some designated staff to be available to facilitate groups.[58] This is a common occurrence. Assigned facilitators are too often not available and other staff must step in to ensure CBT resource group facilitation. While it is essential to have all YCCs be able to facilitate any module, the optimum approach is consistent delivery by the same staff person. It is unclear if this problem is a result of contract agreements with labor or some other reason. What is clear is that it is a pattern that needs to be studied and staff need to know that failure to facilitate a group should only happen in extreme circumstances. Exploration of not just group delivery but whether or not the facilitators are consistently delivering their assigned groups should be undertaken. As with the use-of-force process, the best method to change behavior is to follow-up with those staff who are not available to facilitate their assigned group. Defendant is aware of these issues and there has improvement in ensuring groups are rescheduled timely.

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[58] For example, one facilitator was supposedly not available to facilitate and then the person was seen on campus shortly after the group was completed. No one could explain the reason for the change of facilitators.

The RS is being implemented in all units but there is still considerable variation in how the system works. Some managers have clear rules about types and quantities of rewards for number of stars while others do not. There is some confusion about how to not undermine the system by having unit activities similar to the RS activities provided for all youth. Facility staff should be meeting with their SYCC and TTS to better understand how the RS is being implemented and if modifications should be made. Managers should also be observing the RS to determine if the checks that are given for youth demonstrating behaviors are for goals in their case plans and not just for general unit issues. Finally, there is dramatic variation among educators. Some teachers are actively engaged in providing positive checks while others are not. Unit staff needs to reinforce staff in other disciplines to participate. Security staff should also be actively engaged in the RS.

An agency-wide training plan that allocates training resources to ensure they align with the strategic direction of senior leadership is still needed. The Special Master asks that the plan outlined in the twenty-eighth report be developed.

Another recommendation from the twenty-eighth report of the Special Master was the development of a comprehensive quality assurance plan. Defendant has several quality assurance tools but their effectiveness will hinge on integration into the broader change effort through a coordinated implementation plan. The UCCI consultant has indicated that Defendant has assigned staff to work with her to develop a quality assurance plan. The Special Master requests an update on this issue.

The IBTM Central Team that has been critical to the implementation of the model is once again undergoing staffing challenges. One key long-time member is retiring and

other members are absent for a variety of reasons.[59] Defendant has moved quickly to bolster the team on an interim basis by rotating two staff members onto the team for a limited term.[60] The addition of facility staff members has proven to be valuable for the team and for the facilities in the past. Defendant continues to demonstrate an understanding of the critical role of the IBTM Central Team.

IV. MENTAL HEALTH

The Mental Health Expert, Dr. Bruce Gage, conducted a round of site audits between March 2013 and April 2014. The sites visited include the NACYCF, VYCF and the CO. OHCYCF has no mental health units. Dr. Gage completed a draft of his comprehensive report and submitted it to the parties and the Office of the Special Master for feedback on May 25, 2014; the final version was sent out June 19, 2014.

Dr. Gage used both objective and subjective measures to assess Defendant's progress in implementing the IBTM at facilities and the CO. He used an audit instrument (audit tool) that was reviewed by the parties as the primary measure of progress. For each site audited, he presented the audit results in accordance with the reporting format specified in the audit tool. He made qualitative assessments through youth and staff interviews, on-site inspections and case file reviews as well as quantitative analysis of data. He provided a summary report of his observations to assist management with their implementation efforts.

Consistent with the rating system of other *Farrell* remedial plans, Dr. Gage assigned ratings of substantial compliance, partial compliance, and non-compliance to each of the audited items. The following table provides a summary of the ratings at each

[59] Mr. Henry Lum is retiring. He is a long-term member of the committee who will be sorely missed.
[60] *See* Staff Reassignment – June 20, 2014.

of the facilities and at the CO. In general, while the overall percentage of audited items found to be in substantial compliance appears low at each audit site, this is not surprising. As pointed out in Dr. Gage's comprehensive report, the mental health youth population declined drastically and the mental health leadership has undergone significant changes, which caused constant instability in mental health programs, organizational structure, and uncertainty with regard to the model of care and nature of treatment to be provided.

Table 13
Summary of Compliance Rating Percentages[61]

	NACYCF	VYCF	Central Office	Cumulative
Substantial Compliance	42%	50%	52%	47%
Partial Compliance	44%	40%	30%	40%
Non-Compliant	14%	10%	17%	13%

A. Current Progress

Progress continues to be made with the Mental Health Implementation Plan.[62] Of the eight key areas, four have been completed. They are the mental health youth definition, levels of care, intake procedures and the entrance and exit criteria. The remaining issues including developing an evidence-based mental health treatment program, a program guide for unit operations, the policies and procedures to guide all mental programs and the development of quality assurance outcomes and measures are in various stages of development.

[61] *See* email of June 27, 2014 from Nancy Marker, Research Manager, Quality Assurance Section.
[62] *See* Mental Health Implementation Plan Summary 5-23-13.

Developing a Treatment Program

An understandably confusing issue for Defendant is what constitutes treatment as compared to case planning and how the two functions are integrated.[63] The model used prior to the reform effort was one where case management functions were largely separate from treatment. Treatment was provided in individual sessions with Psychologists who varied significantly in education, experience and beliefs about what constitutes effective treatments for delinquent youth. Some Psychologists have no training with youth, and/or cognitively-based behavioral strategies. What happened in the individual sessions was recorded in the health record and there was no mandate for Psychologists to share any information with the unit team. Some Psychologists actively participated in case conferences while others did not. In interviews with Psychologists, the Mental Health Expert and the Special Master have frequently found Psychologists engaging in case management and not treatment functions. A typical example is the Psychologists working with youth on "victim awareness" issues. Helping the staff understand that "treatment" is not "sessions with the shrink" is a challenge for all staff in the mental health units and the core units. Developing a consistent approach to "treatment" is critical to the development of a true mental health program.

While many of the Psychologists claim knowledge of cognitive behavioral treatment strategies, the number who demonstrate efficacy is relatively small.[64] Thus Defendant has identified an evidence-based curriculum, Trauma Focused Cognitive Based Therapy (TF-CBT) and contracted for training of all Psychologists and licensed

[63] It is not uncommon to find the concepts of treatment and case management used interchangeably in juvenile corrections programs.
[64] This conclusion is based on interviews by the Mental Health Expert with Psychologists and reviews of the treatment plans in the Unified Health Record (UHR) and the WIN.

Psychiatric Technicians. The training was delivered on April 24th and 25th, 2014. The Special Master was in attendance. The training was comprehensive and the trainer was a skilled facilitator with extensive knowledge in delivery of the program and with the research the program elements are based upon.

Defendant is now in the process of creating a day-long training for the unit team on each mental health unit.[65] Training is also being created for each facility executive team and elements that need to be incorporated into the unit monthly report as quality assurance measures are being identified.[66] Unlike in the past, Psychologists and unit staff will all have to understand the TF-CBT program elements so they can ensure that all unit activities support the program goals.

Clarifying the role of mental health providers, in this case Psychologists, is a basic issue that must be addressed to develop robust mental health programs in the mental health units and targeted services for outpatient treatment on other units. As noted in his Mental Health comprehensive report, the Mental Health Expert said, "While the mental health chain of command and its relationship to other clinical services is clear, it is not clear how mental health relates to others."[67] The lack of role definition confounds issues such as how to make referrals, creating an integrated case plan, and of greatest importance, ensuring that all members of the unit team are clear about the goals and strategies to be employed when working with a youth.

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[65] The unit team consists of the program administrator, SCWS or TTS, SYCC, Senior Psychologist, Psychologist, Psychiatrist, CWS or PA, YCC and teachers if the program has its own classroom.

[66] These current activities were described in an e-mail from Project Coordinator Marc-Aurelle on June 28, 2014. *See* Next Steps on TF-CBT.txt

[67] Appendix A, Mental Health Audit Comprehensive Summary, p.2.

Creating a mental health program where staff members communicate effectively verbally and in writing is a challenge Defendant is attempting to address this in the draft program guide and policies and procedures. Confidentiality issues are often provided as a reason for not sharing information. There are ways to protect the provider/client relationship and still ensure that mental health considerations are addressed in the case plan. Similarly, as the Mental Health Expert notes, there is agreement regarding many things that can be shared such as "behavioral observations and behaviors to monitor, the fact that a youth is on medication, information that is needed in order to preserve the safety of the youth and others, and any other information that other staff need to know in order to perform their duties (assuming those duties are properly defined)."[68]

Effective communication requires having the Psychologists not just attend the case conferences but ensuring they actively participate in sharing treatment goals and that mental health issues are addressed in case plans. "[T]he Treatment Plan can be very narrowly focused on the specific interventions that clinicians are to make and the majority of the emphasis of all staff, including Psychologists, would be on the Case Plan which would then be more behaviorally robust and in tune with the mental health problems of the youth."[69] This is true for mental health and core units.

Just as standards need to be created for who participates in what level of case planning in mental health units, so must Psychologists develop standards for the development of treatment goals and case notes. It is the exception, not the norm to actually find a written treatment goal with identified action steps and progress notes in the treatment plans of Psychologists. Just like the YCCs' case notes, the Psychologists'

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[68] *Id.,*p.3.
[69] *Id.,*p.2.

notes rarely relate to defined goals for the youth and fail to demonstrate if progress is taking place. It is common to see the diagnosis repeated and little else.

Similarly, Psychologists and unit team members should partner to create the type of structured unit activities that support mental health. The amount of unstructured time in the mental health units is troubling. Even more than the core units, staff members need to ensure youth are engaged in appropriate structured activities. Structured activities are not watching MTV. The mental health units in the Northern Complex were rightly proud of the Christmas decorations their youth and staff created. The level of creativity and attention to detail was amazing. The staff noted that during the period of making the decorations, the most problematic youth took on leadership roles and the level of violence decreased. This is an excellent example of how structured activities serve both youth and staff. Such activities should not fall to those staff that volunteer for these type of activities. All staff must learn to understand that structured activities are part of milieu therapy.

Policies and Procedures

Defendant has worked with the Mental Health Expert to understand his concerns about the current policies and procedures. Chief among the Mental Health's Expert's concerns is that the policies are:

- Repetitive and too complex.
- Procedural in nature and this is part of the reason they are so long and complex.
- Internally inconsistent.

The informed consent policy also requires revision. The policies do include most of the important topics that should be addressed.[70]

One policy issue that has not been resolved is the issue of use of chemical agents against youth with a mental health diagnosis. Defendant's use-of-force policy was developed in collaboration with Plaintiff and the relevant *Farrell* experts. Plaintiff supports Defendant's current policy that severely restricts the use of chemical agents against youth with a mental health diagnosis, but believes that it should go further.[71] The parties are discussing this issue and, as recent trends suggest that such incidents are becoming increasingly rare, the Special Master is hopeful that a reasonable compromise can be reached on this issue.

Defendant has drafted revised mental health policies and procedures. The Mental Health Expert and the Special Master have provided feedback on both documents. The policies and procedures are in the final review stages.

Program Guide

For any program to have internal consistency and coherence, a framework that describes the program's goals and objectives, entrance and exit criteria, program elements, staff roles and quality assurance mechanisms must exist. The Mental Health Expert opined in his comprehensive report that "DJJ has recently identified Trauma Focused CBT as the centerpiece of its mental health program but this alone is not sufficient. There need to be services often termed rehabilitative such as medication, education, relapse prevention, social skills (which may need to be different than or

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[70] *Id*.,p.4.

[71] This issue is discussed in Section V, Safety and Welfare, p. 43.

augment those provided in IBTM modules), and specialized community transition services including accessing community services and family engagement."[72]

An excellent example of the effectiveness of such a framework can be found in the Program Guide of the Sexual Behavior Treatment Program (SBTP). Staff ensures consistency and accuracy in delivery of the program through the use of the Program Guide. Defendant has completed a first draft of a Program Guide and has sought the feedback of the Mental Health Expert and the Special Master. There has been good progress. The main outstanding components include the development of a unified treatment plan for the residential mental health units, emphasis on the need for psychologists to assist in developing the case conceptualization beginning with the initial assessment, and clarification of the role of psychologists in case planning.

One issue that needs immediate attention in the Program Guide is the implementation of a structured interview at intake: it is a foundational element for the case conceptualization. The Mental Health Expert agreed that Defendant need not use the V-DISC assessment at intake if a structured interview was implemented. While the V-DISC is no longer used, a structured interview has not been developed and implemented.

B. Next Steps

Defendant has made good progress in moving toward the implementation of a true mental health program. Progress has been made in training, the revision of policies and the development of a Program Guide in this reporting period. The Mental Health Expert noted that interaction between mental health and the other programs is substantial and

[72] *Id*.,p.5.

makes it more challenging to develop this program than others that have more discrete boundaries.[73]

If Defendant is committed to having Psychologists provide treatment, Defendant must hire Psychologists who are trained in working with youth and in cognitive behavioral strategies. Further, Defendant must insist that all Psychologists provide assessment, treatment and documentation in the same way and that is consistent with the cognitive behavioral strategies of the IBTM. Finally, Psychologists must see themselves as a part of the IBTM and not function as a stand-alone service provider who is not accountable to the rest of the unit team.[74] Defendant's quality assurance methods should ensure observations and reviews of Psychologists to ensure fidelity with the TF-CBT in the mental health units and with cognitive-behavioral approaches in the core units. Defendant should also ensure that all Psychologists complete the IBTM overview as well as one of the full CBT resource group curricula.[75]

The complex nature of delivering different levels of care in different types of living units makes the mental health program challenging to develop and to integrate into the IBTM. Defendant is doing a good job of moving toward the integration of the mental health providers into the IBTM.

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

[74] It should be noted that some Psychologists work hard to overcome the current structural barriers to their full engagement with the unit team. They partner with the PA or CWS and put notes in the case files so that unit team members can better understand how to support the Psychologist's treatment efforts with their case management efforts. The Psychologists on the mental health units appear to be very committed to their work and in most cases actively engaged with the unit team.

[75] Once again a problem faced by Defendant is the challenge of being in an adult corrections system. The Psychologists are part of a combined adult/youth bargaining unit and this makes it more difficult to ensure that Psychologists from the adult system do not have transfer rights into the juvenile system. Defendant again faces the challenge of training staff only to lose the staff and have to start over again.

V. EDUCATION

It was recommended in the twenty-fifth report of the Special Master that monitoring of the *Educational Services Remedial Plan* be returned to Defendant. Pursuant to the Education Experts' recommendations, the Special Master agreed to assume the monitoring of a few school attendance-related issues at VYCF that remained outstanding. Accordingly, the parties entered into a stipulated agreement in July 2013 dismissing the *Educational Services Remedial Plan* with the exception of certain audit items pertaining to general and special education at VYCF. The parties further agreed that the Special Master will monitor the outstanding issues as part of the IBTM portion of the *Safety and Welfare Remedial Plan*.

In her twenty-eighth report, the Special Master found Defendant has successfully addressed two of the three remaining issues, one pertains to special education (Audit Item 5.8) and the other is related to compensatory services (Audit Item 5.22). However, the Special Master found Defendant has demonstrated virtually no progress in resolving the school attendance issue. VYCF's attendance data from August through December 2013 showed the monthly absence rate to be in excess of 21.7% with the exception of the beginning of the new semester in August 2013 when the absence rate was 18.7%. The absence rate encompasses "unexcused absence rate" and "excused absence rate." The Special Master retains monitoring responsibility of this audit items until the absence rate reaches a reasonable level.

A. Current Status

After years of lack of progress, VYCF's absence rate declined for two consecutive months in March and April 2014. After months of rates well above 20%, the

absences rates dipped to 19% and 19.2% in March and April 2014, respectively. Had the facility not had to cancel certain classes due to a lack of substitute teachers, the April 2014 absence rate likely would have been below 18%. While the two-month duration and the slight decline in rates are not sufficient to establish a definitive trend, it nevertheless represents a step in the right direction.

Table 13
Comparison of Monthly Absence Rates at VYCF[76]

	Unexcused Rate	Excused Rate	Education-Related Rate[77]	Monthly Rate
January	9.5%	14%	.1%	23.4%
February	10.2%	15%	.1%	25.2%
March	7.6%	11.4%	0.0%	19%
April	8.0%	11.1%	1.3%	19.2%
May				

Weekly, the facility produces a School Absence Audit Report (SAAR) that identifies youth absences by youth name, by living unit, and by absence codes. Bi-weekly school truancy reduction meetings are held with the Superintendent, Principal, and managers from each living unit to go over the weekly reports and discuss which youth missed class and what is being done to remedy the situation. In addition, the facility developed a "School Truancy Reduction Strategy" that outlined an approach to address this issue. This is an excellent document that defines the roles and expectations of managers and staff members as well as delineating counseling strategies that incorporated IBTM principles. A PowerPoint presentation was prepared and training sessions were held for unit staff, education staff, and security staff during team meetings and staff meetings.

[76] Data compiled from monthly School Absence Audit Reports.
[77] Education-related rates are included as a component of excused absence rates.

Data seem to suggest that the facility's intervention strategy is starting to take effect. While the weekly unexcused absences, largely consisting of youth who refused to attend classes, generally remains high at 10% or above, there were weeks when it declined to the 5% to 7% range. In the past, absences were consistently above 10%. In addition, the average monthly unexcused absence rate is 8.8% for the first four months of the current school term in comparison to 10.6% over five months during the last school term. While the rate is still too high and more work is needed to sustain rate reduction from week to week and month to month, the Special Master is encouraged by the progress that has been made to date.

The key components of VYCF's excused absences have consistently been youth placed on Temporary Intervention Program (TIP), youth not allowed to attend classes at the discretion of the TTS because of safety and security concerns, and program change protocols (limited programs) that usually occur as a result of group disturbances or staff assaults. Again, review of the SAAR reports revealed absences tend to fluctuate drastically from week to week. For example, absences due to TIP ranged from a low of 50 during the week of March 17, 2014 to a high of 366 during the week of May 5, 2014. Similarly, absences due to TTS decisions ranged from 63 during the week of February 3, 2014 to 356 during the week of March 10, 2014. The Special Master reiterates the suggestion in her twenty-eighth report that Defendant consider performing more in-depth analyses to assess how to reduce the length of time and scope of negative consequences that result in youth not being able to attend school and to develop incentives for youth when those with high absentee rates to attend school.

In addition, the Special Master discussed the education-related issues in this report with former Education Expert Tom O'Rourke who offered additional measures for Defendant's consideration. Mr. O'Rourke noted that the "in-school suspension" class was designed to address minor behavior issues that occur in classes and suggested Defendant review its current practices to ensure that it is still being used appropriately. Defendant may also wish to consider expanding the scope of the bi-weekly school truancy reduction meetings to include assessments of the validity of the youth's TIP placement by teachers, especially those with a history of frequently placing youth on TIP. The Special Master appreciates and agrees with Mr. O'Rourke's suggestions.

In her twenty-eighth report, the Special Master also suggested that more could be done to encourage the youth to attend school by enhancing the quality of education services and by making the classes more interesting and meaningful for youth who have a history of failure in school. School administrators need to attend and observe classes, evaluate the teachers' performance, and provide constructive feedback on a timely basis.[78] Teachers with consistently poor performance evaluations need to be held accountable. A review of the Principal's Monthly Reports for January, February, March, and April 2014 suggests little has been done in this area. The reports contain no indication that any quarterly classroom observation has been made during this four-month period. According to the April 2014 report, three performance evaluations were completed during the month, leaving another 24 still outstanding. All of the outstanding evaluations apparently have been listed outstanding in the Principal's August 2013 report. Defendant's Superintendent of Education, has ample administrative and program staff

[78] The question must be asked why the Superintendent of Education is not ensuring that classroom observations and teacher performance evaluations are not being conducted and what support the Superintendent can provide to ensure these critical functions are performed timely.

available at the CO, to ensure performance evaluations and classroom observations are completed (quality assurance measures) and to take action to intervene if the Principal is unable to carry out these essential management functions and duties. Defendant also may wish to consider implementing a peer review program to ensure and improve the quality of teaching at the schools.[79]

B. Next Steps

While encouraged by the recent progress and efforts being made by management and staff at the facility, the Special Master finds the absence rate at Mary B. Perry High (MBPHS) School to be still too high. Furthermore, there is insufficient data to fully assess the progress to ensure it is sustainable. The Special Master will continue to monitor this one remaining issue in the *Educational Services Remedial Plan* and report progress to the Court.

VI. SAFETY AND WELFARE

The Special Master identified in the twenty-eighth report a list of issues that she developed in consultation with the Safety and Welfare Expert as outstanding issues that need to be addressed by Defendant. Some of the issues are department-wide while others are specifically related to VYCF. The list was circulated to the parties for review and Plaintiff was in agreement that these are the issues that need to be resolved in order to return full monitoring of the *Safety and Welfare Remedial Plan* to Defendant.

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[79] The quantity of complaints about the lack of quality of many of the education classes at Mary B. Perry High School by youth and staff is higher than at the other facilities. It is rare to hear youth or staff complain about either N.A. Chaderjian High School or Johanna Boss High School. It is common to hear youth and staff complains about the lack of quality of teaching at Mary B. Perry High School. In addition, both youth and staff are complaining that the teachers are too rigid with regard to their expectations of what constitutes acceptable behavior in a classroom. Teachers are removing youth from classes for minor behavioral problems and not allowing them to return to class for long periods of time. VYCF managers are meeting with some of the teachers to discuss what are reasonable expectations for young people in classrooms. What is not reasonable is to expect teenagers to sit quietly at their desk for the entire classroom period with little or no interaction with other students or the teacher.

In response, Defendant has developed a corrective action plan for each of the identified issues and has been working diligently to address these issues. The Special Master is pleased to report that all issues specifically related to VYCF have been resolved. However, while Defendant is continuing to make progress, further monitoring is needed for the department-wide issues. The Special Master agrees to assume monitoring responsibility for these items consistent with the approaches of transferring monitoring responsibility to bring closures of the *Educational Services Remedial Plan* and the *Wards with Disabilities Program Remedial Plan*. In addition, there are other unresolved treatment-related issues (IBTM, and gender responsive program) in the *Safety and Welfare Remedial Plan* that will be monitored by the Mental Health Expert and the Special Master.

The outstanding issues and the current plan to resolve each of these issues are discussed below:

A. Use of Force (Departmental Issue)

In her twenty-eighth report, the Special Master made the following general observations with respect to Defendant's use-of-force practices:

1. OHCYCF has already achieved the desired outcome and its use-of-force rate could be used as a reasonable target for NACYCF and VYCF.

2. Over the six-month period of July through December 2013, NACYCF's use-of-force numbers were close to or below the numbers of OHCYCF. If the trend continues, NACYCF also has achieved the desired outcome.

3. The number of force incidents at VYCF remains high in comparison to the other two facilities. Single youth incidents and incidents that occurred at the two high core units accounted for the disparity between VYCF and the other two facilities and pose the greatest opportunity for significant reduction in force incidents.

4. The appropriateness of use of chemical agents against youth with a mental health designation is an issue that remains outstanding and requires further dialogue by the parties.

A review of use-of-force data for the first four months of 2014 suggests that OHCYCF and NACYCF continue to achieve the desired outcomes. The numbers of incidents were low and consistent with the previous patterns that were deemed acceptable. In addition, there were minimal number of incidents involving a single youth or use of chemical agents against youth with a mental health designation. However, the number of force incidents at VYCF remains high in comparison to OHCYCF and NACYCF. Except for February 2014, the total number of force incidents at VYCF exceeded the combined total at the other two facilities. The same trend also persisted throughout the last six months of 2013.[80]

Table 14
Use-of-Force Incidents
January through April 2014[81]

	January	February	March	April	Total
VYCF	36	19	41	31	127
NACYCF	16	10	15	18	59
OHCYCF	9	9	12	11	41
Total	61	38	68	60	227

The Special Master also compared the monthly rate of use-of force incidents from April 2013 through May 2014, which takes into account fluctuation in the youth population among the facilities. At OHYYCF, the rate remained fairly constant over the fourteen-month period except for temporary spikes in August 2013, September 2013, and May 2014. At NACYCF, after a significant decline from .38 in July 2013 to .18 in

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[80] *See* OSM 28, p.62
[81] Data based on each facility's quarterly report for the first quarter of 2014 and the monthly report for April 2014.

August 2013, the monthly rates remained fairly steady and in line with the rates at OHCYCF. While there has been a noticeable decline in its monthly use-of-force rates since May 2013, VYCF's monthly rates in general significantly exceeded the monthly rates at NACYCF and OHCYCF, which suggest there is a substantial potential for further rate reduction.

Table 15
Use-of-Force Rate – Per 100 Youth Days
April 2013 through May 2014[82]

	NACYCF	OHCYCF	VYCF
April 2013	.24	.09	.69
May 2013	.36	.18	.73
June 2013	.33	.23	.42
July 2013	.38	.17	.24
August 2013	.18	.29	.42
September 2013	.25	.32	.55
October 2013	.14	.24	.44
November 2013	.06	.15	.53
December 2013	.15	.20	.45
January 2014	.24	.16	.51
February 2014	.16	.18	.30
March 2014	.23	.21	.56
April 2014	.30	.20	.45
May 2014	.21	.38	.48

Single youth incidents continue to account for a significant percentage of all use-of-force incidents at VYCF. Over the four-month period, 42% (53 of 127) of all incidents at VYCF were single youth incidents, which is slightly higher than the 41% (80 of 194) during the last six months of 2013.[83] Similarly, consistent with the past trends, incidents at the two high core units represent approximately 43% (54 of 127) of all incidents at the facility in comparison to 41% (80 of 194) for the last six months of 2013.[84]

[82] Source: Dashboard -- 1st Quarter QSR 2014
[83] *See* OSM 28, p.62
[84] *See* OSM 28, p.67

Table 16
Use-of-Force Incidents Involving Single Youth
January through April 2014[85]

	January	February	March	April	Total
VYCF	16	8	17	12	53
NACYCF	2	4	3	5	14
OHCYCF	3	0	3	0	6
Total	21	12	23	19	73

The use of chemical agents against youth with a mental health designation occurred infrequently at all facilities during the first four months of the year. With no mental health unit and a very few youth with a mental health designation, such incidents have rarely occurred at OHCYCF. At NACYCF, the pattern of a very few youth with a mental health designation being exposed to chemical agents started in July 2013 and continued through April 2014.[86] The same pattern occurred at VYCF starting November 2013 and persisting throughout 2014.

Table 17
Mental Health Youth Exposed to Chemical Agents during Use of Force Incidents
January through April 2014[87]

	January	February.	March.	April	Total
VYCF	4	2	6	3	15
NACYCF	2	1	1	1	5
OHCYCF	**0**	0	0	0	0
Total	6	3	7	4	20

While the above data may suggest that little change has occurred at VYCF, the Special Master believes a substantive reform is taking place under the leadership of the new Superintendent. Data show that an overwhelming percentage of incidents that

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[85] Data based on each facility's quarterly report for the first quarter of 2014 and the monthly report for April 2014

[86] NACYCF only had five such incidents over the five month period of August 2013 through December 2013. *See* OSM 28, p.63,

[87]Data based on each facility's quarterly report for the first quarter of 2014 and the monthly report for April 2014.

require security response are being resolved through dialogue rather than through force. The percentages of incidents resolved through dialogue for January, February, March, and April 2014 were 82%, 84%, 73%, and 79%, respectively.

A review of force incident reports reveal that staff routinely look at the youth's crisis intervention plan before the incident and revise it afterwards when appropriate. There also appear to be less reliance on chemical agents and more use of physical strength and hold on situations that do not involve fights or disturbances. In addition, a study of the facility's monthly reports that summarize the incidents reviewed by the Force Review Committee (FRC) clearly show that the FRC members are placing greater emphasis in exploring means to prevent and avoid future incidents. Moreover, the facility's analyses of use-of-force trends and patterns are more in-depth, thorough, and meaningful. Although this issue requires further monitoring, the Special Master is reasonably confident that VYCF will be able to bring down its force usage to an acceptable level within the foreseeable future.

The data on the use of chemical agents against youth with a mental health designation is also highly encouraging. While the parties have been unable to reach agreement on this issue, the limited number of such incidents, some of which occurred during fights or disturbances, should help enable the parties to achieve a reasonable compromise. The Special Master will continue to work with the parties to bring closure to this issue.

B. Facility Improvements (Departmental Issue)

Since the release of the twenty-eighth report, the Special Master found that Defendant has taken a number of important concrete action steps to improve the

appearance and functionality of the living units to provide for a setting and environment conducive to treatment. Furniture suitable for the livings units has been ordered and is scheduled for delivery during the 2014-15 fiscal year. In addition, each facility has begun to take action to make treatment-related improvements to the living units. In the past, with few exceptions, most of the improvements have been security-related.

At VYCF, the facility has installed a recreation hall that became operational in June 2014 with a special event promoting its activation. The recreation hall is to be used for incentive activities and all furniture and equipment were acquired based on direct input from the youth. Plans have been made to host co-educational activities at the recreation hall and both male and female youth have expressed enthusiasm for the opportunity to participant in such events.[88] A Program Administrator stated that continuous efforts will be made to improve the appearance of the recreational hall after its activation.

All living units at all facilities are in the process of installing honor/incentive rooms and computer rooms. The Special Master has seen some of the completed rooms and met with youth who are using them at OHCYCF. The rooms are painted in pastel colors, have nice linens and a television. Youth are very excited about earning the use of the room. All honor rooms are scheduled to be activated no later than June 30, 2014 and some living units have begun to accept applications for occupancy of the honor rooms while other units are already using them. The progress of the computer rooms lag behind

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[88] Co-ed activities have been held successfully for many years at VYCF and provide an important learning opportunity for youth if appropriately structured. The activities were cancelled because of some inappropriate contact between girls and boys. The Special Master has indicated to Defendant that while this type of situation should be avoided, cancelling all co-ed activities and thereby punishing youth who did not violate the rules is neither fair nor rewards the youth who followed the rules. The first successful co-ed event in the recreational hall was held June 29 2014.

the honor/incentive rooms due to wiring and other logistical considerations. As the planned improvements are not scheduled to be completed until Fiscal Year 2014-15, the Special Master agrees to assume monitoring progress of the implementation of this item starting in July 2014.

C. BTP Units (Departmental Issue)

The *Safety and Welfare Remedial Plan* prescribed the BTP model to provide intensive behavior treatment intervention for those youth exhibiting violently disruptive behavior who do not meet the criteria for intensive mental health treatment. While acknowledging significant progress has been made, Plaintiff remains concerned about a small group of deeply entrenched youth with very lengthy stays in BTP units, particularly at VYCF. In addition, youth in a BTP often are segregated into different "program groups" by race, gang affiliation, or other factors, which seriously limit the staff's ability to provide meaningful treatment and services to youth, as most of the staff's time was consumed by youth movement and delivery of basic services.

Defendant on February 12, 2014 established a BTP workgroup comprised mostly of staff members from each of the three BTP units and some program administrators. The workgroup is tasked with developing a plan and strategy to provide intervention and case planning in an integrated setting that promotes the rapid and safe transition of youth out of a BTP. Full implementation of the work plan is anticipated near the end of 2014.[89]

The Special Master's review of the most recent BTP monthly reports and follow-up inquiries found progress has been made at all facilities with respect to the length of

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[89] *See* BTP Action Steps.doc for the deliverables and timeline. While the goal of BTP is rapid transition in a fully integrated setting, it is expected that the inherent nature of BTP youth population will sometimes lead to special circumstances that may result in lengthy stays and less than fully integrated settings even under the most optimal intervention and treatment environment.

stay issue. The average length stay for all BTP units declined from 132 days in January 2014 to 83 days in May 2014. The decline was most significant at VYCF where the average length of BTP stay decreased from 172 days in March 2014 to 136 days in April 2014 and 106 days in May 2014.[90] However, further review revealed that the decline at VYCF was largely caused by the serious staff assault described above.[91] The County District Attorney Office has agreed to prosecute six of the eight youth over the age of 18 and they were transferred to the county jail in April 2014. The average length of stay for these six youth is well in excess of 200 days, which accounted for a significant aspect of decrease in average length of stay for VYCF and for all BTPs.

Two more youth with the length of stay in excess of 100 days were transferred to VYCF's high core units in May 2014. Attrition should further reduce the number of youth at the BTP with lengthy stays. As of May 30, 2014, VYCF had 10 youth assigned to its BTP with length of stay in excess of 60 days. Three of the 10 will be released by November 2014 when they reach their actual confinement time.[92] However, the remaining seven appear to be highly challenging cases, three of which committed repeat staff assaults and another one has been in BTP for 400 days after failing to integrate into a core unit three different times. Most of these youth belong to the same program group with the same gang affiliation and therefore are particularly entrenched to the BTP environment.[93] Staff members remain committed to work with these youth to transition them out of BTP. At the same time, they must be cognizant of the need to devote efforts

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[90] *See* email of June 10, 2014 from Program Administrator Alicia Ginn forwarding a document entitled BTP Average LOS from January 2014 – May 2014

[91] *See* Section III, pp. 14-15 of this report.

[92] One youth is scheduled for release in June 2014, another in July 2014, and another in November 2014.

[93] Based on discussion between the Deputy Special Master, VYCF's BTP Treatment Team Supervisor, and Parole Agent on May 30, 2014.

to transition youth with less than 60 days of confinement time out of BTP to preclude them from becoming entrenched in the BTP environment.

Recent data suggest the length of stay issue has not been of particular concern at NACYCF and at OHCYCF. At NACYCF, five youth had length of stay in excess of 60 days as of April 30, 2014. Since then, one youth transitioned from BTP to a high core unit on May 2, 2014, two are scheduled to be transferred to the Division of Adult Institutions (DAI), and one is scheduled to attend his discharge hearing in early July 2014. Another youth was transferred to VYCF's high core unit in May 2014.[94] OHCYCF had only one youth with a length of stay in excess of 60 days as of end of April 2014. That youth was transferred to DAI on May 29, 2014.[95] Given the unpredictable nature of the BTP youth population, it is not always possible to totally preclude lengthy stays. Current data suggests that efforts to reduce the length of stay appear to be reasonable, appropriate and working to move youth back to core units faster.

To date, most attention has been directed to Defendant's inability to transition a small segment of youth out of the BTP units. It should be acknowledged that there are ample cases where staff eventually succeeded after numerous failed attempts to integrate youth into core units. For example, one youth who arrived at VYCF on April 8, 2011 spent an overwhelming portion of his time in the BTP unit. He was referred to the BTP on three separate occasions with one BTP stay lasting from October 20, 2011 to July 11, 2013. Despite treatment interventions, the youth expressed no motivation to exit from the BTP until one day during his individual counseling session with his PA when he

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[94] *See* emails of June 10, 2014 from Superintendent Erin Brock and Assistant Superintendent Teresa Perez to Deputy Special Master John Chen.

[95] *See* email of June 10, 2013 from Assistant Superintendent Craig Watson to Deputy Special Master John Chen.

expressed a desire to integrate. The BTP staff immediately worked with him to develop a transition plan, which he successfully completed and was transferred to a high core unit on July 11, 2013. His attempt to integrate at the high core unit failed because of his past difficulties with certain youth in the unit. He was returned to the BTP on August 30, 2013 where the staff members continued to work with him. After several meetings and discussions between the youth and staff members at the BTP and the low core unit, he was transferred to the low core unit on November 18, 2013 where he programmed successfully with all youth in the unit. He lowered his (CA-YASI) overall risk from very high to moderate and was one of eight VYCF youth to graduate from the California Prison Industry Authority's Pre-Apprentice Construction Labor Program on May 28, 2014. In another example, a youth was housed in VYCF's BTP for 494 days after he was released from the BTP where he previously had been held for 350 days. Numerous attempts to integrate him were unsuccessful, some largely due to his past history with the other youth in the receiving units. However, staff recognized his sincere desire to integrate and recommended a transfer to a core unit in NACYCF. He was transferred in March 2014, where he is continuing to program successfully at a core unit.

While progress has been made, severe challenges still lie ahead. At NACYCF, the BTP had 14 youth assigned to the unit segregated into five program groups as of June 9, 2014.[96] As of May 30, 2014, VYCF had 24 youth in the BTP segregated into seven program groups.

The Special Master will continue to monitor this issue and report progress in future reports until completion.

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[96] *See* email of June 9, 2014 from Superintendent Erin Brock to Deputy Special Master John Chen.

D. Drug and Contraband (VYCF-Specific Issue)

The Safety and Welfare Expert found drug and contraband issues to be very troubling at VCYF. Both youth and staff interviewed (including the Chief of Security) acknowledged that this is a serious issue that needs immediate management focus and attention. In response, VYCF's Superintendent on January 16, 2014 prepared a memorandum detailing the facility's drug and contraband interdiction strategy.[97] The strategy calls for youth searches, room searches, and holding youth accountable when drugs or contraband are found. The strategy includes elements such as a protocol for visiting, procedures for random and unannounced staff searches, unannounced vehicle/visitor searches, and increased drug testing on all housing units.

In March 2014, consistent with the strategy identified in the Superintendent's January 16, 2014 memorandum, Defendant developed a corrective action plan (CAP)[98] and forwarded it to the Safety and Welfare Expert and the Special Master for review and comment. The CAP identifies action steps to be performed, the individual responsible, and the target date for completion under seven different areas – visiting, vehicle/visitor search, enhanced staff searches, youth work assignment, tactical operations/searches/intelligence, technology, and supervision. A review of the CAP disclosed that all but five of the action steps have been completed. Two of the five action steps are technology related that require CO intervention and are not scheduled for completion until December 31, 2016. The three remaining action steps are related to visiting, one of which requires CO intervention, and are not scheduled for completion

[97] *See* memorandum of January 16, 2014 from Superintendent Mark Blaser regarding drug interdiction strategy.

[98] *See* Drug Interdiction Strategy at Ventura Youth Correctional Facility, Corrective Action Plan for Ongoing Concerns, January 27, 2014.

until December 31, 2015. The Special Master agrees these not yet completed action steps are more long term in nature[99] which, when enacted, will enhance Defendant's effectiveness. However, their absence in the short term does not hamper Defendant's current drug and contraband interdiction efforts.

In addition to the action items outlined in the CAP, VYCF partnered with California Institution for Men State Prison to bring in their K-9's to search housing units, plants operations, and work sites for cell phones, drugs, and other contrabands. Approval has been obtained to purchase a drug/cell phone detection K-9 and designate a YCO post as the handler. Plans are being developed to purchase a drug detection machine for visitors and staff searches.[100]

VYCF also significantly increased the frequency of youth drug testing. In the first five months of 2013, VYCF completed 402 youth drug tests with a total of 1,142 tests completed for the year. The number of drug tests more than doubled to 840 during the first five months of 2014. The facility also started to use "Quick Strips" to obtain immediate feedback to determine if a urine sample is contaminated.[101]

VYCF reported a drop in contraband found since its efforts began. The facility also reported that youth are becoming increasingly violent when caught in possession of a cell phone, which suggests that cell phones are becoming increasingly rare at the facility.

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[99] For example, one of the technology-related action steps is to install a institution telephone call monitoring and retrieval system that records and "brands" all outgoing youth phone calls.

[100] *See* memorandum of June 4, 2014 on "Contraband Eradication" from Superintendent Mark Blaser to Deputy Special Master John Chen.

[101] *Ibid.*

[102] The high degree of violence has prompted the Superintendent to issue a memorandum to all staff urging caution when encountering youth with cell phones.[103]

The Special Master concludes that this is a closed issue. As this issue requires ongoing efforts and there is no provision in the *Safety and Welfare Remedial Plan* audit tool to monitor it, Defendant may wish to consider working with the Office of Audits and Court Compliance (OACC) to incorporate procedures to monitor this issue in their future audits.

E. Re-Entry Program (VYCF-Specific Issue)

While he found the re-entry programs to be exemplary at NACYCF and OHCYCF, the Safety and Welfare Expert found the re-entry services at VYCF need to be better coordinated and quality assurance measures need to be implemented to consistently deliver useful and meaningful services. Some youth indicated that they did not have a re-entry plan when attending board hearings and youth reported mixed results on the quality of re-entry groups and services -- some said it is outstanding while others did not find it useful at all.

Defendant has prepared a CAP that requires every youth at VYCF to have an Integrated Re-entry Plan at his/her discharge hearing by April 1, 2014. On May 22, 2014, Defendant conducted an audit of discharge hearings conducted after April 1, 2014 and prepared a report of its findings.[104] The audit, performed by the Associate Director and NACYCF Re-Entry Coordinator, found completed Integrated Re-Entry Plan for 33 of 34 discharge hearings scheduled for April and May 2014. VYCF's Re-Entry Coordinator

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[102] *Ibid.*
[103] *See* memorandum of March 12, 2014 entitled "Cell Phones/Contraband" from Superintendent Blaser to all staff.
[104] *See* Plan and Process to Resolve Outstanding Issues, Re-Entry Program—Ventura Youth Correctional Facility—Specific Issues.

prepared all plans. The one exception was a dual commitment case involving a youth who recently returned from the Division of Adult Institutions.

The audit also found that, while the re-entry plans have been timely, the quality could be improved by adding specificity to the plans. VYCF's Re-Entry Coordinator also prepares a portfolio for each youth that contains his/her re-entry plan as well as resources and brochures to assist transition back to community. The portfolio is given to youth upon release.

Recognizing its re-entry program needs further support, VYCF was the first site selected to undergo Re-Entry Policy training. A total of 29 staff members attended the training that included PAs, CWSs, TTSs, Supervising Casework Specialists (SCWSs), administrators, clinicians, case records technicians, and the PA II. The quality of the re-entry plan should continue to improve as more staff members gain a better understanding of their role and responsibility in the re-entry planning process and work collaboratively to achieve the desired results.

The Special Master concludes this is a closed issue. Given the apparently high demand for the Re-Entry Coordinators' services, Defendant may wish to closely monitor her workload and provide support and assistance when necessary.

F. Wards with Disability Program (WDP) (VYCF-Specific Issue)

The Safety and Welfare Expert assumed monitoring of this issue from the Disability Expert. He noted that in a few instances, a youth with a disability was not receiving staff assistance to help them maneuver through grievance hearings, DDMS hearings, case conferences, and Board of Parole hearings. He expressed a concern that the problem may be systemic and recommended the facility assess its processes and

procedures to ensure disabled youth are receiving appropriate representation and staff assistance.

In her twenty-eighth report, the Special Master noted that Defendant has adopted her recommendation and will provide a staff assistant training to all PAs at VYCF. She also noted that procedures were being developed to ensure staff members who serve as staff assistants gain familiarly with a youth's history and accommodation needs prior to the hearing and such procedures will be disseminated to staff. The Special Master suggested this issue will be closed when the above tasks are completed.

Defendant has completed staff assistant training to all PAs. In addition, procedures have been developed that require each youth's assigned PA to serve as his/her assistant during all proceedings before the Juvenile Justice Administrative Committee (JJAC) and the Juvenile Parole Board (JPB). All staff assistants are required to be familiar with the youth's needs and will obtain a printed copy of WDP Board Information Report prior to the proceeding. The procedures were disseminated on May 13, 2014.[105] Based on her observations during case conferences, annual reviews, and Parole Board hearings, the Special Master concludes that appropriate representation and staff assistance is provided by the WDP at VYCF.

G. Report of Accomplishments by the Safety and Welfare Expert

In addition to the above outstanding issues, the Safety and Welfare Expert suggests that he prepare a summary report highlighting the accomplishments achieved under the *Safety and Welfare Remedial Plan*. The parties agree that the report is useful and appropriate. The report is anticipated to be completed by September 1, 2014.

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[105] *See* memorandum of May 13, 2014 entitled Providing Staff Assistant for JJAC or JPB Proceedings from Deputy Director Anthony Lucero to Superintendents.

H. Next Steps

The Special Master recommends immediate transfer of monitoring of the *Safety and Welfare Remedial Plan* to Defendant with the exception of the departmental issues (use-of-force, facility improvements, and BTP units).[106] The Special Master will continue to work with the parties to bring closure to those issues as expeditiously as possible. The Special Master commends the diligent efforts of Defendant and the creative problem-solving skill of the Safety and Welfare Expert whose oversight and guidance over the years have been instrumental in bringing this high complex and multi-faceted remedial plan toward full closure.

VII. CONCLUSION

Director Minor did an excellent job of attending to the concerns raised by the Court at the last Case Management Conference. The Court expressed concern that Superintendents and other facility managers had not demonstrated ownership of the IBTM and relied too heavily on the CO IBTM Team to engage and align facility staff with the IBTM principles. In this reporting period, there is clear evidence that Superintendents are demonstrating stronger leadership in IBTM implementation.

Chief among the strategies employed that demonstrate greater facility ownership of the IBTM is the reporting of CBT resource group. A clear format was consistently used to report on group delivery. No unit failed to provide complete reports to Superintendents who reviewed group delivery weekly at their executive team meetings. The monthly report is being modified to ensure accurate capture of data needed for future monitoring. The Special Master looks forward to reviewing the monthly reports during

[106] Monitoring of IBTM implementation progress has already been transferred to the mental health expert..

the next reporting period and working with Defendant to ensure systems are in place that ensure accurate and consistent testing of reporting systems is being done by facility managers. Such measures will help to assure Plaintiff and the Court that CBT resource group delivery as well as RS and eventually level system elements of the IBTM will be sustained when monitoring by the Court ceases.

Similarly, the Court suggested assessment and case planning required better alignment to the IBTM and that Defendant seek guidance from the Mental Health Expert and Orbis Partners to assist with needed changes. Defendant has done so. The Special Master looks forward to reviewing the strategies Defendant chooses to employ now having received feedback from both.

Steady progress has been made in the implementation of a comprehensive mental health program. The first mental health audit indicates a high level of commitment to developing both residential and outpatient programs of the highest quality. The difficult and arduous process of policy reform and program guide development is nearing completion and training in an evidence-based cognitive behavioral program is underway. Soon the challenging task of ensuring that mental health unit treatment and case planning functions are integrated and supported by milieu therapy should begin.

Defendant has also addressed each of the Safety and Welfare Expert's remaining concerns about VYCF. The clear and consistent direction and leadership provided by the VYCF Superintendent to address these issues appear to indicate this institution will now be able to address the few remaining education issues in the next school year.

The Special Master recommends immediate transfer of monitoring of the *Safety and Welfare Remedial Plan* to Defendant with the exception of the departmental issues

(use of force, facility improvements, and BTP units).[107] The Special Master will continue to work with the parties to bring closure to those issues as expeditiously as possible. The Special Master commends the diligent efforts of Defendant and the creative problem-solving skill of the Safety and Welfare Expert whose oversight and guidance over the years have been instrumental in bringing this highly complex and multi-faceted remedial plan to closure.

The Special Master respectfully submits this report.

Dated: July 28, 2014

Nancy M. Campbell
Special Master

[107] Monitoring of IBTM implementation progress has already been transferred to the mental health expert by agreement of the parties.

Mental Health Audit Comprehensive Summary

INTRODUCTION

The Farrell lawsuit remedial plan specifies a number of requirements for the delivery of mental health services within the Division of Juvenile Justice (DJJ). This Comprehensive Summary reviews the salient findings of the mental health audits of NACYCF, VYCF and Headquarters conducted in March and April of 2014.

The remedial plan addresses a variety of requirements that include organizational structure, level of care, sufficiency of resources (including qualified staff), proper oversight, adequacy and completeness of policies, adequacy of assessment and treatment, identification and management of self-harm, substance abuse treatment, and quality assurance.

Many of the provisions of the remedial plan must be construed in light of the changes within DJJ, primarily the dramatic reduction in census. This reduction has included, quite reasonably, the closure of licensed mental health facilities within DJJ. There has also been a great deal of change within mental health leadership. At the same time, the Integrated Behavior Treatment Model (IBTM) was being implemented, which also bears directly on the function of mental health both by virtue of changing roles of mental health providers and the degree to which behavioral change is conceptualized as being the purview of mental health. The more effective is the IBTM, the less extensive mental health services need to be.

It is beyond the scope of this summary to provide great detail with regard to the above but it is important to note the context within which this audit was conducted. Such substantial change necessarily hampers the creation of stable programs and organizational structures. It has only been recently that there has been some degree of stabilization in the census. But all these factors have resulted in uncertainty in the direction mental health was being asked to take with regard to the model of care and the nature of treatment to be provided by mental health. Thus it is not surprising that mental health is the last function to find definition.

It is important to recognize that there is substantial interaction between mental health staff and the rest of the staff working directly with youth on the units. Thus mental health is not as discrete in terms of function as dentistry or medical, which are relatively separated from the units. Establishing the boundaries and responsibilities of mental health service provision is accordingly much more challenging than for other clinical services.

And it is also important to state up front that the most seriously mentally ill will require specialized mental health services, some even at an inpatient level; the greater challenge is to determine how much service is needed for the remainder of the youth, virtually all of whom qualify for some diagnosis, if only Conduct Disorder, or are psychologically troubled to some degree. DJJ has established a definition of Mental Health Youth that greatly assists in this process. Youth have been evaluated in light of this definition and this has begun to drive the organization of the mental health program. This single accomplishment was an essential and well-considered early step in the process.

ORGANIZATIONAL FUNCTIONS

Given the above, it is not surprising that this is an area that requires some attention.

Relationship Between Mental Health and Other Staff

At the top is to clarify how mental health interacts with other staff, especially non-clinical staff. While the mental health chain of command and its relationship to other clinical services is clear, it is not clear how mental health relates to others. Mental health does not appear on the facility organization charts and there is lack of clarity regarding their exact roles on the units, especially units not designated as residential mental health units. This shows up in a variety of ways including the referral system, degree of involvement in case planning, and lingering uncertainty about the sharing of confidential information.

Put simply, the referral system for mental health is not functioning as a referral system. The existing referral system is used more as a notification system that staff use for a variety of purposes including actual referral (rarely), notifying mental health about a variety of youth behaviors, requests for consultation, and requests to see youth already in treatment. A true referral should be reserved for youth who are not currently in treatment. A referral requires some degree of assessment that is clearly associated with a particular referral. In order to do this, there needs to be clarity about which youth are in treatment and which youth are not; there is no mechanism in place for this outside of assignment to residential mental health units, where referrals are unnecessary. Sometimes the system is used for true referrals but there are also youth in treatment for whom no referral has ever been made.

Part of the difficulty has to do with distinguishing between crises and routine referrals. A crisis necessitating mental health involvement (and not all crises do require mental health involvement) may be called for a youth whether or not the youth is in treatment. But a crisis call for a youth not in treatment may or may not result in a referral and the determination of a need for a referral (at whatever level of service is necessary) should be made by the responding mental health clinician in such situations. For a youth already in treatment, the responding mental health clinician must make a similar judgment about what level of service is necessary at the time. For routine referrals where a non-mental health clinician or a non-clinical staff have concerns about a youth that is exhibiting potential signs of mental illness, there needs to be a formal referral detailing what behaviors have been observed. This youth should then be scheduled to meet with a mental health clinician who conducts an appropriate assessment. This should occur even when mental health clinicians are assigned to units. It is also clear that there will be informal and formal discussion of youth on the units and that through such discussions it may come to the attention of the psychologist that a particular youth may be in need of more thorough assessment to determine whether actual mental health treatment is indicated. Even though these latter cases are essentially referrals by the treating psychologist to him or herself, this still needs to be tracked not just for audit purposes but for DJJ to be able to monitor use of resources (in essence, utilization review and utilization management).

This is not to say that youth are not being referred at all or are not getting any treatment. But it is not possible to get a clear picture of the timeliness and completeness of referrals and, equally important, which youth are actually in treatment.

With regard to case planning, mental health involvement is inconsistent. There are numerous case plans on residential mental health units at NACYCF where psychologists have not been involved. On core units, involvement is also inconsistent. Even considering that psychologists are generally 0.5 time on such units, their involvement is at 50% only at VYCF. Not surprisingly, case plans in general do not reflect consideration of mental health related behavioral problems and barriers to change, even quite frequently on residential mental health units.

The issue of sharing of information is challenging for many institutions not firmly established as clinical in nature. And all licensed clinicians have a responsibility to protect confidential information according to law; but the laws are often difficult to interpret even for attorneys. Regardless, there is some information that there is general agreement can be shared: behavioral observations and behaviors to monitor, the fact that a youth is on medication, information that is needed in order to preserve the safety of the youth and others, and any other information that other staff need to know in order to perform their duties (assuming those duties are properly defined). And once a youth makes information public, that information is generally able to be freely shared thereafter, though it is not always wise or helpful to do so. In addition to legal requirements regarding confidentiality, it is a good practice if only because confidentiality allows youth to participate in needed treatment without fear that sensitive personal information (with the above exceptions) will be made public. While openness and sharing is to be encouraged among the youth and all staff, such openness often only comes after progress has been made in therapy for some youth.

But it is also clear that maximal sharing of information is the desired stance both because it is consistent with DJJ's efforts to create a more behaviorally therapeutic environment through the IBTM and because it allows better case planning.

There are essentially two ways to accomplish maximal sharing. One is to make some (or all) units purely clinical, which is not a likely or even desired solution. It would require in essence that all staff interacting with youth report through licensed clinicians. This might be an option for residential mental health units but even there that is not necessarily desirable. But it would allow collapse of the Case Plan and the Treatment Plan into one document while on those units. Alternatively, and more consistent with the direction of DJJ, the Treatment Plan can be very narrowly focused on the specific interventions that clinicians are to make and the majority of the emphasis of all staff, including psychologists, would be on the Case Plan which would then be more behaviorally robust and in tune with the mental health problems of the youth.

Policies

Comments here will be limited as DJJ is currently in the process of reworking its mental health policies. In general, the existing policies are unduly complex, often quite procedural, and overlap far too extensively. With regard to the latter, it is important for policies to address a

particular issue in one place only to minimize internal inconsistency; referral to other policies is appropriate when needed.

Policies also do not need to address details such as clinical standards, the content of forms, or articulation of clinical programs other than in general terms. These things belong in quality assurance processes such as peer review, forms libraries, and program manuals respectively. Policy should direct that these things exist and general guidelines for their development but the details belong outside of policy. This allows adaptation to changing needs and developments in the field without having to constantly rewrite policy.

DJJ policies do address most all important topic areas in mental health. One area that needs attention is informed consent. The current rewrite will address legal changes with regard to involuntary psychotropic medications but informed consent for therapy is problematic. The current informed consent is not really consent but instead is notification of the limits of confidentiality. While certain non-therapeutic (such as initial assessment) and all therapeutic interactions require such notification, this is not the same as rendering consent for therapy. It is also not reasonable to have youth sign a global consent to mental health treatment. While some global consent to basic medical care and mental health assessment may be reasonable, any treatment provided for a specific disorder requires consent.

The role of mental health in forensic functions such as DDMS, JJAC, and parole board hearings needs to be clarified in policy. It is reasonable for mental health to be involved in all of these functions but in general, treating clinicians should not be asked to render forensic opinions. Treating clinicians are obligated to be advocates for their patients and to work in their patient's best interests; non-treating clinicians are free to render objective opinions regardless of the impact on the youth. The policies need to be clarified with regard to the clinical and forensic roles to assure that these boundaries are clear.

Staffing

Mental health staffing is mixed. There are easily sufficient psychology positions when filled. Psychiatric coverage at NACYCF is not adequate. Licensed Psychiatric Technician (LPT) positions are adequate but not filled.

DJJ has virtually no ancillary clinical staff such as Occupational Therapists and Recreational Therapists and few Social Workers. These job classes are not necessary to meet the terms of the remedial plan but DJJ may want to consider whether using such staff on residential mental health units might be a more efficient way to render necessary services.

Ancillary Services

Ancillary services such as laboratory, imaging, electrophysiology, and medical consultation are adequate. The formulary is sufficient, given that non-formulary requests are generally honored. There is no clinical pharmacist available for consultation; this could be easily remedied by using CDCR resources.

RESIDENTIAL MENTAL HEALTH SERVICES

The most important point to make is that the vast majority of mental health youth are housed on residential mental health units. Thus it is clear that DJJ is focusing its attention appropriately on those youth most in need of services. Placement processes are sufficient but need to be adhered to.

However, the services and structure of the residential mental health units have yet to be developed to the degree that they can be called a program. There is no program manual and limited specialized structuring of the environments to meet the needs of the mental health youth. DJJ has recently identified Trauma Focused CBT as the centerpiece of its mental health program but this alone is not sufficient. There need to be services often termed rehabilitative such as medication education, relapse prevention, social skills (which may need to be different than or augment those provided in IBTM modules), and specialized community transition services including accessing community services and family engagement.

Mental health youth also need highly structured activities designed to promote socialization in a safe environment, including recreation. Unstructured program time should be minimized. The structure of the environment also needs to be designed to promote medication adherence and treatment engagement. This is likely to require a level or privilege system that is consistent with but augments the general level system being develop (or current Youth Incentive Program).

A unified Treatment Plan shared by all clinical staff needs to be developed. The Treatment Plan should be developed by and specify what each clinical staff, including psychiatry, psychology, LPT, and any other clinical staff assigned to the case are to do. As noted above, it is recommended that the Treatment Plan be narrowly focused on the clinical interventions to be made by these staff.

More general behavioral interventions to be shared by all staff and youth program assignments outside of the formal treatment detailed in the Treatment Plan need to be addressed in the Case Plan. The Case Plan should be comprehensive and robust rather than narrowly focused as described for the Treatment Plan. All residential mental health unit staff must participate in the development of the Case Plan and it must be consistent with the Treatment Plan.

In terms of the services being rendered at the present time this consists mostly of medications and some psychotherapy. Psychotropic prescribing is sound, though as noted above psychiatric availability at NACYCF is inadequate at present. Group and individual therapy is very inconsistent with groups being virtually absent. Individual therapy is sometimes clearly focused and delivered in accordance with a clear assessment and well-developed treatment plan but most often is not. Goals are not uniformly articulated and the charting often does not demonstrate that interventions are in accordance with the modalities specified in the Treatment Plan. Progress notes most often demonstrate a case management or supportive function rather than formal therapy.

OUTPATIENT MENTAL HEALTH SERVICES

Outpatient psychiatric services are generally sound. Assessment and psychotropic prescribing are sound and youth needing psychiatric services are generally receiving them timely.

Psychotherapy services are generally poorly structured. Clear assessments with targeted treatment plans are the exception. There is little evidence of goal-oriented treatment. There is minimal group therapy, which may not be a big problem but might be a more efficient and effective means of providing treatment for some disorders.

OTHER MENTAL HEALTH SERVICES AND FUNCTIONS

Licensed Mental Health Care

The lack of availability of licensed mental health care is a significant problem for DJJ. It is important to state up front that DJJ has been making reasonable efforts to secure contracts and agreements in order to be able to provide services to the seriously ill, but there are gaps in the available services. At present, DJJ has no provision for minor youth needing more than acute level services. Eventually, a case will arise where such services are needed. While this may be a general problem in the state of California, if such services are needed, they must be provided somehow.

Screening

Both pre-admission screening and post-admission screening are adequate and reliably done.

Initial Psychological Assessment

The initial psychological assessment generally includes basic cognitive testing, substance abuse testing, and an interview. The semi-structured interview intended to replace previously used structured assessments (MAYSI, V-DISC) has not been implemented. This needs to be completed to assure a thorough initial assessment. The YASI, a rich source of information, is also not being included in psychological assessments.

The most substantial problem is that the assessment results in no formulation or summary of the results that can be used to guide either treatment or case planning. There is no evidence that the results of the psychological assessment are being used to help formulate Case Plans. These assessments can provide important information about sources of risk, barriers to treatment, and protective factors. But perhaps most importantly, they can help the teams identify specific targets of intervention specific to each youth within the domains of risk identified by the YASI. For example, a youth may have problems with aggression/violence for a variety of reasons. And while general CBT approaches may be of value to nearly all such individuals, focusing on the particular nature of the risk (e.g. traumatic brain injury, mental illness, trauma) can be of vital importance in many cases.

Psychologists' IBTM Functions

At present, psychology is not playing a significant role in the IBTM. Their work is not inconsistent with the IBTM nor are they interfering with implementation. Some are assisting in IBTM groups. But they are not providing as much guidance and leadership in terms of the

implementation of the Reinforcement System and promoting skill development on the units as they could be.

Use of Force

Use of force in general is down. While it is not possible to be certain about all the reasons this is so, the implementation of the IBTM and the diligent and serious efforts of the Institutional Force Review and the Departmental Force Review.

While there have been some problematic uses of force on mental health youth at VYCF where there was no clear imminent danger, continued diligent use of the force review process and continued implementation of the IBTM are likely to continue to reduce these cases.

Self-Harm

While there are problems with the informatics and charting used to document the functions, there was no evidence of failure to screen for, detect, or respond to significant self-harm risk or events. However, these informatics problems could result in error as the facilities have had to develop work-arounds. There is prompt and appropriate evaluation by mental health staff with good follow-up. Monitoring is being done reliably and appropriately.

Respectfully submitted,

Bruce C. Gage, M.D.
5/25/14

Observations and Recommendation following the Site Visit to Department of Juvenile Justice State of California

Eva Kishimoto
Research Associate
March 2014

Corrections Institute
School of Criminal Justice
University of Cincinnati

UNIVERSITY OF Cincinnati

INTRODUCTION

The California Department of Juvenile Division (DJJ) contacted us, The University of Cincinnati Corrections Institute (UCCI), to provide them with technical assistance. The technical assistance involves five components:

1. Re-Assess current DJJ programming
2. Recommend Adaptations
3. Additional Training
4. Coach Staff on IBTM implementation
5. Consultation on QA and program integrity for IBTM Implementation

On March18-20, 2014, this writer, Eva Kishimoto, Research Associate University of Cincinnati Corrections Institute, conducted a site visit for DJJ. The first two days were spent on site at the Ventura Youth Correctional (VYCF). The third day was spent meeting staff at the DJJ headquarters.

This report will review the recommendations made in the previous report then update on this quarters activities to address those recommendations.

SUMMARY OF THE PROGRESS MADE REGARDING RECOMMENDATIONS FROM THE JANURARY 2014 REPORT

1. Adequately staff and re-allocate responsibility for quality assurance activities.

   While quality programming is the responsibility of every staff person, there is still a need for an entity who's responsibility it is to educate, advise and develop

protocols for the collection, analysis and distribution of data. This entity should also have the capability to provide technical assistance to programs for ongoing quality improvement activities. This group must be appropriately situated within the DJJ administration to ensure direct communication with the governing executives. In my assessment, that should be the function of the IBTM group. **Update:** Director Minor has made the IBTM lead, Ms. Sanders a member of the Executive Team. Since this appointment, Ms. Sanders has initiated a quality improvement project for decreasing the number of groups being cancelled or rescheduled. Ms. Sanders along with the executive committee has developed a series of reports whereby group cancellations are reviewed by each facility at the respective Superintendent's meeting with program supervisors. The findings are then sent to Executive Committee for review. Previously these reports when to the IBTM team but they were not adequately empowered to make the necessary adjustments. Situating Ms. Sanders within the Executive Committee as a conduit for reporting data has established the link between the administration and IBTM activities. This has created the motivation for facility supervisors to take ownership of the group cancellations since the facility Superintendent is now holding staff accountable for group delivery.

One cannot underestimate the importance of this quality improvement project. This project services as the new business model that DJJ is utilizing to move responsibility for IBTM to every level. This mechanism will be used for other major initiatives of IBTM. DJJ is building a system of shared responsibility, powered by open reporting and accountability. The OSM 28 report

noted that IBTM staff had to resort to "harassing and haranguing" staff to turn in reports. Under this new model, the IBTM facilitates the development of a report to the Executive Team and the Director hold the facility Superintendents accountable. This has proven to be a very effective model. As was observed by this writer upon observing a facility supervisors meeting, supervisors were now actively participating in a discussion on proper reporting protocols, utilizing the updated forms etc, because now reports were being generated and their boss was being attending to these issues.

Applying this model to another 'in much need of improvement' area namely group fidelity and adherence. There has been much concern over the diversity in the quality of groups and model adherence. Utilizing this model, the IBTM staff will be "re-training" staff on case planning. Instead of "yet another training," this training will include that staff demonstrate understanding of the training content by demonstrating proficiency during the training. A failure to demonstrate proficiency within training will then generate reports back to supervisors who will have some level of responsibility for coaching and working with staff to develop proficiency. Supervisors will also be trained to be coaches, first with the modeling and coaching of the IBTM staff and then by themselves. Success or failure on their part to achieve the necessary level of proficiency will be included in feedback to supervisors and an aggregated report to executive team. This signals a significant 'paradigm shift' within the organization of offering training and coaching only now a level of demonstrating proficiency has been added along with openness and transparency in the result reporting process.

2. Develop a QA plan for IBTM components to support sustainability. This plan should address fidelity monitoring of both groups and units, appropriate dosage based on risk levels, oversight of programming to minimize mix between risk levels, especially low risk youth, case planning, staff coaching, supervision, etc. Update: Director Minor has appointed Tammy McGuire to head this initiative. Ms. McGuire will be working with UCCI and the leadership team at DJJ to develop a QA plan to increase the uptake of IBTM philosophy and activities within DJJ. This plan will be reporting out to the Executive Team.
3. Implement Unit Observations (similar to group observations except it is done on the interactions present in the various units). This speaks to the model being implemented across the facility not just in groups.

   Proposed Action for Recommendations 1-3: This writer can work with designated DJJ staff to set up an infrastructure for monitoring quality improvement activities within the system.

   Update: This practice will be planned and implemented as part of the QA plan.
4. Clarify the assessment and case planning process. The goal for each step in the intake/case planning process needs to be clearly defined and roles can then be assigned. Persons tasked with the various "deliverables" in this process need to be well informed on the "technology" that leads to their recommendation. This is especially important when (mental health) clinicians are making recommendations that impact criminality and risk to corrections staff, and visa versa.

Proposed Action: This is an issue being actively discussed by the court special master.

Update: Update: This practice will be planned and implemented as part of the QA plan.

5. Train clinical staff on targeting primary versus secondary criminogenic needs and how to negotiate it with the youth achieve consensus. (Using the "Value Clarification" activity). This would consist of 1)identifying basic values of the youth 2) utilize the findings from the YAZI to identify the primary criminogenic needs, 3) assisting the youth to identify how targeting the primary criminogenic needs will strengthen their basic values or increase their success in secondary need areas.

   Proposed Action:

   - Option 1: Train IBTM staff to work with clinical staff
   - Option 2: Train both IBTM and clinical staff directly

6. CBI SA Proposed Action: Convene a task force to evaluate the current implementation of CBI SA and plan for broader dissemination.
7. Victim Awareness: There is not a large body of research that supports victim awareness or empathy in reducing recidivism. Primarily because it does not specifically target crinimogneic needs. In some cases it might address a specific responsivity area, but the overall premise is that by making the youth aware of the

impact of their crime, and crimes in general it will reduce their risk. Doing so may raise their awareness of the impact of their crime but this does not necessarily reduce their risk unless it is coupled with targeting criminogince needs especially the primary needs. Having said this, I also realize that Victim Awareness programming is a requirement in state statute and based on staff report, emphasized by the parole board. To that end, I recommend the following:

a. DJJ needs to provide consultation and information to the parole board regarding correlates of victim awareness to recidivism.
b. The current Change Company material should be augmented with more behavioral programming which targets the youths specific crinimogenic needs. Thinking reports, structured skill building and role plays should be integrated into the course work beyond the narrative type assignments currently included. General and specific responsivity should be addressed and primary crinimogenic needs (i.e. criminal attitudes, peers and personality styles) need to be targeted.

UCCI Activities for Department of Juvenile Justice, State of California		
Development of 2013 4th Quarter Report	Eva Kishimoto	Jan. 7 & 8, 2014 8 hours
Research on Victim Awareness	Eva Kishimoto	Jan 28, 2014
Consultation with IBTM team leader, Chris Sanders	Eva Kishimoto	Jan. 31, 2014 1.5 hours

and call preparation		
Site Visit Preparation Call w/IBTM members	Eva Kishimoto	Feb. 20, 2014 1 hour
DJJ site visit preparation and planning	Eva Kishimoto	March 4, 2014 90 minutes
DJJ site visit Ventura	Eva Kishimoto	March 18-20