SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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

THIRTIETH REPORT OF THE SPECIAL MASTER

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Appendix A: Gage, *2014 IBTM Audit Comprehensive Summary*, (October 26, 2014).

Appendix B: Krisberg, *Reforming the California Division of Juvenile Justice, Lessons Learned*, (August 15, 2014).

I. INTRODUCTION

The Special Master submits for filing the Thirtieth Report of the Special Master. This report reviews the *Farrell* Mental Health Expert Dr. Bruce Gage's second Integrated Behavioral Treatment Model (IBTM) comprehensive report for his 2013-2014 round of audits (site visits June and July 2014) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plans. The IBTM comprehensive report is attached to this report as Appendix A. The Special Masterôs 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 an update on the implementation of the IBTM followed by an analysis of progress in implementing the Mental Health Program, an update on the status of the one remaining issue in the *Educational Remedial Plan*, 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 and twenty-ninth reports to transfer monitoring of the *Safety and Welfare Remedial Plan* to Defendant.

II. YOUTH POPULATION, PROGRAMS AND STAFFING

A. Overview

The Special Master in her twenty-ninth report included an overview of youth demographic trends and pertinent program information to provide the court with greater understanding of Defendantôs programs and operations in order to place the reform measures and Defendantôs progress into proper context. The Special Master also indicated that any significant fluctuations, deviations, and program changes will be reflected in future reports. No significant

changes have taken place since the last report. However, one issue pertaining to a shortage in ñpostò positions has caused some concern over Defendantôs ability to keep on delivering quality treatment and other services in a safe and secure setting if the shortage continues.

B. Youth Population

The youth population level remained remarkably constant throughout 2014 as depicted in Table 1. The stability in the overall youth population has resulted in very little fluctuation in the youth population at the three facilities and at the fire camp (Table 2). There has not been any change in the facilitiesô living unit mix and the living unitsô youth population remains constant with the exception of expected fluctuations in the Behavior Treatment Program (BTP) units. For example, a group disturbance could result in several youth being placed in the BTP but the program is designed to rapidly transition such youth back to their units.

One positive trend that recently emerged is the decline in the Ventura Youth Correctional Facilityôs (VYCF) BTP population. Throughout 2013 and the first half of 2014, VYCFôs BTP youth population constantly was at or near the maximum capacity of 24. In recent months, the number is typically well below 20, which suggests greater effectiveness in the facilityôs ability to manage youth in core units.

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

	Committed	Physically Count
January 31, 2014	694	679
February 28,2014	694	680
March 31, 2014	694	679
April 30, 2014	693	672
May 31, 2014	687	667
June 30, 2014	686	668
July 31, 2014	688	665
August 30, 2014	689	664
September 30, 2014	703	676

Table 2
Comparison of Youth Population by Facility[2]
Between December 31, 2013, April 30, 2014, and September 2014[3]

	O.H. Close Youth Correctional Facility (OHCYCF)	N.A. Chaderjian Youth Correctional Facility (NACYCF)	Ventura Youth Correctional Facility (VYCF)	Pine Grove	Total
September 30, 2014	184	206	223	63	676
April 30, 2014	186	199	231	56	672
December 31, 2013	177	214	231	57	679

C. Staff Shortage at "Post" Positions

For Youth Correctional Counselors (YCC) and Youth Correctional Officers (YCO), Defendantôs collective bargaining agreement with the labor union designates the number of ñpostò positions that must be filled during each shift by living unit or by security function at each facility. A relief staff must fill a post when a staff member assigned to a post is absent due to

[1] Compiled by the Office of the Special Master based on data in the ñMonthly Facility Population Tableò on DJJôs website.
[2] 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.
[3] Compiled by the Office of the Special Master based on data in the ñMonthly Facility Population Tableò on DJJôs website.

vacation, illness, training, or for any other reason. If relief staff is unavailable, the post is to be filled by overtime staff, which could be voluntary or involuntary.

As a result of unanticipated attrition in the YCC and YCO classifications, combined with the fact that a large number of staff members in these classifications are on long-term sick leave status,[4] all three facilities have staff shortages that constantly required the use of overtime to fill behind vacant posts. The problem is particularly acute at OHCYCF where, in addition to eight staff members being on long-term sick leave status, the facility had vacancies of 10 YCC positions and one YCO position as of November 3, 2014,[5] that often necessitated excessive use of involuntary overtime to fill vacant posts. Extensive use of relief staff or staff from other living units on an overtime basis jeopardizes youth treatment as it creates instability, less familiarity and rapport with youth, and in some instances the cancellation of treatment functions.[6] When occurring over an extended period, excessive overtime causes fatigue, inattention, and poor morale that compromise the safety and security of the staff and youth as well as delivery of treatment services.

Defendant management is well aware of this issue and is actively engaged in addressing it. However, the problem could become even more acute as the hiring process for YCCs and YCOs is lengthy and takes time. In addition, revisions to the YCC and YCO initial training academy have resulted in a delay in the ability to train new staff who are hired. Defendant is in the process of screening applicants to identify prospective candidates for the 16-week training academy that is tentatively scheduled for the spring of 2015. In the meantime, Defendant is

[4] According to its Staff Vacancies Report, DJJ had seven YCOs and 36 YCCs on long-term sick leave status as of November 3, 2014.
[5] Based on DJJ's Staff Vacancies Report as of November 2014.
[6] For example, a treatment group may be cancelled as a result of the relief staff not being trained to facilitate a particular treatment program.

pursuing other measures, such as contacting individuals on the reemployment list, to alleviate this problem.

III. INTEGRATED BEHAVIORAL TREATMENT MODEL

A. Current Progress

The Mental Health Expert Dr. Bruce Gage conducted a round of site audits during June and July of 2014. During this audit round, Dr. Gage did not conduct a site visit to the Central Office because Defendant stated that there were no changes relevant to the Central Office since his last audit round. 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 October 8, 2014. The Special Master has received the partiesô feedback on the report. The final comprehensive report for his site visits is attached as Appendix A.

Dr. Gage used both objective and subjective measures to assess Defendantôs progress in implementing the IBTM at facilities and the Central Office. He used an audit instrument (audit tool), which he developed in consultation with the parties as one measure of progress. For each site audited, he presented the audit results in accordance with the reporting format specified in the audit tool. In addition, he made qualitative assessments through youth interviews, staff interviews, and onsite inspections. For each audit site, 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 of the facilities and at the Central Office for the audit in comparison with his last audit round. The overall percentage of audited items found to be in substantial compliance has increased at all facilities audited.

Table 3
Summary of Compliance Rating Percentages[7]
Comparison between Round One and Round Two

OHCYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 1	34%	56%	10%
Round 2	43%	46%	11%

NACYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 1	11%	78%	11%
Round 2	32%	57%	11%

VYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 1	22%	68%	11%
Round 2	46%	43%	11%

Central Office

	Percentage in SC	Percentage in PC	Percentage in NC
Round 1	13%	87%	0%
Round 2[8]	13%	87%	0%

Implementation of the IBTM remains consistent and focused. In his second IBTM comprehensive report, Dr. Gage noted that Defendantôs leadership continues to demonstrate strong commitment toward reform and observed greater penetration of the core IBTM principles among staff. He saw staff members spontaneously applying the core concepts with youth, which is highly encouraging. While some staff lag in their understanding, Dr. Gage indicated that this is at the level to be expected when engaging in such a substantial cultural shift. He observed wide acceptance of the IBTM among staff that the IBTM is Defendantôs treatment model.[9]

Dr. Gage also opined that the transfer of key functions such as quality assurance from the Central Office IBTM Team, while happening, is slow because of the reduced resources of the

[7] Source: DJJôs Quarterly Compliance Report for the quarter ending September 30, 2014.
[8] The compliance rating for the last audit round is applied because DJJ reported that there were no changes since the last audit.
[9] 2014 IBTM Audit Comprehensive Summary, p.1.

team. While the team has no vacancies at this time, it has suffered staffing challenges. Retirement and medical leave resulted in the loss of some senior staff expertise but Defendant backfilled with additional staff on loan from facility units.[10] The Special Master reminds Defendant that this team is essential to the successful implementation of the IBTM.

NACYCFôs overall percentage lags behind the other two facilities primarily due to a failure to ensure staff are trained. This issue was addressed for line staff shortly after the Mental Health Expertôs site audit as NACYCF has increased its focus and emphasis on training these staff members.[11]

Defendant's senior leadership continued to model their commitment to the IBTM by hosting an all managers meeting in June 2014. The Special Master was invited to assist in the development of the meeting agenda. Sessions included didactic sessions on adolescent development, role plays, case studies and team building activities.[12] The Special Master heard nothing but positive feedback regarding the meeting from managers of all levels at all facilities. Managers indicated they now better understand some of the principles of the IBTM and appreciate the complete and consistent commitment of senior leaders.

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.
- Cognitive-based Behavioral Treatment (CBT) resource groups, the approach used to teach skills.
- The Behavioral Management System (BMS), which includes the Reinforcement System (RS) and a level system (currently the Youth Incentive Program [YIP] and the Disciplinary Decision-Making System [DDMS]), is the system through which youth are encouraged to practice skills and receive feedback.

[10] *See* email Fwd: Responses to your questions.
[11] According to an email dated September 5, 2014 from Superintendent Erin Brock, 93% of direct-care staff at NACYCF and 88% of staff members who may be assigned to either NACYCF or OHCYCF have completed IBTM Overview training. In comparison, the percentages were 80% and 71%, respectively, as of July 8, 2014.
[12] *See* Leadership Forum Final Agenda 6-2014.

- 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.

The Assessment Process

Defendant has been engaged in discussions with clients of Orbis Partners to determine if another contract with the company is needed to make possible modifications to the California Youth Assessment Screening Instrument (CA-YASI). Discussions are also underway with the Mental Health Expert regarding how to use the CA-YASI for initial unit placement decisions. Understanding of the CA-YASI continues to grow among staff and youth as exhibited from a fairly consistent discussion of the ñYASI wheelò and domains.

Case Management Process

The Mental Health Expert has been clear from his first IBTM audits that the case management process is seriously flawed. As noted in the twenty-ninth report of the Special Master, Defendant has worked to improve the structural challenges with the case management process. Improvements include:

- Expectations regarding who and how progress is input into the case plan.
- How and when the plan is updated.
- The case plan being identified separately from the case conference report.
- Case updates occurring within the prescribed timeframes.
- Supervising YCC being present at case conference more often.
- Some evidence of a clearer progression in case planning goals from one case conference to the next is beginning to appear.

In addition, case conference observations indicate that youth are more often given copies of their case plan at the conclusion of the case conference and more staff are beginning to speak to and not about the youth in the case conference meeting. Some Parole Agents (PA) and Case Work Specialists (CWS) are doing a better job of exploring issues with youth using Motivational Interviewing (MI) approaches that direct youth less but engage them at their current level of understanding.

As noted by the Mental Health Expert, challenges remain with the content of case plans.[13] These challenges begin at the development of the case plan or the stage typically referred to as the case conceptualization or formulation.[14] One of the strengths of Defendantôs system is having Psychologists trained to perform clinical assessments that gather a variety of quantitative and qualitative data when a youth enters the intake unit. This function has been eliminated or significantly reduced in many corrections systems resulting in supervisory staff not having information needed to really understand the factors underpinning criminal behaviors. Unfortunately, the information gathered by Defendant as currently used, for the most part, does not help the unit supervisory staff better understand a youthôs presenting issues.

As the Mental Health Expert noted, ñthere is no mechanism to integrate the vast array of information collected during the assessment process and boil it down to a simple case conceptualization.ò[15] While the information gathered at intake is provided to the unit staff, there is little to no evidence of the information being incorporated into the initial conceptualization of the case plan. The Mental Health Expert suggests Defendant simplify the initial assessment process and the Psychologists and the intake staff synthesize the information gathered into a case conceptualization.[16] The Special Master advises Defendant to not just train the intake staff in this process but also train the unit staff in how to interpret and use a case formulation.

Staff needs more training and coaching in the development of the targets, goals and action steps of a case plan. These critical case plan elements are typically not well differentiated or accurately defined and, of great importance, do not address primary criminogenic needs. The

[13] 2014 IBTM Audit Comprehensive Summary, p.5-6.
[14]Case conceptualization is the process where data from clinical assessments, historical socio-demographic, criminogenic, education, vocational and medical information are reviewed and synthesized into a narrative that describes what factors influenced the youthôs development to date.
[15] *Ibid.*
[16]*Ibid.*

lack of specificity and responsivity in the critical task of identifying what behavior needs to change through mutual development of targets, goals and action steps between staff and youth must be addressed.

Defendant has submitted a training plan that identifies the staff that needs to be trained in the effective case management modules. It appears the draft training plan identifies all direct-care staff, first and second-level supervisors (Senior Psychiatrist, Senior Psychologists, Treatment Team Supervisors (TTS), Supervising Casework Specialists (SCWS), Senior Youth Correctional Counselors (SYCC), Chiefs of Security, Lieutenants and Sergeants as well as Program Administrators and Parole Agent IIIs will all be trained in the effective case work modules.

CBT Resource Group Delivery

Defendant has implemented several reporting mechanisms regarding resource group delivery. The first provides detailed data about when a youth entered a unit and the dates of group attendance. It also shows if any groups were missed or rescheduled.[17] This report provides useful information for line and management staff to determine if fidelity to group delivery is happening. Secondly, a monthly summary of all groups for each unit needs further refinement. The report is designed to provide a snapshot across a unit over time but as completed, it often fails to do this.[18] For the most part, the reports from the core units provide sufficient data to show trends over time.[19] Reports from specialized units like the BTP provide so little data as to be

[17] For examples, *see* ABC Model Report-Sept 2014 - Redacted and Anger Control-Sep 2014 - Redacted.
[18] For example, if the start time of a group is ñvariedò it is impossible to tell if a group is ever completed.
[19] For example, *see* OHC Amador Intervention Group Summary June-Sept 2014 and OHC Glenn Hall Intervention Group Summary June-Sept 2014.

meaningless.[20] Senior headquarters leaders have indicated they are aware of this problem and are working to make this report more useful.

Despite some of the typical implementation issues with the reporting mechanisms, they are already showing their value in ensuring fidelity. The data from the core units shows what appears to be consistent delivery of groups with a few groups being rescheduled for a variety of reasons. This is the pattern that is hoped for with group delivery. In some cases, a disconcerting pattern arose where groups took far too long to complete.[21] The group curriculum is designed for a youth audience with an understanding of what is a reasonable timeframe to address issues like material retention and absorption. Groups spread too far apart undermines the fidelity of the material and reduces the potential impact of the groups. The Special Master was pleased to learn that Defendant headquarters staff had indeed noticed this trend and is working with facility staff to rectify this problem.[22]

Through the lens of the IBTM principles, management should celebrate with staff that the data systems are working to illuminate such problems so they can be corrected. Work needs to continue to get staff to complete the forms in the same way in all units so that valid comparisons can be made across units. The Special Master is celebrating the fact that when questions are raised, they can now be answered quickly and that management is using their data systems to improve fidelity.

Quality of group facilitation still varies significantly among staff members. The Special Master and the Mental Health Expert observed trainers who could be designated as ñmaster

[20] For example, *see* NAC Kern BTP Intervention Group Summary June-Sept 2014. The Special Master did receive a sample of the reports by youth in the BTPs that show youth are participating in the treatment modules. The underlying data as seen in Fwd: BTP Data for the Office of the Special Master's Report (OSM) 30 and BTP August NACYCF show consistent attendance by youth in treatment modules.

[21] *See* VYCF Miramar Intervention Group Summary June-Sept 2014 and VYCF AltaVista Intervention Group Summary June-Sept 2014. The CounterPoint curriculum should not take 10 months to complete.

[22] Conversation between the Special Master and Tammy McGuire, Associate Director, on October 27, 2014.

trainersò and observed staff that quite frankly are not skilled enough to train by themselves. This issue will be further discussed in the training and quality assurance sections below.

Behavioral Management System RS and Level System (LS))

Even if the groups have excellent facilitators who adhere to the curriculum, training alone typically only provides exposure to a topic. Skill development and application requires practice with coaching, mentoring and role modeling to apply and to learn new behaviors. The behavioral management system will be composed of the RS, reinforcement of skills being learned, the LS, reinforcement of skills over time through a privilege system and the DDMS that provides a framework for when punishment and/or negative consequences must be applied.

Defendant has experimented with the RS for well over a year. The Mental Health Expertôs characterization of the implementation of the RS system is fair.[23] In his comprehensive report, the Mental Health Expert noted that the daily RS, while implemented on all units, is being applied differently and the weekly and monthly reinforcers are not being applied on some units. The typical daily reinforcement is limited to extra late-night time. The RS is not being widely used to reinforce goals and targets identified in case plans.

Defendantôs data shows a continued increase in the number of positive checks being given in the RS. The data shows active use of the RS by educators and the beginning of use by Psychologists and security staff.[24] While there is no right or wrong number of positive checks, the data clearly shows differences between the facilities' application of the system. For example, the VYCF mental health providers (largely Psychologists) are much more engaged in using the system than their counterparts at NACYCF and especially OHCYCF. The same trend holds true for security staff. Clearly VYCF is doing something to engage their staff in using the RS that

[23] 2014 IBTM Audit Comprehensive Summary, p.4.
[24] *See* Positive Behavior Reinforcement Checks 6-2014-9-2014.

other facilities should explore. The lower number of overall checks at OHCYCF mirrors the anecdotal experience of the Special Master and the Mental Health Expert while observing units during the IBTM audit.

The development of the new level system has been challenging for Defendant. As has been the experience on other issues, there has been a tendency of Defendant to produce a very complex schema that the Mental Health Expert has warned will be difficult to implement and is potentially a recipe for disparate application. If Defendant is challenged to get consistency in the RS, a much simpler system, introducing a complex LS will present unnecessary hurdles that may result in system failure. The primary issue is the integration of the RS into the LS that the Mental Health Expert has advised against and the introduction at several points of staff discretion.[25]

Defendant has incorporated some suggestions and feedback from the Mental Health Expert and the Special Master into their revised proposal. To be effective the LS must:

> ñé mark mastery of skills in relevant domains and that progression <must> correspond to the process of change. Additionally, the level of mastery needs to correspond to the privileges acquired as privileges are also associated with increased risk, necessitating greater skill development to utilize the privileges safely.ò[26]

Defendant plans to pilot the LS in a few units in one facility to identify and modify any issues before full implementation at all facilities.[27]

Training

In her twenty-eighth report, the Special Master recommended four training strategies be undertaken. They are:

- Deliver training to enable managers at all levels to fully understand and articulate the IBTM concept and principles.

[25] Ideally, level systems avoid discretionary actions to ensure equal application across all youth.
[26] 2014 IBTM Audit Comprehensive Summary, p.5.
[27] *See* Reinforcement Codes Draft 10-14-14 and Level System 1ð 16-14.xls for the current draft.

- Prescribe appropriate IBTM training courses for managers and staff at each classification and deliver such training in a timely manner.
- Provide training to all case managers and all living unit staff on the use of assessment tools and results for case planning.
- Create a mechanism to ensure the trainers understand the subject matter and deliver messages consistent with the IBTM.
- Develop a learning model for trainers that ensures trainers are observed and certified to train the materials in the course.

Defendant in October 2014 completed a training plan that provides a comprehensive assessment of its training needs, current progress, and a timeframe for delivery and completion for each type of training. The training plan includes training scheduled for managers and staff members of all levels and functions for the current and upcoming fiscal year and will be updated annually. Both the Mental Health Expert and the Special Master find the document to be thorough, well considered, and highly useful in providing a roadmap for this critical function. The training plan also includes the percentage of staff members at various levels who have completed the IBTM-related training and establishes benchmarks and goals for the current fiscal year. The training plan breaks the staffing into the following groups:

- Executive and Senior Managers
- Middle Managers and Supervisors
- Direct Care Staff
- All Other Staff

The type of training that is required for each level of staff is identified. The plan also prioritizes those staff that are most in need of immediate training and sets target dates for training completion. For the first time, data about training completion for all staff is summarized in one place in the same way.[28]

Based on her analysis of the training completed and the targeted goals, the Special Master makes the following observations:

[28] In the past VYCF collected its training data in a slightly different form than the other facilities making it difficult to compare across institutions.

RS Training

RS training should be provided to all staff members at the facilities. With a few exceptions, this goal is close to being accomplished as an overwhelming percentage of staff members in various classifications/functions have completed RS training. The following table provides the percentage of staff completed RS training as of September 2014:

Table 4
Number and Percentage of Staff Completed RS Training:[29]

	Total Staff	Staff Trained	Percentage
OHCYCF	194	169	87%
NACYCF[30]	313	256	94%
VYCF	240	226	82%

More emphasis and attention is needed for the following classifications/functions:

- Education staff at OHCYCF with a completion rate of 78% (41/51).
- Custody staff at NACYCF with a completion rate of 79% (86/122).

IBTM Overview Training

IBTM overview training should be provided to all staff members at the facilities. This goal is close to being reached as an overwhelming percentage of staff members in various classifications/functions at the three facilities have completed the IBTM overview training. The following table provides the percentage of staff completed the training as of September 2014:

[29] Compiled by the OSM from data in Defendantôs training plan released in October 2014.
[30] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.

Table 5
Number and Percentage of Staff Completed IBTM Overview:[31]

	Total Staff	Staff Trained	Percentage
OHCYCF	194	171	88%
NACYCF[32]	313	282	90%
VYCF	240	185	77%

Although VYCFôs completion percentage is low in comparison to the other facilities, it has made significant improvement since May 2014 when its completion rate was 32%.[33] More emphasis and attention are needed for the following classifications/functions:

- Education staff at all three facilities with a completion rate of 80% (41/51) at OHCYCF, 82% (36/44) at NACYCF, and 52% (24/46) at VYCF.
- Custody staff at VYCF with a completion rate of 73% (55/75).
- Executive staff at VYCF with a completion rate of 40% (2/5).

Motivational Interviewing (MI) Training

MI training should be provided to all staff members at the facilities. MI training encompasses two phases; phase one is a three-day and phase two is a one-day course. Defendantôs completion percentage for MI, especially for phase two, is very low and changed little from reporting period to reporting period. Defendant indicated that it is committed to providing appropriate MI training to all staff members and is currently assessing alternatives to deliver such training in the most timely and cost-effective manner.

[31] Compiled by the OSM from data in Defendantôs training plan that was released in October 2014.
[32] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.
[33] *See* OSM 29, p.25.

Table 6
Number and Percentage of Staff Completed MI Training (Phase One)[34]

	Total Staff	Staff Trained	Percentage
OHCYCF	194	154	79%
NACYCF[35]	313	257	82%
VYCF	240	174	73%

Table 7
Number and Percentage of Staff Completed MI Training (Phase Two)[36]

	Total Staff	Staff Trained	Percentage
OHCYCF	194	77	37%
NACYCF[37]	313	63	20%
VYCF	240	66	28%

Cognitive Behavioral Primer

The training plan has identified a goal of having 100% of its PAs and YCCs trained on Cognitive Behavior Primer by July 1, 2015. The following are the completion percentages of staff at these classifications at the facilities that completed Cognitive Behavioral Primer training as of October 2014.

Table 8
Percentage of Staff Completed Cognitive Behavioral Primer Training[38]

	PAs	YCCs
OHCYCF	92%	83%
NACYCF[39]	90%	55%
VYCF	72%	68%

[34] Compiled by the OSM from data in Defendantôs training plan that was released in October 2014.
[35] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.
[36] Compiled by the OSM from data in Defendantôs training plan that was released in October 2014.
[37] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.
[38] Compiled by the OSM from data in Defendantôs training plan that was released in October 2014.
[39] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.

Substance Abuse

Defendant has set an initial benchmark to have 50% of its PAs and YCCs complete training in substance abuse by July 1, 2015. The following are the staff at these classifications at the facilities that completed Substance Abuse Training as of October 2014:

Table 9
Percentage of Staff Completed Substance Training[40]

	PAs	YCCs
OHCYCF	92%	32%
NACYCF[41]	71%	23%
VYCF	94%	41%

Aggression Interruption Training (AIT), CounterPoint (CP), and Introduction to Treatment

Defendant made an assessment and determined that it currently has sufficient staff capacity to facilitate groups on AIT, CP and Introduction to Treatment.[42] Based on the last round of IBTM audits by the Mental Health Expert, this is a valid assessment as all three facilities achieved a substantial compliance rating for the audit items pertaining to the sufficiency of staff trained to facilitate these groups. In the training plan, Defendant indicated that it will continue to reassess its training needs in these areas and, if needs arise, update the training plan accordingly.

Core Correctional Practices (CCP)

Defendant has done an excellent job of ensuring all staff has received the CCP training. This training provides a foundation for the IBTM. With the exception of NACYCF that needs to ensure its executive staff members are trained, the completion rate is excellent.

[40] Compiled by the OSM from data in Defendantôs training plan that was released in October 2014.
[41] NACYCFôs total includes staff members in some custody classifications who may be assigned to either NACYCF or OHCYCF.
[42] Only the intake staff at NACYCF and the El Toyan Hall (female unit) are required to be trained on Introduction to Treatment module. OHCYCF does not have an intake unit.

Table 9
Percentage of Staff Completed Core Correctional Practices

	OHCYCF	NACYCF[43]	VYCF
Executive	100% (3/3)	33% (2/6)	80% (4/5)
Custody[44]	100% (44/44)	94% (115/122)	95% (71/75)
Treatment[45]	96% (73/76)	93% (113/121)	95% (101/106)
Mental Health		100% (20/20)	75% (6/8)
Education	65% (33/51)	89% (39/44)	98% (45/46)

Defendant is making progress in many areas not the least of which is ensuring senior leaders are educated in the IBTM principles. Defendant has prioritized senior and middle managers and supervisors for training.[46] This is essential because these are the staff that through their behavior and attitude either model the IBTM or undermine it and are being tasked with quality assurance functions.

The Special Master again opines it's absolutely essential that leaders are trained not only in all elements of the IBTM but before the middle managers, supervisors and the direct-care staff. As the IBTM pilot and with greater emphasis on staff training in the past, OHCYCF is ahead of the other facilities in this regard. Moving forward, it is critical to ensure that agency and facility leaders understand the IBTM principles so they can ensure alignment with them in all program activities. The numbers of senior leaders may be small but they are the policy makers and they cannot ensure alignment with the IBTM if they do not understand it. Defendantôs comprehensive and methodical approach to training should remedy the historical problems of not correctly sequencing the training for staff (line staff being asked to implement

[43] NACYCF staff total for custody and mental health classifications includes staff that are assigned to either NACYCF or OHCYCF.
[44] Custody includes staff in the following classifications: Lieutenant, Sergeant, YCO.
[45] Treatment includes staff in the following classifications: TTS/SCWS, SYCC, PA/CWS, YCC.
[46] This is identified in the Training Plan and in early drafts of the Quality Assurance Plan.

when supervisors are untrained) and not integrating the block training with the specific IBTM training.

In many cases, Defendant has certified trainers that can deliver the required training. Where this is not the case, Defendant is exploring options to determine if they should train their own trainers or contract for training. This is particularly true for case management training and MI. In both cases, Defendant has contracted with a credible provider to train Defendantôs staff to be trainers. The feedback regarding the quality of case plans clearly raises questions regarding the effectiveness of the current training strategy. It is unclear if the content of the current training is problematic or if it was the sequencing of training but what is clear is that most case managers cannot develop a case plan that has clearly defined criminogenic behavioral goals and targets. Defendant is wisely discussing different training approaches and strategies in these areas. The Special Master encourages Defendant to have the Mental Health Expert review any case management curriculum for efficacy.

Missing from the plan is a quality assurance methodology for ensuring that trainers have the level of skills needed and that their understanding and delivery of material are consistent with the IBTM principles. This helps to remind staff that all activities have a quality assurance loop that should be considered and reviewed to ensure desired outcomes are achieved.

Quality Assurance Activities

The Central IBTM Team has done an excellent job of creating the tools and systems for quality assurance activities. As is often the case, the implementation of such tools has been more challenging. As discussed above, in some cases, the mid managers and supervisors assigned to review the quality of facilitators, the RS system and soon the LS, have not

undergone the basic training let alone any specialized training for quality assurance roles and activities.

The role of supervisors and managers is changing from managing crisis, performing what are often line-staff tasks (in essence being additional unit staff) to being true managers who monitor data and provide coaching and mentoring to ensure fidelity to the principles of the IBTM and in particular, to both groups and the behavior management system. Just as the shift for line staff from ñguardò to group facilitator is difficult, so is the shift for supervisors and managers from ñdoersò to facilitators of the culture.

Defendant is in the process of creating a quality assurance plan for the agency. Early drafts of the plan indicate that Defendant understands that quality assurance is an on-going responsibility of all staff but must begin with the facility management staff. The Special Master is pleased to see the transfer of responsibilities to the facility and in particular, to the unit staff from centralized headquarters groups like the IBTM Central Office Team.

The plan appropriately focuses on ensuring the supervisors and managers are well versed with the curriculum. After this, the staff will be trained how to not just observe but to coach and mentor staff. Finally, a proficiency rating system is being developed. The system also includes a focus on case planning and data collection. The focus should be expanded to also include the behavior management system. The Special Master encourages Defendant to send a copy of the draft plan once completed for review by the Mental Health Expert.

B. Next Steps

Defendant is beginning to systematize the approach to IBTM implementation. For a variety of valid reasons, the early roll out of the IBTM was confounded by unorganized approaches to training, failure to help line and management staff understand and adjust to the

required changes in roles and failure to understand how to use the data management and quality assurance systems that were being developed. The development of training and quality assurance plans for the agency, not just a unit, is helping to address these barriers to implementation.

Defendant needs to continue to work on ensuring the reliability of the CA-YASI and to determine if the current factors are sufficient for initial unit placement. Teaching unit staff to understand criminogenic needs and how to develop concrete and actionable goals and targets that align with the identified needs must continue to be a focus of next steps. Focus on consistent treatment group delivery must continue as must efforts to improve the quality of the facilitation. Consistency in the application of the RS is needed. After much effort, the development of the LS is almost complete. Finally, Defendant is to be congratulated for developing comprehensive approaches to training and quality assurance. Defendant has actively engaged the Mental Health Expert and the Special Master in the development of strategy to address these issues.

IV. MENTAL HEALTH

On October 8, 2014, Defendant announced that the Governor has appointed Dr. Heather Bowlds as the Assistant Director of Mental Health. Dr. Bowlds is an excellent choice for this leadership position. The Special Master has interacted closely with Dr. Bowlds over the years when she served as the Sexual Behavior Treatment Program (SBTP) Coordinator. Her leadership was instrumental in the significant achievements of the SBTP program, which include dismissal of the *Sexual Behavior Treatment Remedial Plan* and the SBTP program becoming a national model for treatment of adolescent sex offenders. Her leadership will undoubtedly further enhance Defendantôs efforts and progress toward meeting the goal and intent of the *Mental Health Remedial Plan.*

A. Current Progress

In the twenty-ninth report of the Special Master, she noted that four of the eight key areas identified in the Mental Health Implementation Plan[47] have been completed.[48] Significant progress has been made in all of the four remaining areas. They are: developing an evidence-based mental health treatment program, a program guide for unit operations, policies and procedures to guide all Mental Health Programs and development of quality assurance outcomes and measures.

Developing a Treatment Program

Developing a consistent approach to ñtreatmentò is central to the development of a true Mental Health Program. Defendant has identified an evidence-based curriculum, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and contracted for training of all Psychologists and Licensed Psychiatric Technicians. As noted in her twenty-ninth report, the training was delivered in April 2014 and the Special Master found the training comprehensive and the trainer skillful.

Defendant created a day-long TF-CBT overview training that is based on the contracted training for the unit team on each mental health unit.[49] The training was delivered at NACYCF on August 25, 2014, at Sacramento Hall and August 26, 2014 at Merced Hall. At VYCF, the training was delivered on September 3, 2014 at El Toyon Hall and September 4, 2014 at Alborado Hall. An abbreviated version of the training (two to three hours) was created for each facility executive team and was presented at the Northern California Youth Correctional complex

[47] *See* Mental Health Implementation Plan Summary 5-23-13.
[48] The four areas are the mental health youth definition, levels of care, intake procedures and the entrance and exit criteria.
[49] 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.

on August 18, 2014 and at VYCF on September 2, 2014. All management and supervisory staff above the TTS and SCWS levels, selected medical, mental health, educational professionals, and senior managers of auxiliary functions attended the abbreviated training session.[50]

Under the guidance and direction of the contracted consultant, who also served as the trainer for the TF-CBT training, all youth with mental health diagnoses have been assessed for suitability of individualized or group-based TF-CBT treatment sessions as of September 30, 2014. Weekly TF-CBT treatment groups started the beginning of October 2014. As of October 22, 2014, three group sessions each have been held at the Sacramento, Merced, and Alborado Halls.[51] The groups at the El Toyan Hall were scheduled to start on November 4, 2014[52] when the unit Psychologist returned from leave status.

Meanwhile, the contracted project consultant continues to provide advice and support to the program. The consultant on October 7, 2014 conducted a conference call with Dr. Bowlds, Senior Psychologists and Psychologists on the mental health halls to respond to questions related to implementation of the program. The conference call identified additional implementation issues and Dr. Bowlds and the Senior Psychologists are in the process of formulating a plan to resolve them.[53]

Policies and Procedures

Defendant released the Mental Health Service Policy on July 8, 2014. The policy became effective on July 24, 2014. This is a significant accomplishment as the policy scope is very broad and covers all aspects of the Mental Health Program, from assessment and intake to delivery of services and program quality assurance. The policy also includes a procedural

[50] *See e*mail of October 14, 2014 from Ms. Yvette Marc-Aurele to Deputy Special Master John Chen.
[51] *Ibid.*
[52] *See* email of October 28, 2014 from Ms. Yvette Marc-Aurele to Deputy Special Master John Chen.
[53] *See e*mail of October 14, 2014 from Ms. Yvette Marc-Aurele to Deputy Special Master John Chen.

section to provide guidance to staff members in their day-to-day functions and activities.[54] The Mental Health Expert and the Special Master have provided extensive feedback and their comments have been incorporated into the policy and procedures.

Most other mental health-related policies are near completion. The current status of the mental health-related policies that are undergoing revision for final adoption are noted below:[55]

- The final draft of the revised policy on involuntary medication has been completed and pending review and processing by the Policy Unit for final release.
- Revision of the policy on treatment confidentiality has been reviewed by the Mental Health Expert whose comments have been incorporated into the final draft and is now pending legal review.
- The informed consent policy has been reviewed by the Mental Health Expert whose comments have been incorporated into the draft and is now pending legal review.
- A draft of the revised policy on psychopharmacology has been completed and is pending review by Defendantôs medical and mental health professionals.
- A revised draft of the policy on Suicide Prevention, Assessment and Response (SPAR) has been completed and is currently under review by the Senior Psychologist.

In her twenty-ninth report, the Special Master identified one policy issue that has not been resolved and that is the issue of use of chemical agents against youth with a mental health diagnosis. Defendantôs use-of-force policy that addresses this issue was developed in collaboration with Plaintiff and the relevant *Farrell* experts. While Plaintiff and the Special Master support Defendantôs current policy that severely restricts the use of chemical agents against youth with a mental health diagnosis, Plaintiff believes that it should go further. Based on a close examination of Defendantôs current practices and data governing this issue, the Special Master opines that Defendantôs current policy sufficiently meets the requirements of the *Mental Health Services Remedial Plan* and the *Safety and Welfare Remedial Plan*. This issue is discussed in greater details under the Safety and Welfare Section of this report.

[54] Examples of procedures include the mental health referral procedures, family request for mental health services, and initial mental health evaluations.
[55] *See* email of October 14, 2014 from Yvette Marc-Aurele to Deputy Special Master John Chen.

Program Guide

The Mental Health Services Program Guide is near completion. In developing the latest version of the program guide, Defendant followed an outline developed by the Mental Health Expert and prepared a draft program guide that is clear, concise and includes the pertinent elements and components. The Mental Health Expert and the Special Master both commented extensively on a draft version of the program guide and their comments and suggestions have been incorporated into the final draft. The final draft is undergoing Defendantôs internal review process. The anticipated release date is in November 2014.

The Special Master believes that the Mental Health Services Program Guide, if properly implemented, will address most of the Mental Health Expertôs previously identified concerns relative to Defendantôs Mental Health Program. The program guide is structurally consistent with the Mental Health Services Policy that was released on July 21, 2014 and provides a coherent framework that describes the programôs goals and objectives, entrance and exit criteria, program elements, transfer and referral processes, case planning, staff roles, IBTM support role and responsibilities, and quality assurance mechanisms.

The program guide also addresses the outstanding elements identified in the twenty-ninth report that 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.[56] Arrangements are being made for all Psychologists to complete CBT, AIT, Advanced Practice and MI training so they can facilitate these groups and mentor and coach other staff members.

[56] *See* OSM 29, p.36.

Quality Assurance

The soon to be released Mental Health Services Program Guide contains a section on quality assurance that includes internal and external quality assurance elements. The components include:

- Gathering, reviewing, and analyzing relevant data.
- Group observations.
- Supervisory review.
- Peer review.
- Internal and external report requirement.

The Special Master believes the measures identified in the program guide are sound steps in the initial phase of implementing a quality assurance system. As quality assurance entail many facets, further refinements may be needed as the program continues to develop and evolve.

B. Next Steps

Based on recent progress toward addressing the outstanding issues identified in Defendantôs Mental Health Implementation Plan, and barring unforeseen circumstances, it is not unreasonable to expect the completion of the remaining tasks by the end of November 2014. While the administrative tasks of the implementation plan are near completion, Defendantôs challenge is now directed toward implementing a true mental health program by properly executing the components identified in the program guide. A training curriculum will need to be developed, staff trained and mentoring, coaching, and quality assurance measures implemented. The role of the mental health clinicians and their interaction with the other program staff is a critical element in this endeavor and Defendant needs to carefully monitor and assess progress as it proceeds with implementation of the program.

In consultation with the Mental Health Expert, the Special Master has scheduled another round of audits of the Mental Health Program at the end of 2014 to assess progress and provide

feedback and suggestions. Defendant has made excellent progress in the implementation of the Mental Health Program this round.

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 Expertsô recommendations, the Special Master agreed to assume the monitoring of a few school attendance-related issues at VYCF that remained outstanding.

In her twenty-ninth report, the Special Master found Defendant has successfully addressed all remaining issues with the exception of the school attendance issue at VYCF. While the absence rate had declined during March and April 2014, the Special Master noted that the rate remains too high and the two-month period was not sufficient to establish a pattern and thus required further monitoring.

A. Current Status

During the Fall 2014 school semester, VYCF has made remarkable progress toward reducing school absences as the monthly absence rate declined sharply. After months of rates well above 20%, the absences rates dipped to 19% and 19.2% in March and April 2014, respectively. The rates further declined significantly to 11.6% and 9.5% in August and September 2014, respectively. The reduced rate is well within an acceptable range.

Table 10
Comparison of Monthly Absence Rate at VYCF[57]
Fall Semester -- 2014

	Unexcused Rate	Excused Rate	Monthly Rate
August	3.8%	7.8%	11.6%
September	3.9%	5.6%	9.5%

[57] The monthly rates exclude absences caused by school closures because unseasonably high temperature in Ventura, which is beyond VYCFôs control. The rate that includes heat closure would be 13.1% for August 2014 and 13.3% for September 2014.

A number of factors contributed to the significant improvement in school attendance. Key among them is a cultural shift in staff attitude at VYCF that now aligns more with the IBTM principles and is producing positive changes in youth behavior. The newly appointed Superintendent and Assistant Superintendent have demonstrated clear and consistent leadership that models the IBTM principles and this has played a large role in the cultural change at the facility. In addition, VYCF is addressing all issues affecting youth absences whereas past discussions primarily focused on reducing ñunexcused absences,ò (youth refusing to attend classes) under the premise that little could be done about the so-called ñexcused absences.ò Excused absences typically occur because of safety concerns and make up a greater portion of the overall youth absence rate. Thus, a meaningful reduction in the absence rate cannot take place without a significant decline in safety and security issues that are the reason for excused absences.

In the past, with a few rare exceptions, YVCFôs monthly rate of excused absences constantly exceeded 10%,[58] sometimes by significant margins. The excused rate dropped to 7.8% and 5.6% during August and September 2014, respectively. The key components of VYCFôs 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 assault incidents. There has been less violence at the facility as the number of use-of-force incidents declined sharply in recent months. During the two-month timeframe of August/September 2014, VYCF had a total of 32 use-of-force incidents in

[58] OSM 28, p.57.

comparison to 72 such incidents during the two-month timeframe of March/April 2014.[59] As discussed further in the Safety and Welfare section of this report, the declining trend of use-of-force incidents has emerged at VYCF since June 2014.

Less use-of-force incidents eliminates the need to place youth on TIP that accounts for a significant proportion of excused absences. During the two-month timeframe of August/September, VYCF reported 293 TIP placements in comparison with 221 in March/April.[60]

Less youth violence also resulted in fewer TTS decisions to preclude youth from attending classes because of safety and security concerns. In addition, in the past, reported absences from TTS decisions were inflated as a result of teachers rejecting youth from classes for minor infractions (such as sleeping in class) and then coded them as absences due to TTS decisions. This issue has been rectified as staff have been notified that the absence code cannot be used without explicit approval of the TTS. Reported absences due to TTS decisions plummeted from 5.8% to 1.3% between the 2013-14-fall semester and the 2014-15 fall semester.[61] Declines at the three living units with the highest absence rates included: Monte Vista BTPôs rate declined from 33.6% to 12.5% between Spring 2013-14 and Fall 2014-15 semesters,[62] Miramarôs rate declined from 1.5% to .5% and Casa de Los Caballerosô rate declined from 1.8% to .1% between semesters (see tables below).

For the unexcused absences, VYCFôs managers and staff members have been much more proactive in encouraging youth to attend classes. Facility-wide events such as coed BBQs are being organized. VYCF modified the monthly incentive program at the two high core units

[59] Source: VYCFôs Use-of-Force Monthly Reports.
[60] Data provided by Program Administrator Alicia Ginn via email of October 23, 2014 in a document titled *VYCF TIP analysis, March – September 2014.*
[61] *See* email of October 28, 2014 from Superintendent Mark Blaser to Deputy Special Master John Chen.
[62] Email of October 24, 2014 from Superintendent Mark Blaser to Deputy Special Master John Chen.

(Miramar and Casa de Los Caballeros) to require youth to meet certain attendance criteria besides attaining behavioral targets. Such incentives contributed to the 50% decline in the unexcused rate from 7.6% to 8.0% in March and April 2014,[63] respectively, to 3.8% and 3.9% in August and September 2014, respectively. As depicted in the following tables, the decline is particularly profound at the two high core units. The unexcused absence rate at Miramar declined from 6.7% to 1.6% while the rate at Casa de Los Caballeros declined from 14.5% to 3.2% between Spring 2013-14 and Fall 2014-15 semesters.

Table 11
Comparison of Miramar Hall School Absence Rates[64]
Spring 2013-14 and Fall 2014-15

Miramar Absence Rates		
	Spring 2013-14	**Fall 2014-15**
	(1/6/14 - 5/22/14)	**(8/8/14 - 10/15/14)**
Overall	24.4%	11.8%
Excused	17.7%	10.2%
Unexcused	6.7%	1.6%
TIP	12.4%	6.1%
TTS	1.5%	0.5%

Table 12
Comparison of Casa de Los Caballeros Hall School Absence Rates[65]
Spring 2013-14 and Fall 2014-15

Casa de Los Caballeros Absence Rates		
	Spring 2013-14	**Fall 2014-15**
	(1/6/14 - 5/22/14)	**(8/8/14 - 10/15/14)**
Overall	27.8%	14.0%
Excused	13.3%	10.8%
Unexcused	14.5%	3.2%
TIP	8.7%	6.5%
TTS	1.8%	.1%

[63] OSM 28, p. 39.
[64] Source: email of October 16, 2014 from Superintendent Mark Blaser to Deputy Special Master John Chen.
[65] *Ibid.*

The living unit staff members are also more involved in engaging youth in structured activities, which has produced positive outcomes. At the Miramar Hall, the unit staff in recent months started to organize structured activities such as singing contests, debates about current events, game contests, and greeting card making. During August and September 2014, the unit had one use-of-force incident each month and the absence rate declined by more than 50% in comparison with the previous school semester.

VYCF has increased the frequency of the school truancy reduction meetings from bi-weekly to weekly. The facility produces a School Absence Audit Report (SAAR) that identifies youth absences by youth name, by living unit, and by absence codes. The Superintendent, Assistant Superintendent, Principal, and managers from each living unit meet to go over the weekly reports and discuss which youth missed the class and what is being done to remedy the situation. The Deputy Special Master attended and observed the meeting held on October 9, 2014 and found the meeting to be interactive and helpful. Staff members generally respond when top management expresses interest and pays attention to a particular issue.

In the past, staff usually simply acquiesced when a youth refused to go to class. As discussed in the Special Masterôs twenty-ninth report, VYCF developed a ñSchool Truancy Reduction Strategyò that defines the roles and expectations of managers and staff members as well as delineating counseling when a youth refuses to attend class. Training has been provided and staff members from the living units evidently are applying the intervention strategy when interacting with youth who refused to attend classes.

B. Next Steps

As the absence rate now is well within the acceptable range, the question is whether the rate reduction is sustainable. Based on her assessment of VYCFôs efforts in totality, the Special

Master firmly believes that it is sustainable. As education is closely related the treatment and security functions, the significant improvement in school attendance is symptomatic of broader improvements that have been made at the facility. As the IBTM principles are more embedded into the culture, the absence rate should reduce further. Accordingly, the Special Master recommends discontinuation of monitoring of this one remaining issue in the *Educational Services Remedial Plan.*

VI. SAFETY AND WELFARE

The Special Master identified in her twenty-ninth report three outstanding issues that require further monitoring under the *Safety and Welfare Remedial Plan*. The issues include use of force, facility improvements and BTP units. She agreed to assume the monitoring responsibility for these items consistent with the approaches of transferring monitoring responsibility that brought closure 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 Special Master finds Defendant is continuing to make progress, particularly in the use-of-force issues. The three outstanding issues and the current plans to resolve each of these issues are discussed below:

A. Use of Force

In her twenty-ninth report, the Special Master found both OHCYCF and NACYCF have achieved the desired outcome with respect to use of force. Over an extended period,[66] the numbers of incidents at these two facilities were low and consistent with patterns that are

[66] OHCYCFôs use-of-force rates have been considered within an acceptable range since prior to 2013 and NACYCFôs rates became in line with OHCYCFôs rates starting August 2013.

deemed acceptable. In addition, there are a minimal number of incidents involving a single youth or use of chemical agents against youth with a mental health designation. In contrast, the number of force incidents at VYCF remained high as its total number of force incidents constantly exceeded the combined total of OHCYCF and NACYCF. The number of incidents involving a single youth and use of chemical agents against youth with a mental health designation was also much higher at VYCF than at the other two facilities. The Special Master suggested that the use-of-force rate at OHCYCF and NACYCF is a reasonable target for VYCF.

Recent data suggests that, since June 2014, VYCF has made significant progress and its force incident rate and the other key indicators are similar to those of the two other facilities. This is consistent with the Special Masterôs observation in her twenty-ninth report that she is reasonably confident that VYCF will be able to bring down its force usage to an acceptable level within the foreseeable future.[67] She based her observation on evidence showing that the facilityôs Force Review Committee (FRC) members are placing greater emphasis in exploring means to prevent and avoid future incidents and the facilityôs analyses of use-of-force trends and patterns are consistent with policy and are more in-depth, thorough, and focus on prevention of force.[68]

Except for July 2014 when it had an unusually high number of incidents of physical altercations in its female unit, VYCFôs monthly incident totals are near or below the totals of OHCYCF and NACYCF. Over the four-month period, the average monthly totals for OHCYCF, NACYCF, and VYCF were 17.5, 17.5 and 18, respectively. The problems at the female youth were identified and promptly addressed and as a result, the total number of incidents in the female unit declined from nine in July 2014 to one in August 2014.

[67] OSM 29, p.47.
[68] *Ibid.*

The other facilities also are analyzing the trend and patterns of those strategies that result in a reduction of force. For example, when NACYCFôs intake unit experienced a spike in its use-of-force incidents, gang issues were identified as the cause of the problem and the facility took action, which resulted in the number of incidents declining from 10 in July 2014 to one in August 2014. Similarly, OHYCYC FRCôs review identified a trend of increased number of single youth incidents in the Inyo BTP unit. The FRC review found evidence suggesting staff members in the BTP unit did not have a clear understanding of the distinction between immediate use of force and controlled use of force. The Chief of Security for the Stockton Complex provided special training to Inyo BTP staff that has resulted in the number of use-of-force cases at the unit to decline from seven cases in July to six cases in August and to three cases in September 2014.

Temporary spikes in youth violence are difficult to avoid in the institutional setting and the facilityôs ability to promptly identify the cause(s) of the problem and to resolve the problem is a key indicator that the force review process is functioning as intended. Data suggests Defendant has an effective system and process in place to minimize use of force.

Table 13
Use of Force Incidents by Facility[69]
January 2014 through September 2014

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
VYCF	36	19	41	31	34	14	26	12	20
NACYCF	16	10	15	18	13	12	20	17	17
OHCYCF	9	9	12	11	20	17	12	18	19
Total	61	38	68	60	67	43	58	47	56

VYCFôs number of single youth incidents has declined sharply since August 2014 as has its total use-of-force incidents that was below the totals of the other two facilities for August and

[69] Compiled by OSM based on the facilitiesô use-of-force monthly reports.

September 2014 (see Table 14 below). This is unprecedented, as VYCF historically consistently has had a higher number of use-of-force incidents than the other facilities. The facilityôs FRC, repeatedly identified situations where the staff members were too quick to apply force in single youth incidents, and emphasized the need to slow down whenever possible. This approach apparently has achieved the desired effect, as staff in general have been more patient in situations where youth became defiant or refused to follow instructions. For example, in September 2014, one youth with a mental health designation was involved in 21 situations that required responses from the security personnel, but only one case resulted in a physical use-of-force incident.[70] Moreover, in its review of that one case, the FRC found staff acted too quickly and should have initiated the controlled use-of-force protocol instead of using immediate force. Such reinforcement should lead to further force reductions in the already minimal number of single youth use-of-force incidents.

Table 14
Single Use of Force Incidents[71]
January 2014 through September 2014

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
VYCF	16	8	17	12	21	7	8	3	3
NACYCF	2	4	3	5	2	3	1	6	6
OHCYCF	3	0	3	0	4	1	3	7	4
Total	21	12	23	17	27	11	12	16	13

Incidents that involved youth with a mental health designation who were exposed to a chemical agent have become infrequent, partially because fewer youth now meet the new mental health designation. OHCYCF, which has no mental health hall and none or few youth with a mental health designation, did not report any such incidents during the first nine months of 2014. NACYCF has been averaging one such case per month since January 2014. Since August 2014,

[70] Email of October 10, 2014 from Superintendent Mark Blaser to Deputy Special Master John Chen.
[71] Compiled by OSM based on the facilitiesô monthly use-of-force reports.

VYCF also significantly curtailed the number of incidents that involve the use of chemical agents against youth with a mental health designation to one case per month.

Table 15
Mental Health Youth Exposed to Chemical Agents
January through September 2014

	Jan	Feb.	Mar.	Apr	May	June	July	Aug	Sept
VYCF	4	2	6	3	0	4	4	1	1
NACYCF	2	1	1	1	2	0	1	0	1
OHCYCF	**0**	0	0	0	0	0	0	0	0
Total	6	3	7	4	2	4	5	1	2

The Special Master also compared the monthly rate of use-of force incidents from April 2013 through September 2014, which takes into account fluctuation in the youth population among the facilities. The comparison shows VYCFôs use-of-force rate has declined significantly while the othersô rates remained fairly constant. Since June 2014, VYCFôs rate has been similar to that of OHCYCF and NACYCF, which the Special Master suggested as a reasonable target for VYCF in her twenty-ninth report.

Table 16
Use-of-Force Rate – Per 100 Youth Days
April 2013 through September 2014[72]

	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
June 2014	.20	.32	.20
July 2014	.32	.22	.38
August 2014	.27	.33	.18
September 2014	.28	.35	.30

The data demonstrates that VYCF has achieved the desired reduction in use of force this round. The Special Master believes the effort is sustainable because the facilityôs use-of-force review process is consistently applied according to policy and continues to improve. The Special Master based her belief on the following considerations:

- The quality of FRC review continues to improve. In previous reports, the Special Master questioned the value of VYCFôs use-of-force review process because the FRC reviews appeared perfunctory and resulted in few instances where meaningful issues or action steps were identified or addressed.[73] As previously noted in this report, the Special Master in her twenty-ninth report acknowledged that VYCFôs FRC review has become more meaningful and places greater emphasis on force prevention in line with Defendantôs Crisis Prevention and Management Policy. Review of more recent FRC cases found the FRC review to be more thorough, which likely is one of the key factors in the reduced number of force incidents at VYCF.

[72] The rates from April 2013 through May 2014 were reported in OSM 29. The rates from June 2014 through September were provided by DJJ via an email of October 24, 2014 from Associate Director Tammy McGuire to Deputy Special Master John Chen.
[73] OSM 28, pp. 65-66.

- Facility senior management and Central Office administrators (Director, Deputy Director, Use-of-Force Coordinator) have comprehensive, accurate, and reliable data to provide oversight and intervene when necessary. Each facility now produces monthly and quarterly reports in a standardized format that provide a broad array of relevant useful data, such as the number and types of force incidents, incidents avoided through dialogue, location of the incidents, single youth incidents, and the number of mental health youth exposed to chemical agents. The monthly reports also capture other information such as summaries of cases reviewed by the FRC and identification of youth engaged in multiple incidents. This management tool enables facility management and the Central Office administrators to closely monitor the facility's use-of-force practices by reviewing and analyzing trend and patterns and identifying anomalies for attention. For example, the aforementioned spikes in the number of incidents at VYCFôs female unit and NACYCFôs intake unit during July 2014 were readily apparent in the facilitiesô monthly reports.

- More staff members are being held accountable for failing to adhere to prescribed policies. Past FRC reviews seldom identified action against staff beyond training or informal verbal counseling. In reviewing recent FRC review cases, there were more incidents that resulted in the initiation of progressive disciplinary action such as work improvement discussion formally documented in the staff memberôs record. Three staff members recently have been disciplined, two of whom were dismissed from state service for inappropriate action during a single youth incident. This action sends a strong signal to all staff members that inappropriate use-of-force practices will not be tolerated.

- The Central Office administrators exert oversight and intervene when necessary. The Central Office administrators closely monitor use-of-force practices of the facilities through review of the monthly and quarterly reports and through the Department Force Review Committee (DFRC), which monthly selects a sample of cases completed by the FRC for a secondary review. In some instances, specific cases were returned to the facilities for further review or action. Broader action steps have been taken when the DFRC identified issues that are systemic. For example, the DFRC review identified a pattern suggesting the supervisors of VYCFôs security staff may not have a full understanding of all Crisis Prevention and Management Policy provisions and a training session was held in September 2014 for all Lieutenants and the Chief of Security at VYCF to go over the policy. The Deputy Special Master attended and observed the training session and found it to be very useful in clarifying common misperceptions through discussion and analysis of recently completed use-of-force case packages that were reviewed by the training session attendees.

- Process and procedural shortcomings are promptly addressed. At Plaintiffôs request after a site visit by the counsel, the Special Master reviewed allegations of excessive use of force against one youth during two incidents; one occurred during March 2014 and the other in May 2014. The Special Masterôs review found Defendantôs use-of-force process in general is functioning as intended. In both

instances, the review processes correctly assessed the situation and determined that further action was necessary. In the March 2014 incident, the DFRC appropriately identified the incident as in need of further review after the FRC missed it. In the May 2014 incident, despite misgivings regarding the youthôs statement, staff nevertheless recommended an inquiry to take place. When the youth filed a staff misconduct complaint, the Superintendent acted appropriately in bypassing the inquiry process and ordered the case to proceed directly to the investigation process. However, while Defendantôs use-of-force review processes effectively identified cases in need of additional inquiry or investigation, a staff member at VYCF had failed to timely initiate action to start the process. This process lapse apparently was not uncovered until July 2014 when the Special Masterôs review began. The investigation requests for both cases were immediately processed and VYCF implemented a process to closely track requests for inquiries and investigation that require weekly review by the Superintendent. Further, on August 15, 2014, the Deputy Director issued a memorandum to all Superintendents, Assistant Superintendent, Principals, and Executive Staff prescribing procedures to ensure complaints and allegations of staff misconduct are properly assessed and accounted for.

- Finally, VYCF continues to make progress in implementing the IBTM principles and this will continue to change the culture from one of punishment to one of behavioral shaping.

The Special Master opines that, with the recent improvements at VYCF, Defendantôs use-of-force practice is in substantial compliance with the *Safety and Welfare Remedial Plan*. Her opinion is based on the following considerations:

- Defendantôs use-of-force policy is sound, has been fully implemented, and has demonstrated to be effective. Defendantôs current policy was developed after an extensive internal review and in consultation with Plaintiff, relevant *Farrell* experts, and the Special Master. All staff members have received training on the policy and update and reinforcement training is provided annually during block training.

- Defendant has complete, accurate, reliable, and timely data regarding management review, oversight, and intervention. As previously noted, each facility now produces a monthly use-of-force report, due by the tenth of the following month. The monthly report provides sufficient and relevant data, trend analyses, lessons learned, best practices and other information to provide a full picture of the facilityôs use-of-force practices and outcomes during the report period. The monthly report data are summarized into a quarterly report. These reports provide transparency and have proven to be a useful management tool for oversight and quality assurance.

- Quality assurance is taking place continuously. Quality assurance is achieved through FRC review, DFRCôs secondary review of sample cases, and monitoring of the monthly and quarterly reports. In addition, each youth involved in the use-of-force incident is interviewed to gain his/her perspective about the incident.[74] Quality assurance has proven to be effective in identifying strengths and shortcomings in individual cases as well as systemic issues that require broader attention and action.

B. Use of Chemical Agents Against Youth with a Mental Health Designation

To date, the parties have not been able to reach agreement on the issue of use of chemical agents against youth with a mental health designation. As there appears to be a lack of clarity on what is needed to bring this issue to closure, the Special Master shares her assessment of status and progress of this issue for consideration and resolution.

Both the *Safety and Welfare Remedial Plan* and the *Mental Health Remedial Plan* contain similar provisions governing use of chemical agents against youth with a mental health designation. *The Safety and Welfare Remedial Plan* states:

> ñUnder situations where **an immediate use of force is unnecessary**, DJJ policy will include special procedures and/or alternative interventions to protect youth whose medical or mental health condition indicates the use of certain types of force are contraindicated.ò (Emphasis added)
>
> "DJJ will immediately implement a system to recognize and identify any youth with medical or mental health conditions that might preclude the use of some types of use of force or restraint and communicate this information to prevent exposure to **control methods** that are contraindicated.ò

The Mental Health Remedial Plan states:

> ñBecause of potential medical complications, **in any controlled use of force**, oleoresin capsicum spray (OC ï also known as pepper spray or mace) is not to be used on youth who are on psychotropic agentsé ò (Emphasis added)
>
> ñIf at all possible, **controlled use of force (i.e. use of force not requiring immediate action)** will include the presence of mental health personnel if the youth is on a mental health caseload. In addition, all controlled use of force is to be proceeded by a cooling down period to allow the youth to voluntarily comply with staff instructions.ò (Emphasis added)

[74] Each use-of-force incident package now contains a staff counseling note documenting the result of youth interviews.

Thus, both remedial plans impose limited use of chemical agents against youth with a mental health designation, but only in controlled use-of-force situations. Defendantôs current policy and the preceding policy contain provisions consistent with the above remedial plans' provisions by requiring a cool down period, mental health clinician presence and intervention, and prohibition of chemical agents against youth with a mental health designation during controlled use-of-force incidents. However, in the past, it was difficult to assess compliance with these policy requirements as immediacy is subjective and staff members routinely construed almost all incidents to be immediate in nature. Moreover, such staff judgment had rarely been challenged during the various levels of review processes. Defendant asserted that there were few reported controlled use-of-force incidents because many incidents were avoided through dialogue and mental health clinician intervention after staff initiated the controlled use-of-force protocol. However, in the past, Defendant did not have data to support this assertion. Anecdotally, the Special Master, during her past review of use-of-force incident packages, identified a number of cases where chemical agents were used on youth with a mental health designation that apparently did not merit immediate force.[75]

Defendant now maintains complete data on the number of incidents where through dialogue no force was used after the security staff was contacted. In each of those instances, the controlled use of force protocol had been initiated and staff intervention avoided use of force.

Data in the Table 17 shows that 75% or more of the potential use of force incidents in the mental health halls have been avoided through dialogue over the three-month period of July through September 2014. The aforementioned case of one youth with a mental designation having been involved in 21 situations that required a security response during September 2014

[75] Review of the recent use-of-force incident packages suggests this condition no longer exists.

but only one resulted in one physical use-of-force incident suggests staff members are exercising restraint in dealing with youth with a mental health designation.

Table 17
Percentage of Use-of-Force Incidents Avoided through Dialogue in Mental Health Units
July, August, and September 2014

	Alborado	El Toyan	Sacramento	Merced
July 2014	100% (1/1)	57% (12/21)	89% (8/9)	83% (5/6)
August 2014	71% (5/7)	83% (2/3)	67% (2/3)	80% (4/5)
September 2014	75% (3/4)	93% (28/30)	80% (8/10)	100% (4/4)
Total	75% (9/12)	78% (42/54)	82% (18/22)	87% (13/15)

As noted in previous reports, the quality of review by the DFRC and FRC has improved immensely.[76] Actions against staff have resulted from FRC reviews that routinely identified cases where a controlled use-of-force protocol should have been applied instead of immediate use of force. A review of recent cases suggests that staff members now adhere to policy in cases that may result in use of chemical agents against youth with a mental health designation. For the five-month period of May through September 2014, the facilities had 14 youth with a mental health designation exposed to chemical agents during use-of-force incidents. Twelve of the 14 youth who were involved in a physical altercation, one was charged with staff assault, and one had a weapon while threatening to engage in self-injurious behavior. All 14 cases were found to have met the criteria for immediate force under the current policy

As Defendantôs current policy and practices appear to conform to the requirements of the *Safety and Welfare Remedial Plan* and the *Mental Health Remedial Plan*, the Special Master believes the question might be the appropriateness of using chemical agents against youth with a mental health designation engaged in one-on-one fights. The use-of-force incidents may be broadly categorized into single youth incidents, group disturbances, and one-on-one fights.

[76] OSM 27, pp. 35-36.

Defendant does not dispute the fact that chemical agents should only be used against a single youth with a mental health designation under extreme situations and Plaintiff does not question the need for their use during group disturbances. However, as the circumstance and severity vary significantly during one-on-one fights, staff judgment and discretion are needed to determine what the most appropriate force option under the circumstance is to ensure youth and staff safety. Moreover, the youthôs mental health status may not be apparent when the incident occurs outside the youthôs living unit.

As the cases involving use of chemical agents against youth with a mental health designation now occur very infrequently, the Special Master suggests the issue might be resolved through a more in-depth review of the appropriateness of using chemical agents in incidents involving youth with a mental health designation. This approach appears to be consistent with the approach outlined in the *Safety and Welfare Remedial Plan* that states:

> ñThis Plan does not require targeting or eliminating any specific force option as a way to reduce reliance on force. Such requirements can have negative consequences and may result in staff migrating to the use of those force options remaining or circumventing the approved methods. Training following the UOF review must reinforce selection of the proper prevention or intervention and, if an inappropriate selection of method occurs, by appropriate administrative actions. The reviews are to examine not only the methods employed but also the supervision extended to staff in the use of force incident and the documentation provided.

C. Facility Improvements

Defendant continues to improve the appearance and functionality of the living units to provide for a setting and environment conducive to treatment. During site visits to the facilities on other *Farrell*-related matters, the Deputy Special Master visited a number of living units to observe the conditions of the units. At VYCF, he visited Monte Vista, Casa de Los Caballeros, Miramar, and El Toyan Halls. At OHCYCF, he visited Inyo, Glenn, and Butte Halls and at NACYCF, Kern, Feather and San Joaquin Halls.

With the exception of the San Joaquin Hall, the common areas of all living units were clean, neat, and graffiti free. The conditions at San Joaquin were poor as the unit had a group disturbance and was in limited program protocol until the day of the Deputy Special Masterôs site visit. Most of the units appear to be recently painted ï Monte Vistaôs dayroom was being painted during the day of the site visit. The units are more decorated, such as youth at Casa de Los Caballeros and Miramar put up Halloween decorations in the hallway area near the dayroom. The Deputy Special Master randomly selected and inspected several youth rooms and found the fixtures (lighting and plumbing) to be functioning properly.

Most living units received new furniture, consisted of a foam desk and three foam chairs. Visually, the new furniture is noticeable in the living units with smaller-size dayrooms, such as the Glenn Hall at OHCYCF. However, at NACYCF where the dayrooms are much larger, it is difficult to distinguish the furniture from others and more will be needed to make a difference in appearance.

All living units at all facilities have installed honor/incentive rooms and library/study rooms. The conditions and functionality vary significantly from unit to unit. For example, Glenn Hall has two incentive rooms that are well decorated and furnished with a television, game console, and bedding that are clearly distinguishable from the other rooms. Similarly, its library/study room is furnished with appropriate furniture, books well organized in a bookshelf, and a checkout list to track the books. Meanwhile, at the nearby Butte Hall, the incentive room is sparsely furnished, the walls are bare and, other than a television on a stand and a game console on the floor, it could not be distinguished from a typical youth room. Similarly, the library did not appear to be functional as it only had a desk, a chair, and a few books scattered on

the bookshelf. All three facilities continue to encounter delays in computer installation due to wiring and other logistical considerations.

As Defendant continues to make facility improvements, there is still a lack of clarity as to how much more work is needed to resolve this issue. This is highly subjective and difficult to ascertain without knowing what a unit should look like. One approach Defendant might consider is to develop a model unit at each facility for discussion and concurrence before proceeding to other units. The Glenn Hall at OHCYCF and the El Toyan Hall at VYCF appear to be likely candidates for the model concept. Another approach would be for Defendant to prepare artist renditions of what the units would look like for consideration and concurrence.

D. BTP

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. Based on their previous site visits, both Plaintiff and the Special Master agree that in general, youth feel safe and well treated. Defendant is improving in transitioning youth out of BTP units on a fairly timely basis, particularly at OHCYCF. However, 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 ñprogram groupsò by race, gang affiliation, or other factors, which seriously limit the staffôs ability to provide meaningful treatment and services to youth, as most of the staffôs time is consumed by youth movement and delivery of basic services.

The Special Master suggested the problem stems from poor case planning, an ineffective level system (inadequate incentives at the core units to encourage positive behaviors by youth at the BTP units), and a lack of coherent intervention strategies to address each youthôs treatment

needs on an individualized basis. Defendant, on February 12, 2014, established a BTP workgroup comprised predominantly 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 the BTP.

On September 24, 2014, members of the BTP workgroup held a meeting that was also attended by Director Minor, Plaintiff, the Mental Health Expert and the Special Master. During the meeting, each BTPôs SYCC, who also serves as a member of the committee, provided a progress update on the current climate and conditions of the BTP. In addition, discussions were held on the trend of the youthôs length of stay in the BTP and Defendantôs oversight review processes to ensure youth are only confined to a BTP for issues related to aggression and violent behavior. Information presented during the meeting suggests Defendant continues to make progress on all aspect of the program.

The workgroup continues to confront challenges in its effort to develop a program guide to clearly define and describe the program and its key components/elements. Prior to the meeting, a draft version of the program guide was developed for review and comment and both the Mental Health Expert and the Special Master found it to be repetitive, complex, too procedurally oriented, and internally inconsistent. The Mental Health Expert has developed an outline for the workgroup to follow to revise the draft. This approach appears to have worked well in the development of the Mental Health Program Guide.

The BTP is also in need of a Behavior Management System, which is a departmental issue that is being separately addressed. As discussed in the IBTM section of this report, the

Mental Health Expert is also actively engaged in assisting Defendant with the development of this system.

BTP Youth Population and Average Length of Stay

While the average daily population of the BTP tends to fluctuate significantly depending on the climate of the facility, gang dynamic and other factors, Defendantôs BTP youth population appears to be in a downward trend, particularly at VYCF. As of September 2014, Defendant had a total of 33 youth in its BTP units. The numbers of youth placed in OHCYCF, NACYCF, and VYCFôs BTP units were eight, 10 and 15, respectively. During previous site visits, VYCF BTP youth population constantly was at or near the maximum capacity of 24. Now the number is typically well below 20. As previously discussed, the number of use-of-force incidents at VYCF, particularly in the two high core units, declined significantly. Less youth violence result in fewer BTP referrals.

Defendantôs average length of stay increased from 83 days in May 2014 to 96 days in September 2014. However, the increase likely was caused by fewer new youth with short stays, which inflates the average. This is similar to the Special Masterôs observation in her twenty-ninth report that the decline in average length of stay from 132 days in January 2014 to 83 days in May 2014 was an outlier because the decline was primarily due to a serious staff assault incident that resulted in six youth with lengthy BTP stay being transferred to the county for prosecution.

Another useful indicator may be a stratification of youth placed in BTP under 60 days, between 60 days and 119 days, and 120 days and over. Defendantôs current policy requires the Juvenile Justice Administrative Committee (JJAC) approval of BTP stays 60 days or more and the Deputy Directorôs approval of BTP stay 120 days or more. Generally, youth with BTP stays

under 60 days are able to transition out of the unit rapidly but youth with longer stays tend to become more entrenched in the setting, especially those that are 120 days or more. The following table provides a stratification of each BTP unitôs population as of September 30, 2014.

Table 18
BTP Youth Population[77]
As of September 30, 2014

	Under 60 Days	60 Days to 119 Days	120 Days or more	Total
OHCYCF	3	2	3	8
NACYCF	4	4	2	10
VYCF	7	3	5	15
Total	14	9	10	33

Although this data also could be skewed through youth being transferred from one facilityôs BTP to another facilityôs BTP,[78] it nevertheless highlights the trend and number of youth with lengthy BTP stays that require attention. For example, five of eight youth at OHCYCF BTP had stay of 60 days or more as of September 30, 2014, which is atypical of the unitôs past patterns and merit further attention. At VYCFôs BTP, the number of youth with a stay of 60 days or more declined from 10 as of May 30, 2014 to seven as of September 30, 2014. One of the seven is scheduled to be released in November 2014 when he reaches his actual confinement time. However, according to the BTPôs SYCC, the remaining six are highly challenging youth.

Program Groups

Similar to the youth population, the number of program groups also fluctuates significantly at the BTPs. Staff members at all BTP units clearly are working diligently to integrate youth into larger groups. However, this is a constant challenge as change in the youth population mix, altercations, or other events often dictate expansion of program groups. For

[77] Compiled by OSM based on data in DJJôs BTP Monthly Report for September 2014.
[78] For example, one youth with 678 days in NACYCFôs BTP was transferred to VYCFôs BTP on September 10, 2014. His length of stay at VYCF would restart on September 10, 2014.

example, VYCF was able to integrate 15 youth in its BTP unit into three program groups at the end of September 2014. However, by October 9, 2014 when the Deputy Special Master visited the unit, the number of program groups had increased to five because four new youth had been added to the program and the SYCC was developing strategies to integrate the groups. Similarly, after all youth were able to program successfully as one group, OHCYCFôs BTP had to segregate youth into two groups because of an incident that resulted in a group disturbance. Gang intelligence suggests the incident was instigated by youth from the other living units.

The Deputy Special Master made site visits to all three BTPs during October 2014. Consistent with the previous observations of the Special Master, all youth interviewed stated that they are well treated and have no safety concerns. However, none of the youth were able to describe what goal or action steps he needs to achieve in order to exit the BTP. There are few structured activities other than treatment modules for youth to engage in. For the few youth with a high school degree, activities out of their room are even more limited because they do not attend school. Out-of-room time decreases when there is a large number of program groups due to the logistical challenges of youth movement.

The Special Master believes management and staff members at the BTP units in general are doing the best they can with the tools that are available at their disposal. The BTP program guide and the BTP-specific Behavior Management System, if properly developed and implemented, will provide the needed additional tools. The Special Master cautions that there likely will be some entrenched youth who will not respond to treatment regardless of the merit of the program.

E. Report of Accomplishments by the Safety and Welfare Expert

The Safety and Welfare Expert, Dr. Barry Krisberg, issued a report entitled ñReforming the California Division of Justice ï Lesson Learnedò on August 15, 2014. At Defendantôs request, Dr. Krisbergôs report is included as Appendix B to this report.

F. Next Steps

Because of the progress and improvements made in use of force at VYCF, the Special Master recommends discontinuation of monitoring of this issue. The Special Master again recommends immediate transfer of monitoring of the *Safety and Welfare Remedial Plan* to Defendant with the exception of two issues, facility improvements and the BTP units.[79] The Special Master and the Mental Health Expert will continue to work with the parties to bring closure to these issues as expeditiously as possible.

VII. CONCLUSION

Defendant has continued to make steady progress in the implementation of the IBTM as evidenced by the increase in audited items that are now in substantial and partial compliance as noted in the Mental Health Expertôs Comprehensive Report of 2014. The Mental Health Expert noted increased alignment with the principles of the IBTM. This change in organizational culture is most clearly evidenced in the remarkable reduction in use of force to respond to youth misbehavior. CBT resource groups are being held consistently and strategies to increase fidelity to the curricula are being developed and implemented. There is a significant increase in the use of the RS by staff members in a variety of roles. A comprehensive agency training plan has been developed that targets and sequences training in a logical and thoughtful fashion. Work continues on a comprehensive strategy to address quality assurance. Strategies to improve case

[79] Monitoring of IBTM implementation progress has already been transferred to the Mental Health Expert.

management practices and to implement the LS are well underway. Evidence of systems to ensure that supervisors and managers receive and use reporting systems continues to grow.

In this reporting period, the mental health leadership has made significant strides toward implementing an evidence-based and robust program. The difficult work of laying the program foundation through clear policies, procedures and a program guide are almost finished. The training strategy for units has been comprehensive and inclusive of all unit staff. The next round of audits will no doubt show significant progress in program implementation.

The senior leadership at VYCF continues to turn that facility from the worst in measurable outcomes to one of the best. The Special Master has always had confidence that with the right leadership, the staff at VYCF would demonstrate their ability to effectively implement developmentally appropriate and evidence-based programs for youth. The infusion of new leadership at the SYCC level and the continued skillful leadership of the Senior Psychologist and his team have combined to support significantly greater alignment with the IBTM principles. The adherence to both the content and spirit of the use-of-force review process has resulted in truly remarkable reductions in the level and type of force used to respond to youth misconduct. All of the VYCF staff are to be congratulated for their willingness to trust their senior leaders and to follow them in what is often a challenging change process. Of particular note is the BTP unit staff who, despite some painful incidents, have never stopped believing that the youth in their unit can and will progress to core units.

The many changes at VYCF have resulted in the absentee rate for school being reduced to very reasonable rates. The Special Master finds this issue has been resolved and no longer requires her monitoring.

Finally, the Special Master is of the strong opinion that with the exception of the BTP and facilities, it is time to transfer monitoring of the *Safety and Welfare Remedial Plan* to Defendant. The Special Master has every confidence that the use-of-force review process, combined with the changes resulting from the continued integration of the IBTM principles, has and will continue to result in a level of use of force that is minimal and is reserved only for those circumstances that require force to protect youth and staff. The Mental Health Expert, who is already responsible for monitoring the implementation of the IBTM, should continue to monitor the progress of the BTPs and to provide input regarding the needed environment changes in facilities to the Special Master who will monitor this item.

The Special Master respectfully submits this report.

Dated: November 17, 2014

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Nancy M. Campbell
Special Master

2014 IBTM Audit Comprehensive Summary

INTRODUCTION

The Farrell law suit remedial plan specifies the adoption of the Integrated Behavior Treatment Model (IBTM) throughout the Department of Juvenile Justice (DJJ). This Comprehensive Summary reviews the salient findings of the IBTM audits of OHCYF, NACYCF, and VYCF conducted in June and July of 2014. Note that DJJ stated that there were no changes relevant to the headquarters audit, so this was not conducted; refer to last year's audit results for information about this element.

In order to contextualize the findings, it is important to understand the conceptual underpinnings of the IBTM and the kinds of changes it demands. Please see the Comprehensive Summary from 2013 for an overview of salient concepts.

IMPLEMENTATION OF THE IBTM

The commitment of DJJ leadership has been steadfast during the year since the last series of IBTM audits. Training and supervision of the staff have continued and have achieved steadily greater penetrance of the core IBTM concepts. More than any other finding, this growth of the understanding of the line staff needs to be recognized and appreciated. General staff understanding has progressed to the point where staff are spontaneously applying the core concepts with youth. While some staff lag in their understanding, this is at the level to be expected when engaging in such a substantial cultural shift. That said, there is wide staff acceptance that the IBTM is and will be the model for DJJ.

The IBTM team must again be commended for their diligence and efforts to grow the understanding of the IBTM in their work with DJJ staff. Reductions in their numbers have been a challenge and may have slowed the ability of DJJ to turn their quality assurance (QA) functions over to local managers but this is beginning to happen. But in order to be fully effective, there must be sufficient resource to make this transition effectively. There was a recent training of managers that helped managerial staff, who do not have the opportunities to practice using the principles with youth on as regular a basis as line staff, develop the understanding they need in order to be able to manage in accordance with the IBTM.

The IBTM has been rolled out sequentially beginning with OHCYCF, moving to NACYCF, and lastly incorporating VYCF. All units have now implemented the IBTM. Despite the sequential roll out, all facilities are performing similarly, which is a credit to the agency and demonstrates the general staff buy-in.

The only important systematic difference between institutions at the time of the audits was that NACYCF had fallen somewhat behind in training. However, this is being corrected and it is expected that NACYCF will return to its earlier performance in this portion of the audit.

This document will emphasize barriers to full implementation in the interest of helping DJJ focus its efforts where they are most needed but it is important to bear in mind that overall progress is quite good.

Training

As noted above, the training at NACYCF had fallen off in the time leading up to the audit but this is being corrected.

As noted in the 2013 IBTM Audit Comprehensive Summary, the CBT training for many staff had become stale. Group observations by auditors demonstrated inconsistency in the quality of the groups, some of which may be attributable to this problem though normal staff variation doubtless contributes as well. The CBT group observations that should serve to correct this over time are occurring but review of these documents reveals that virtually none contain any plan for remediation for any staff, including some whose skills clearly demand remediation. While it is understandable and perhaps even desirable that early observations emphasize the positive in order to limit staff anxiety to being observed and allow them to grow accustomed to this kind of transparency, it is essential to identify staff who need help both for their own growth and, of course, because it is essential to effective work with the youth. Frequent staff moves have continued to create challenges though stabilization of the youth population has diminished the intensity of this issue to some degree. DJJ has made reasonable efforts to get staff specialty group training when regular staff are out, for instance at the BTP units. The more substantial problem is that there are many substitute group leaders, leading to fragmentation of the group process. While it is preferable to hold the group with a substitute rather than canceling, every effort should be made to assure that leaders stay with their groups through a whole cycle to the maximum extent possible. But it is important to note that the first order of business was to get groups running reliably, which has been largely accomplished. DJJ now needs to turn some attention to consistency of group leadership and fidelity to the curriculum.

The main training component left to complete involves Motivational Interviewing. This is a vitally important skill. It provides a conceptual framework for understanding the process and stages of change that staff need to be more effective in case planning and working with the youth where they are. It is clear in reviewing the Case Plans and interviewing staff that this is an area where growth is needed. DJJ has plans to bring this training to completion.

Compared to last year, staff at all levels have shown substantial growth in their understanding of positive reinforcement, the intention to help youth develop skills, behavioral principles in general, and how all the components of the IBTM fit together to support behavioral change. This is true of staff at virtually all levels. Leadership and supervisory staff have made important gains in this regard; this needs to continue. With the exception of OHCYCF, psychologists have also developed a strong understanding of and engagement with the IBTM. Some psychologists at OHCYCF had not even heard of the IBTM and almost none were meaningfully engaged in supporting its implementation and fidelity. This is attributable in part to having several who are not regular DJJ employees and to the fact that their offices are not on or near their units.

Staffing

As noted last year and above, excessive staff movement has been a barrier to implementation but this is diminishing naturally with stabilization of the youth population. To limit problems with fidelity, especially on specialty units, it is key to be able to retain staff trained in specialty groups on these units and to preferentially place staff with the relevant skills on such units. This remains a problem.

Again as noted last year, the downsizing has also left DJJ with a hierarchy having more levels than are needed. The comments made last year still apply.

Similarly, the problems noted last year regarding the lack of a floor leader on swing and night shifts the need to re-array staff to accommodate the change to a behavioral model continue to be present.

While these issues do not prevent successful implementation the IBTM, they slow and impair its implementation. But it also bears repeating that the increased engagement of psychologists, especially at VYCF, is a great benefit and is almost certainly contributing to the growth in the general understanding of all staff.

Environment

The point made in the 2013 Summary regarding the environment bears repeating. In short, for the IBTM to be successful, it is essential that the environment support sufficient levels of reinforcement to overcome peer group reinforcement (the primary but not only source of reinforcement) of antisocial behavior. If the environment cannot provide sufficient reinforcement to overcome these, the IBTM cannot succeed. It is very important to understand that it is not that it will not work as well but may not work at all. How enriched the environment needs to be can be measured by its ability to produce behavioral change (assuming fidelity to the model). Clearly, this can be taken to an extreme if one sets the target as zero acting out and recidivism – no system can achieve this. But if youth do not on average progress through the system, reduce their acting out, and recidivate at significantly lower levels, this is evidence of a problem. Probably the best measure of this is the behavioral change of the more challenging youth. In short, healthy youth will do fine regardless so they are no measure and those with intermediate problems are important but the real need is to succeed in reducing the frequency of problem behaviors in the small percentage of youth responsible for the majority of problem behaviors.

In order to achieve any success with this population, their environment needs to be sufficiently enriched to secure their participation. This is counterintuitive if coming at this from a correctional perspective where austere conditions for progressively longer periods are the consequence of dangerous behavior. But as noted in the 2013 Summary, punishment only is a weak change paradigm.

What is needed in terms of environmental enrichment is common sense. It includes the appearance of the units and the locations the youth access, noise control, the types of

recreational activities available (games, music, audiovisual), access to preferred settings/activities (e.g. relative privacy, the gym, sports, movies), food, living quarters, and personal possessions.

It also bears repeating that access to enriched settings must be contingent on the youth's behavior all through their time at DJJ. The challenge is to make meaningfully enriched environments available to behaviorally troubled youth early in their progress and yet have sufficient breadth of privileges and activities to provide yet more to those who have made substantial progress.

The points made regarding the limitations imposed by the physical plants available to DJJ remain applicable as well.

DJJ has made demonstrable progress in this regard. The development of resource rooms, lounges, the unit incentive rooms, and youth gardens are important and beneficial developments. The implementation of the incentive program and expansion of access to games and intramurals are also important and beneficial. Building access to these more formally into the Behavior Management System (BMS) is an important next step. It is essential that the youth recognize and experience that their efforts and progress are directly related to earning this access.

Despite the inherent limitations of the existing physical plants, DJJ has made improvements in the general appearance of the facilities including painting, addition of furniture, décor (including some done by youth) and general cleanliness.

Continued efforts in this regard are still necessary but there is clear progress here.

<u>Behavior Management System</u>

The BMS can be conceptualized as consisting of the DJJ-wide systems supporting behavioral change: Reinforcement System (RS), Youth Incentive Program (YIP), and Disciplinary Decision-Making System (DDMS). The RS has been the appropriate focus of the IBTM implementation process thus far. DJJ is actively in the process of developing a level system to replace the existing YIP which, if done effectively, will be a substantial improvement.

The RS has been implemented on all units and all are providing the daily reinforcement (generally, extra time in the dayroom in the evening). The weekly and monthly reinforcement is being done on some units but not others and fidelity to the RS for these components remains only fair at this point. There has been an increase in the number of checks being given but there continues to be a lack of positive checks being given for skill utilization. Nonetheless, the RS continues to have the desired effects of impacting youth behavior, improving youth/staff relationships, and focusing both staff and youth on positive behavior. As noted in the 2013 Summary, full fidelity will require full implementation of supervisor and psychology coaching. But it is important to assure that these individuals understand the RS and the importance of fidelity. Some supervisory staff are knowingly doing things differently than the RS intends

though it is important to say that this does not appear to be an effort to undermine the RS but either a lack of awareness of how it is intended to work or a personal belief that a different approach is preferable or safer.

The comments made in the 2013 Summary regarding the essential structure and components of the level system still apply. DJJ is moving in this direction. DJJ has chosen to robustly incorporate the RS into the level system. While conceptually reasonable, even desirable, it may be hard to put into effect to the degree planned. The approach being taken with DDMS is simpler and looks to be readily implementable. The one issue with regard to DDMS is that for the level system to be most effective, reductions in levels associated with DDMS cannot await a hearing on the DDMS. It is reasonable and entirely defensible to make the level reduction at the time the behavior is observed or detected and then to restore the level only if the youth has been found not to have emitted the relevant behavior. That said, it is vital to remember that it is the actual behavior of a particular youth that is of interest. Mere suspicion or allegation cannot be used as a reason for level reduction as this will undermine the fairness of the system and promote in appropriate accusation. Additionally, youth that engage in behavior that might lead to prosecution require special due process protections as well, though the ordinary criminal justice consequences of such behavior will often be sufficient to do the behavioral work, assuming there is an immediate response. One of the problems here is that some youth behavior that is potentially prosecutable is not referred for criminal charges, in which case the level system is the only and necessary vehicle for response. In cases where there may be or even is going to be charges filed, it may still be possible to incorporate a response into the level system in much the same way that those accused of crimes may be preventively detained prior to the determination of guilt. These matters will require thoughtful consideration in light of the need to balance the rights of the youth and the rights and interests of the state. But the essential point here is that to the maximum extent possible, immediate response to behaviors of interest is desirable in order to maximize the efficacy of the BMS. Excluding serious problem behavior from the BMS will undermine the BMS and the IBTM in general.

There remains work to do in order, as much as possible, to exhaustively incorporate all potential privileges into the level system.

It is essential that the level system mark mastery of skills in relevant domains and that progression corresponds to the process of change. Additionally, the level of mastery needs to correspond to the privileges acquired as privileges are also associated with increased risk, necessitating greater skill development to utilize the privileges safely.

<u>Case Plans</u>

The 2013 Summary comments regarding deficiencies in the Case Plans are still applicable. But as noted then, it was not time to address this. It is nearing that time now and DJJ has started to work on this with the development of documents and processes to specify the content of Case Plans and to support case planning.

There is an effort to bring psychologists more robustly into the case conceptualization process. This is a critical function and psychologists are well-trained in this area.

One barrier not well-described in the 2013 Summary is the process of the initial assessment and Initial Case Review. As designed, there is no mechanism to integrate the vast array of information collected during the assessment process and boil it down to a simple case conceptualization. As it stands, the information is collected on the intake unit and then handed off the to the Core or Specialty unit to integrate. This is not proving effective as there is no evidence that the subsequent Case Plans well incorporate this large body of data. It makes the most sense for those who collect the information to work together to come to an understanding of the youth's strengths and needs. As a simple example of this, psychologists do testing and interviews that are almost never incorporated into Case Plans.

The elements of the initial assessment have been simplified and streamlined to some extent but more may be possible here. , the complexity of the documentation during the assessment process may be a barrier to its effective utilization. In terms of the content itself, it is generally sufficient. The elements being done by psychology are sufficient and not excessive. The social and educational history is generally present, though not always as fully developed as would be helpful. Criminal history is a strength. But again, the biggest issue is that the material is not being distilled or summarized into a useful case formulation that youth and staff alike can readily understand and articulate.

Quality Assurance

Quality Assurance is a growing strength in DJJ. The mechanisms that have been put in place are effective in most cases and those planned address the most important areas of the IBTM, most notably case planning. As noted above, there is work to be done in terms of identifying staff in need of remediation or development of their group skills. The QA in place for assuring that groups are held and that the Program Service Day is fully developed and implemented are working well. The Use of Force QA mechanisms are proving very effective as well.

The importance of QA cannot be overemphasized. Next to a well-developed model, which the IBTM is, effective QA processes are the most important element of a system. They demonstrate whether the model is being implemented with fidelity which then allows the next, and more important function, quality improvement (QI). For once fidelity to the model is achieved, the effectiveness of the model can be measured and changes designed and implemented to address any deficiencies. This process then of course continues on ad infinitum. It is not excessively hyperbolic to say that once QA/QI is up and running effectively, the system will self-correct and outside monitoring becomes largely unnecessary.

Transfers

There has been some progress on transfers, specifically transfers out of the BTP units. These transfers are being done more and more on the basis of measures of behavior change and progress in skill development and are also being done more expeditiously when youth achieve established behavioral goals.

The process of transfer between core units remains murky, though such transfers are clearly occurring. As noted in the 2013 Summary, transfers between high core, low core, and BTP units should be handled much like a privilege. A transfer should be something that is earned – in either a positive or negative sense. In order to do this, it is important to have a formal process and formal criteria. These are being refined for the BTP but have yet to be developed for the core programs and, as of this point, the level system is not being designed to address this aspect of transfer.

While initial placement on a core unit is sensibly done by emphasizing static risk, with some discretion to deal with unusual circumstances, later moves should be based on treatment progression, essentially the reduction of dynamic risk which is intimately related to the case formulation. Put differently, the case formulation needs to point to the elements of risk that can be modified and then the case plan seeks to address these with specific goals and action steps. Transfer to a less restrictive setting is then predicated on behavioral change driven by achievement of these goals and measured by the level system.

Transfers into and out of the SBTP and mental health units is generally going smoothly. The process put in place with regard to contested mental health transfers, the Mental Health Roundtable, needs to be implemented as designed. While there are other ways to approach this, if DJJ has this mechanism in policy, it needs to be followed.

CONCLUSION

The IBTM is a central feature of the Farrell lawsuit. It represents a dramatic cultural shift for DJJ. This shift has progressed substantially in the last year. It is clearly not fully implemented or entrenched as a culture but at this point, back-sliding is becoming less of a risk, especially if DJJ continues on its current path and completes MI training, the BMS, and QA implementation.

Respectfully submitted,

Bruce C. Gage, M.D.
10/26/14

CHIEF JUSTICE EARL WARREN INSTITUTE, UNIVERSITY OF CALIFORNIA BERKELEY, LAW SCHOOL

Reforming the California Division of Juvenile Justice

Lessons Learned

Barry Krisberg Ph.D.
8/15/2014

Reforming the Division of Juvenile Justice: Lessons Learned

Barry Krisberg Ph.D.[1]

1. Context and Purpose of this Study

The state youth corrections facilities, known as the California Youth Authority (CYA), were once regarded as the pinnacle of enlightened juvenile justice practice in decades of the 1960s and 1970s.[2] International travelers and practitioners from many US jurisdictions conducted site visits and attempted to adopt many California policies and practices. The CYA was particularly prized for its innovations in offender classification, therapeutic innovations, and its commitment to the use of community-based corrections programs. While all was not perfect in the CYA, its operations were superior to those in most other states.[3]

In the 1980s the political environment changed and became focused on increasing punishment to deter juvenile offenders. The CYA budget for treatment and rehabilitation was reduced and there was a deliberate effort to make the conditions of confinement harsher. Also, cutbacks in community alternatives led to a large increase in the confined population in CYA. By 1995 the population of CYA facilities exceeded 10,000 youth. Lengths of stay for incarcerated youth were also increasing and a larger proportion of parole violators were sent back to CYA facilities. Governor Schwarzenegger merged the CYA under the umbrella of the state prison system, renaming it the Division of Juvenile Justice (DJJ).[4]

For nearly 20 years the CYA, now renamed as the Division of Juvenile Justice (DJJ), experienced a steady decline in its treatment and rehabilitation programs and a serious deterioration in how its youth were cared for and managed. In the first decade of the 21st century, there were a series of suicides in DJJ facilities and well publicized media accounts of severe crowding, high levels of violence, and extensive use of solitary confinement and practices of holding some youth in cages not fit for zoo animals as part of their education program. A video that allegedly

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[2] Throughout this paper we will refer to the California Youth Authority and the Division of Juvenile Justice. These different names refer to the same state agency at various points in time. Also, the name of the consent decree changed over time to recognize the new directors of DJJ as the defendant. Originally it was referred to Farrell vs Harper and today it is known as Farrell vs Beard.

[3] Barry Krisberg, **Juvenile Justice: Redeeming Our Children,** Thousand Oaks, CA: Sage Publications, 2005

[4] Barry Krisberg, Lihn Vuong, Christopher Hartney and Susan Marchionna, **A New Era in California Juvenile Justice; Downsizing the Youth Corrections System**, Berkeley Ca: The National Council on Crime and Delinquency and the Berkeley Center for Criminal Justice, University of California, Berkeley Law School, 2010.

showed several DJJ employees beating a young resident was published on the Internet and made almost all the national television network news outlets.

Recidivism rates for youth leaving DJJ facilities were among the worst in the Nation. Some in the legislature called for the abolition of DJJ or at least a halt to new admissions. In 2003 The Prison Law Office and the prestigious corporate law firm of Latham Watkins filed class action lawsuits against DJJ. The California Attorney General Bill Lockyer and the then California Youth Authority ordered an exhaustive investigation led by a panel of juvenile justice experts. This 2003 review found that the DJJ was violating many state and federal laws and engaging in serious violations of the US Constitution.[5] Based on these findings, Governor Schwarzenegger agreed in 2004 to a settlement of a lawsuit that is today known as Farrell v. Beard. This consent decree is one of the most far reaching remedial plans in American juvenile justice history. [6]

Here is when the downward spiral of California youth facilities began to slowly change. The Legislature appropriated a significant amount of funding to remedy some of the critical staffing shortages and several new laws were enacted to limit the types of youth who could be sent to DJJ.[7] New leadership was recruited to lead the reforms.

As of July 2014, the DJJ has met virtually all of the requirements and the outside monitors have agreed that the DJJ is in substantial compliance with issues in the areas of Safety and Welfare of youth, Health and Dental Care, Education, Disability Rights and effective programs for Sex Offenders. While not completed, the DJJ has made major improvements in Mental Health diagnoses and treatment. It is expected that these areas will be completed within the next 18 months.

Even more remarkably, the DJJ population fell below 680 youth in 2013[8]. The legislature enacted several laws that encourage the counties to hold non-violent, non sex offenders in local programs. Parole violators, once about half of the CYA institutional population, are now also managed at the county level. Localities receive approximately $120 million annually to provide services for these youth. The DJJ closed 8 institutions and 5 camp programs. This decarceration effort is the largest one ever in the history of the juvenile justice system.[9] And, despite predictions of "doom and gloom" by many law enforcement officials, the juvenile and young adult arrest rate has continued to decline and there is no evidence that more young

[5] The complete set of reports that were filed by the experts is available via the Prison Law Office (www.prisonlaw.com)
[6] Prison Law Office (www.prisonlaw.com)
[7] Sue Burrell, "The Legislature's Role in Juvenile Justice Reform: A California Example**", NCCD BLOG**, Oakland CA: NCCD, April 7, 2014.
[8] Nancy Campbell and Associates, **Office of Special Master Report #29**, Sacramento, CA: The California Department of Corrections and Rehabilitation, 2014.
[9] Krisberg, Vuong, Hartney, and Marchionna. op cit., 2010.

people are being sent to adult prisons or jails, or being housed in county detention centers due to the decarceration at the state youth facilities.[10]

The goal of this paper is to understand the key elements of this remarkable success story. The story is not well known outside the DJJ and the people involved in the Farrell consent decree. Lessons learned are highly relevant to the future of other juvenile corrections systems and for adult corrections as well.

While not perfect, the current DJJ is one of the most progressive juvenile corrections systems in the Nation. The DJJ today offers many very valuable policies and processes that could well benefit other jurisdictions. This report attempts to understand the people and the methods that produced this extraordinary step forward in the enlightened treatment of troubled and troublesome young people.

2. Study Methods

To complete this study I reviewed the original CYA consent decree materials as well as the remedial plans submitted by DJJ. I had access to all of compliance reports developed by the various experts that were appointed by the court in the Farrell consent decree. These generally included comprehensive summaries that each of the experts produced at year-end for the period 2009-2013. Most important, I could rely on excellent reports on the progress of the remedial plans that were submitted by the Office of the Special Master (OSM). I had in depth discussions with the OSM Nancy Campbell and the Deputy OSM John Chen. [11]

I conducted far ranging interviews with the principal plaintiffs' attorneys Donald Specter and Sara Norman of the Prison Law Office as with Van Kamberian who represented the defendants in the Farrell case.

I developed a very brief questionnaire about the reform process and conducted 30-45 minute phone interviews with many of the Court experts and with virtually every DJJ manager that worked on Farrell remedial plans. I was able to have detailed conversations with the superintendents of all the remaining DJJ facilities. I asked each of these knowledgeable interviewees to reflect on the largest challenges faced by DJJ and their view of major accomplishments. I asked the interviewees to discuss their perspectives on the "unfinished agenda" of reform, the keys to successes. We also discussed remedial strategies that did not yield the expected positive results.

[10] Krisberg , Vuong, Hartney and Marchionna.,, op cit., 2010

[11] All of these materials are available from the Prison Law Office (www.prisonlaw.com) or the California Department of Corrections and Rehabilitation (www.cdcr.ca.gov).

Each of the interviewees was asked to identify other people to be interviewed. In all, I talked with over 50 DJJ and Farrell case insiders. I also reached out to a number of outside youth advocates who had closely followed the DJJ reforms. While I have tried to faithfully reflect these staff, advocates' and management perspectives, I assume the ultimate responsibility for all of the observations and opinions in this report.

While I briefly examined the dynamics of reform in each of the remedial areas, I focused primarily of the major elements of the Safety and Welfare plan with which I had direct familiarity.

In the course of my several site visits to DJJ institutions, I conducted over one hundred interviews with youth residents and staff. These interviews were conducted under strict requirements of confidentiality and privacy. These first hand viewpoints were partially summarized in prior reports written for the court. [12]

I had total access to DJJ data on incident reports, youth grievances and UOF (UOF) reviews. Each month I participated in a multi-disciplinary staff task force that review a cross section of UOF reports, including staff behavior reports about youth, and the case plans and case notes on individual youth. The DJJ allowed me complete access to any information that I requested and respected my request to preserve the confidentiality of the youthful residents. I visited the DJJ facilities many times over the past 10 years and have enjoyed open access to all living units and staff in DJJ.

To place these observations within a broader policy context, I reviewed excellent case studies that were conducted in other state juvenile facilities in Arizona, Massachusetts, Missouri and New York. These were all states that made major strides in correcting legal deficiencies and implementing evidence-based policies and practices. The findings of these case studies will be compared with the DJJ findings.

3. What were the most difficult challenges facing DJJ?

The state facilities faced significant crowding. Even as the population declined from its peak of over 10,000 youth residents in the late 1990s, many living units were still jammed with youth with often more than 65-70 young people in a unit. Custody staffing levels were inefficient and personnel to deliver core services were inadequate. Further, the CDCR possessed byzantine and

[12] Barry Krisberg**,** "The Long and Winding Road: Juvenile Corrections Reform in CA", **Chuo University Law** Review, May 2011; Barry Krisberg, "Reforming the California Division of Juvenile Justice: What is the End Game?" **Federal Sentencing Reporter**, Volume 25:pp.281-285, 2013; and, Barry Krisberg**, Farrell vs. Beard: Final Comprehensive Report on Safety and Welfare,** Berkeley, CA: Chief Justice Earl Warren Institute, University of California, Berkeley Law School, 2013.

time-consuming policies to evaluate and sanction staff engaging in serious misconduct. Abuses in workman's compensation and leave practices reduced the actual number of staff that showed up at work to supervise the youth.

Crowding was exacerbated by the closures of some DJJ facilities due to the crumbling infrastructure and the expense of fixing the electrical, sewage, and plumbing systems in these older facilities. Other facilities were shut down for a variety of other reasons including media accounts of abusive practices, and riots and fires that destroyed several older living units. There were consistent budget pressures by the Department of Finance and the Legislature to reduce the costs of the system. Within a few years the DJJ closed 8 major institutions and 5 camp programs. Despite CDCR plans to "re-purpose" these closed institutions, most have remained shuttered or were torn down. Budget cutbacks led to the closure of many vocational and education programs. Even recreation offerings were shrunk. Medical, dental and mental health services were not well funded and reentry or parole resources were disappearing. Staff morale was very poor.

Annual costs per youth had risen seven-fold in the early 2000s due to new union contracts that included significant salary and benefit increases. There were also added overhead costs created by the oversight of the Department of Corrections and Rehabilitation. The substantially enhanced health care, education and treatment services that were mandated by the legal challenges pushed up the costs of DJJ operations. As the resident population declined, DJJ was unable to shrink its Headquarters staffing and costs to match the smaller system. All of these factors made the per youth costs climb.

For several years DJJ staff had embraced the professional orientation of adult corrections officers. To justify increased pay for its members to the level of state police officers, the DJJ union leaders asserted that youth facilities were as dangerous as the state prisons and constituted "the toughest beat in the state". The conventional corrections mentality was to confront, contain and punish misconduct by the young residents. While there were many staff interested in delivering rehabilitation programming, these employees were not supported by management for many years. In almost all aspects of DJJ daily activities, security and custody were the overriding considerations. DJJ lacked written policies in many crucial areas, leaving staff to make snap judgments on how to handle many complex and threatening situations. The Division was operated with very informal management methods, Programs and services were not routinely monitored or evaluated by DJJ leaders. Anecdotes, not reliable information, drove facility and Headquarters decision making.

There was a major problem of violence in DJJ facilities. Frequent numbers of fights, staff assaults, facility lockdowns and group disturbances became the daily norm. Fear of out-of-control violence led staff to rely excessively on mechanical and chemical restraints to control

the perceived chaos in the living units. The use of solitary confinement and youth locked in their cells 23 hours a day grew. As noted earlier, there was a rash of attempted and completed suicides.[13]

The totality of the facts listed above eroded support for the DJJ among juvenile justice professionals, youth advocates, elected officials, the media, and the public at large. There were questions about how long the state should continue to operate corrections programs for youthful offenders. The largest challenge faced by DJJ managers was to somehow restore confidence that the organization could operate in a professional and effective manner. The steady barrage of criticism of the DJJ in a variety of public forums created bitterness and a sense of impending loss of jobs among virtually all DJJ direct care staff and managers. Over the many years of steady decline, the DJJ suffered from inconsistent and ever changing leadership. Since 1980 there had been more than 20 directors and acting directors of the agency and several of these political appointments lacked apparent qualifications and training to run a major youth corrections agency. In an era dominated by the rhetoric of "getting tough on crime", Governors generally preferred candidates with law enforcement backgrounds and histories of political party loyalty.

Another dilemma was that DJJ became more and more isolated from juvenile justice professionals at the county level and with those from other states. DJJ managers stopped attending national conferences of juvenile justice professionals. The internationally renowned CYA research division was gutted. Very little research and evaluation was being conducted and the DJJ was not especially welcoming to university-based researchers. DJJ leaders were not exposed to the emerging research on evidence-based programming. Moreover, there was great resistance in the agency to learning about alternative approaches that were being implemented in states such as Missouri, Oregon, Colorado or Washington State.

4. Significant Reform Accomplishments

The DJJ has met or exceeded the mandated reforms that were listed in the Farrell consent decree in most areas involving dental and medical health care, sex offender treatment programs and general and special education issues. There is substantial compliance with the dictates of the remedial plans in the areas of the care of disabled youth and in most of the safety and welfare issues. There are only a few outstanding matters in these last two remedial areas that are being monitored by the OSM.

[13] Barry Krisberg, **General Corrections Review of the California Youth Authority,** Oakland Ca; NCCD, December, 23, 2003 and Steve White, **Review of the Temporary Detention (23-and-1) Program at Six California Tooth Authority Corrections Facilities,** Sacramento, CA: Office of Inspector General, December 18. 2000.

Reforms in the Mental Health domain were last to really get going at DJJ but the Court Expert Bruce Gage has noted that substantial progress is being made and that DJJ was almost halfway through to full compliance with the required Mental Health remedial tasks.

Most dramatically, the youth population of the DJJ has been reduced by over 90% from when the initial Farrell case was filed. Today there are less than 700 youth confined in DJJ's three institutions and one camp program. This number includes about 140 youngsters who were sentenced as adults and may be transferred to CDCR when they become 18 years old.

As noted earlier, many obsolete DJJ facilities have been closed and the remaining living units are all well below the Farrell goals of 32 youth in a living unit and 16 youth per wing. While staffing at Headquarters and some facility administrative staff have been modestly reduced, the ratio of direct care staff to youth is quite impressive. Staffing ratios have also been improved for teachers, health care professionals and mental health professionals.

Many of these reductions in the youth population and staffing enhancements were produced via legislative actions and consistent support of DJJ budget requests from the Governor's Office and Senate and Assembly Budget Committees.

Reducing policies and practices harming youth

As noted earlier, the alleviation of crowding and the implementation of more appropriate staffing levels produced a significant decline in violent incidents in terms of youth-on-youth assaults, staff assaults, and group disturbances. Reducing violence and fear at DJJ facilities is at the core of the Farrell remedial plans. These drops in violence were most pronounced at the OHCYCF but also were observed at the NACYCF. Violence reductions took longer to manifest at the VYCF which was the most troubled of all the DJJ facilities for the past several years. But in the first half of 2014, Ventura recorded lower levels of violence than in previous periods. And it appears that more improvements could be expected in the near future.[14]

Reductions on youth violence were also accompanied by a number of very positive outcomes. The frequency of the UOF went down significantly at OHCYCF and NACYCF. There was also progress on this issue at the VYCF. For example, the rate of UOF incidents at Ventura dropped from a high of .73 per 100 days of youth confinement in May 2013 to .48 per 100 days of youth confinement in May of 2014.[15]

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[14] Detailed evidence for much of what is reported in this section can be found in Barry Krisberg, **Farrell vs. Beard: Final Comprehensive Report on Safety and Welfare,** Berkeley, CA: Chief Justice Earl Warren Institute, University of California, Berkeley Law School, 2013 and Nancy Campbell and Associates, **Office of Special Master Report #29,** Sacramento, CA: CDCR, 2014

[15] DJJ, Farrell vs. Beard Consent Decree Dashboard, July 2014.

DJJ developed a set of comprehensive policies designed to limit the UOF and to encourage staff to deescalate the response to youth behavior. Direct line staff received increased training in conflict resolution and safe intervention approaches. The use of chemical restraints has not been completely eliminated but its use is way down in mental health units and in cases involving single youth that do not involve assaults of other youth or staff.[16]

DJJ developed a regular format by which each facility reviews its major UOF incidents on a monthly basis. These reviews are conducted by a multidisciplinary team at the facility and cover topics such as staff compliance with formal policies, the completeness and accuracy of UOF incident reporting, and whether there may have been more appropriate responses to the circumstances that led to the UOF. Where indicated, these reviews lead to internal investigations and/or mandated additional training and close supervision for the involved staff.

Security managers are required to examine whether the UOF was the least amount required to protect the safety and security of the youth and staff. The review must consider the disability status of the youth and if the ADA requirements were followed. The timeliness and adequacy of the medical staff's response to UOF events is also evaluated.

At DJJ Headquarters, an interdisciplinary team of managers, the Deputy OSM and the Court expert on Safety and Welfare convene monthly to examine a sample of the UOF cases at every facility. This Headquarters team assesses the adequacy of the facility-level review process and makes recommendation for further actions as required. The Headquarters team, chaired by the Deputy Director of DJJ, produces a memorandum to each facility on needed corrective actions. Also examined are case notes produced after the event to provide greater insight into causes of UOF incidents and guidance on how to prevent reoccurrences of these events in the future.

The UOF review process evolved from the recommendations of a staff and management task force designed to reduce UOF especially for youth with disabilities. That task force reviewed scores of UOF reports and found that past practices were inadequate. The new guidelines to review UOF were vetted by the OSM, the Court experts for S&W and Mental Health and the plaintiffs' and defendants' attorneys. The resultant UOF scrutiny is comprehensive and thorough. Few if any juvenile corrections systems across the Nation have a comparable UOF review process. No such careful UOF examinations are routinized in most California county facilities. One exception is LA County that was subject to a major US DOJ lawsuit.

There have been significant reductions in the reliance on solitary confinement in DJJ since 2005. The older and discredited policy and practice of confining youth in a lockup unit for 23 hours a day with minimal services is gone. In its place, the DJJ has developed a range of options that constitute a short term limitation on the program of youth who are in some kind of crisis and

[16] Barry Krisberg, 2013 op city and Nancy Campbell and Associates, 2014, op cit.

who may be a danger to themselves or others. These alternatives include a very short term "cool down period in the youngster's room (or in a separate room in those few remaining dormitory units. Another option for staff is to utilize "room confinement" in which the youth stays in their own room, usually for less than a day. Youth needing more specialized attention are managed in the Treatment Intervention Program (TIP) that is designed to last only a few days.

Data on TIP for June 2014 revealed that more than half of the youngsters assigned to this program were returned to regular programs within one day and only 18% were in TIP for more than 3 days. Most important, the TIP program includes educational services, mental health services and is designed to return youth back to their regular programs as soon as possible. The goal of TIP is not punishment, but closely monitored separation for a very short duration to assist the youth to return to a more appropriate program placement and treatment services. These limited program options permitted DJJ to eliminate Temporary Detention that had been a regular feature of past DJJ practice. Further, these programs rely on delivery of counseling and mental health interventions, not depravation of basic services. Youth in TIP generally spend a large number of waking hours out of their rooms and engaged in education, recreation and other positive activities. This approach is consistent with the best professional thinking and the growing literature on the harm to adolescents of extreme isolation.[17]

The most restrictive level of limited programming is the Behavioral Treatment Program (BTP). These youth have engaged in repeated and very serious disciplinary infractions. The BTP program had 65 youngsters assigned to it in June 2014. The 22 youth in the OHCYCF BTP stayed an average of 37 days. At NACYCF there were 15 residents of the BTP, who stayed an average of 106 days and at VYCF there were 28 youth who stayed an average of 106 days. These average lengths of stay figures are greatly affected by a very small number of young people who might remain in the BTP for a very long period. More typical BTP assignments are for less than two months.

Before the Farrell reforms took hold, the DJJ lockup units had as many as 400 youth on any given day and the length of stay was at least 270 days. In the "bad old days" the lockup units included a wide range of youth who had engaged in serious assaults, had defied staff orders, evidenced severe mental health issues, or were in the lockup unit in protective custody. The BTP is now almost reserved exclusively for very assaultive young people and the DJJ uses its

[17] Paul Demuro, **Toward Abolishing the Use of Disciplinary Isolation in Juvenile Justice Institutions: Some Initial Ideas,** Wilmington, North Carolina, January 22, 2014.

other programming options for other young people who may need temporary separation from their regular living units.

Youth in the BTPs spend most of their waking hours outside their rooms, receiving a full range of education and treatment services. The BTP staff assist the youth to gradually reenter their regular housing units through a phased process of helping the youth increase their personal skills to manage and defuse potential violent situations.

The BTPs are still evolving as a program model. In the early days of the BTPs, these units closely resembled the old 23- and - I units– with extensive use by staff of mechanical and chemical restraints that were employed on a routine basis. As staff on the BTP units received more training and coaching in the new model, the conditions and treatment of the young people in the BTPs markedly improved.

DJJ introduced more services, counseling and groups in the BTP units that focused on cognitive behavioral skills, anger management and preparation for community reentry. Staff assigned to the BTPs have embraced its new philosophy of increasing mental health services, improving youth communication and conflict resolution skills, and providing opportunities for vocational and educational achievements.

Idleness was a big issue at DJJ in the early days of the Farrell case. Youth spent many hours in their rooms or in living unit day rooms. School was often cancelled due to lack of teaching staff. Vocational programs and post-secondary classes, once a strong point in CYA facilities, had all but disappeared. Recreational programming was minimal and art and music offerings had all but disappeared. Religious services were under staffed and underfunded. Library resources were poorly organized and not very accessible to the youth. Almost all the young people wanted work assignments but unemployment in DJJ was epidemic and chronic.

The Farrell experts believed that idleness was a major contributor to violence and other serious misbehavior among DJJ residents. DJJ staff also clamored for more activities to keep the young people positively engaged and motivated to succeed. One important component that cut across most of the Farrell Remedial plans was to establish a target of the number of waking hours that youth would be expected to be involved in positive, prosocial activities. Next it was vital to develop a Program Service Day (PSD) for each living unit that would organize the various services, allowing education, counseling, groups, recreation and health care staff to get work assignments completed. Staff struggled over the reconciliation of the different work schedules of differing kinds of DJJ personnel. Management decided to assert the primacy of education services, but insisted that adequate time be devoted to other youth needs. It took some time to develop the Program Service Days and to train staff on the necessity of actually following the schedules. The DJJ was also able to make use of a newly completed automated information

system to ensure that the PSD guidelines were being followed – or that impediments to offering the PSD were identified and removed. The PSD was commenced on a pilot basis, but it was eventually adapted and expanded to all DJJ living units. Staff and youth expressed strong support for the predictability and daily structure that resulted from the PSD.

The implementation of the PSD was indicative of a decisive move by DJJ managers to upgrade and improve virtually all of the agencies policies and procedures. Prior to the Farrell litigation, there were inconsistent and uneven practices between the facilities and within living units at the same facility. Staff were legitimately confused as to what would be expected of them in a multitude of areas. For a major state bureaucracy, it was unusual that the DJJ ran so informally, with little documentation or accountability. When problems would arise, staff were uncertain if they would be blamed for untoward outcomes. DJJ managers and direct care staff became increasingly "risk averse" and thus limited the nature and extent of youth opportunities that could be put in place. Youth interpreted the lack of consistency by staff as prejudice or bias, and they perceived staff reluctance to try new activities as indicative of a general lack of regard for their well-being. If there were rules, no one seemed to know what they were.

In all the DJJ developed or refreshed nearly 800 operational policies and procedures. Rewriting policies encouraged different disciplines to work together and for facility managers to weigh in on particularizing the agency-wide policies for their facilities. The revised policies were closely vetted by the Court experts and the Plaintiffs' counsel. The updated policies were designed to be consistent with federal and state legal requirements, and the policy teams looked to best practices identified in the juvenile justice literature. The DJJ policy development team surveyed several other states for advice and copies of existing policies. Union representatives were included in these discussions through a "meet and confer" process, but did not possess veto power on the central elements of the policies. Once the policies were approved by top DJJ management, the agency mapped out a deliberate strategy to train all of those who needed to understand and implement the new policies. In a sense, this process led to a fundamental reinvention of the DJJ that was consistent with its new mission to be a place of high quality evidence-based services for troubled youth.

Expanding and enhancing treatment and rehabilitation services

The transitions at the DJJ are all examples of the efforts to counteract or eliminate ineffective and harmful methods to influence youth behavior. However, of equal importance were major strides forward towards enhancing the positive interventions with DJJ youngsters. There have been substantial upgrades in the quality and quantity of resources devoted to health care, mental health services, and support of youth with disabilities and educational and special education programming. As part of the Farrell consent decree, the DJJ committed to constructing and implementing a model treatment program. While this objective was very

ambitious, and very few states offer good prototypes of model treatment systems, the DJJ made an unequivocal commitment to offering high quality evidence-based rehabilitation services in a planned and systematic manner.

DJJ managers visited other juvenile corrections systems in Washington, Colorado and Missouri to learn from the treatment approaches in these jurisdictions. The decision was made to develop an Integrated Behavior Treatment Model (IBTM) that was tailored to the unique attributes of youth and to other localized factors including the length of stay, the influence of gangs in DJJ, the shared responsibility with counties, and the larger size of California facilities. The Court experts worked closely with DJJ managers as well as consultants from Orbis Associates, faculty at the University of California campuses at Davis and Irvine, and the University of Cincinnati to build the IBTM. Representatives of the Prison Law Office were intimately involved in the review and definition of the new IBTM.

The first important element of the IBTM was to implement a validated risk and needs assessment system to inform case plans. Next, DJJ staff needed to develop a comprehensive case management process and train those staff that would fulfill this function. The case planning process would logically lead to DJJ youngsters being assigned to evidence-based interventions, both group sessions and one-on-one counselling. The IBTM envisioned that case plans would be updated at a regular interval and would help support subsequent reentry planning.

Another critical element of the IBTM were clear policies to respond to youth conduct with both appropriate negative sanctions and a system of positive incentives or rewards for youth who were actively participating in rehabilitation and educational programming. The older behavior management system was “all sticks and few carrots”. Staff needed to embrace a different viewpoint that valued positive reinforcements for youth rather than the routine reliance on punishment and deprivation of basic services. The theory of the IBTM envisioned youth going through a series of stages as they progressed towards returning to their communities. Staff at several facilities started up incentive programs that encouraged young people to strive for prosocial behavior and attitudes.

The IBTM was a giant step forward for the DJJ which had not stayed current with the latest research and evidence on what worked to reform chronic and violent youthful offenders. However, it was not enough to just have a set of written policies that articulated the goal and objectives of the IBTM. It was imperative that the leadership of the DJJ, the facility superintendents, the middle managers and direct care staff needed to understand and embrace the new approach. High quality training was required for all staff in many areas that were essential to the success of the IBTM. Further, the IBTM needed clear metrics so that managers and the Farrell and internal monitors could assess progress of individual youth, of particular

living units, and of facilities. Staff buy-in and willingness to try new interventions were very important. Cynicism and poor staff morale had to be overcome if the new IBTM was to live.

The evolution of the IBTM was a very difficult and time consuming struggle that surfaced fundamental issues of trust and cooperation among various DJJ staff. There were myriads of concrete policy decisions that had to be made after appropriate staff input. For several months the IBTM was more a "paper tiger" than a real reform, although that situation changed. The DJJ needed to reevaluate staffing needs to make the IBTM a reality and all levels of personnel from youth corrections officers, to counselors, mental health professionals and administrative and support personnel needed to prepare for changed job descriptions and changing work relationships. More will be said later about the strategies employed by the DJJ to move the IBMT from theory to reality and the continuing challenges to fully actualizing the IBTM.

Part of the IBTM was a significant upgrading of the treatment services available to youngsters. In the past, a very large number of rehabilitation programs would be started and ended without a thorough analysis of whether these efforts were successful. Individual staff would start up groups and introduce treatment curriculum, but these were delivered on an erratic basis. Programs were often responsive to various fads like "tough love, "the inner wounded child", "scared straight" and "correctional boot camps" or to outside vendors who sought to sell curriculum materials to the DJJ. There were many discrete programs tried but no evidence that any one of these interventions had the proper "dosage" to produce positive outcomes. No one seemed interested in whether the young people found value in these programs. Too often "treatment" meant sitting in your room for hours and filling out a workbook that might be looked at some point by staff.

One of the most significant positive reforms was that DJJ chose to implement a limited set of interventions that possessed very strong research support. Moreover, the unproven efforts were gradually phased out. Consultants, especially from the University of Cincinnati helped DJJ staff focus on fidelity to the details of the treatment models. A process of ongoing assessment of the selected treatment programs was instituted. Most important, treatment became more interactive and allowed for greater communication and connections among DJJ young people and staff.

Another area of very encouraging reform was improvement of DJJ processes to protect youth rights. Placing great value on fairness in dealing with youth was a vital part of the Farrell consent agreement. Upgrading protections for youth are very important to the overall treatment mission and caused a fundamental shift in staff culture.

DJJ rewrote the Youth Rights Manual and paid special attention to the needs of youngsters with disabilities, eventually the DJJ labored to make sure that the written products were "user

friendly" and available to the youngsters on their living units. Another major area of improvement was a refinement and clarification to the due process afforded to youth at disciplinary hearings and in determinations about program alterations, especially the process that assigned youth to BTPs and other limited programming units. DJJ also developed clear and consistent criteria and a thoughtful process to decide whether youngsters committing very serious infractions should be subject to criminal charges.

At the beginning of the Farrell case, the grievance and complaint process for youth was completely dysfunctional. In the 1970s, California was recognized as a national leader in advancing the appropriate youth rights. Federal legislation such as the Civil Rights of Institutionalized Persons Act (CRIPA) was strongly influenced by many policies and practices of the California Youth Authority.

The DJJ revamped the entire grievance process and retrained staff in new procedures. There were also several external and internal audits of the grievance system that led to further refinements. Over time, the number of youth grievances declined precipitously and the remaining youth complaints were being handled in a timely manner. Problems of staff manipulation of the grievance process were curtailed and youth and staff were encouraged to resolve minor issues on an informal basis so as to build more trust between them.

Prominently displayed in every living unit was basic information about the grievance process, access to the Ombudsperson, opportunities for religious services and timely access to health care. DJJ eventually agreed to provide more opportunities for its youth to regularly confer with lawyers and community youth advocates. Youngsters were given briefings about the impact of federal laws such as the Americans with Disability Act (ADA), the Individuals with Disabilities Education Act (IDEA) and the Prison Rape Elimination Act (PREA). The Youth were also informed about the requirement of the Farrell consent decree. Staff also received this training and they were sensitized to the renewed and enhanced DJJ focus of fairness and consistency in its dealing with youngsters and with their families. Discussions of these issues were often integrated into the large groups held in the living units each morning. Not surprisingly some staff objected to the heightened attention to youth rights, but their opposition diminished over time. The role of top leadership in explicitly supporting the renewed direction on youth rights was crucial.

The Farrell consent decree placed a strong emphasis on involving families in the care and rehabilitation of DJJ youth. Support for this idea had been traditionally limited among DJJ managers and staff, although there were some superintendents that pushed this concept. Many staff assumed that the youth suffered from the abuse and criminal activities of their parents and guardians, so greater involvement with "negative" adults made no sense them.

Over time with training and coaching, this anti-family bias was greatly diminished. Each facility assigned a person to be the family involvement coordinator, the number of visiting hours was expanded and visiting times were lengthened .The DJJ even experimented with video conferencing to help youth keep in contact with parents and guardians who lived very far from the institutions. Each facility began organizing family days for those youth who were doing the best in their education and programming. The family days often involved special activities that allowed the youth and their families to enjoy more normalized interactions. The visiting rooms were redecorated to minimize the jail-like atmosphere of the institutions and to create a welcoming environment. Staff were asked to attend the family days so that they could give the parents an update on how their child was progressing. The DJJ tracked the visiting process and tried to remove barriers to youngsters who wanted to connect with their families.

The DJJ has made impressive progress in implementing a new reentry process for its youth. The best research makes clear that quality reentry planning and support are closely linked to reducing recidivism. Historically DJJ had a Parole Division that was responsible for youth who exited its facilities. In 2010 the Legislature eliminated parole services within the DJJ and transferred this responsibility to the counties. Under SB 1628, the DJJ discharges youth back to the county of commitment. While the state gives localities some funding for the aftercare function, it is less than was previously allocated to DJJ parole, and counties were given little or no direction on how to best organize aftercare programs. There were numerous reports of prior DJJ youngsters who were homeless, unemployed or drifting without assistance. Former DJJ young people who needed medical care, especially medication, found these services difficult to obtain.

Staff with DJJ decided to “step into the gap” by designing an internally delivered reentry and aftercare program, led by a designated reentry specialist at each DJJ facility. The protocol for this program is very detailed and comprehensive.

The reentry specialists help youth to prepare for their hearing before the Juvenile Parole Board and even invite the Parole Board Members to hold seminars for the youth on the release process. Each youth develops an individual aftercare plan with the assistance of the reentry specialist and this plan actively involves the youth’s family members when possible. The plan includes goals in the sectors of housing, education and employment as well as helps the youth to identify local resources to continue work on personal issues after release. Aftercare preparation also includes helping the youngsters obtain a valid driver’s license or ID, registering the young person to vote and signing them up for Social Security, State Disability and Unemployment benefits and the Covered California health program.

The reentry specialist works with the youth to help them to clear up outstanding legal challenges such as warrants, unpaid victim restitution or court costs, and ICE holds. Where

possible, The DJJ aftercare planning and actions are coordinated with county probation officials where the youth will eventually reside.

This aftercare work is very labor intensive and demands that the reentry specialists are committed to "go the extra mile" to make in person or phone contacts and to smooth the transition process as much as possible. The youth report that they greatly value these services and the net public benefits should be realized in terms of fewer young people being rearrested or incarcerated in the future.

5. The Unfinished Reform Agenda

Reforming the DJJ is very much a "work in progress". Many of the excellent changes discussed above are not finished, but are clearly headed in the right direction. More important, it was clear that virtually all of the top leadership, middle managers and a majority of the direct line staff have embraced this new direction for the DJJ.

The current DJJ staff that I interviewed said that they now realized that the reform process would never be completed. They reported that the agency was committed to a constant process of learning about the latest research and best practices, attempting to implement those new ideas, and measuring the results. Ongoing and expanded staff training was seen as a key agenda item for the future.

Other of my interviewees suggested that more progress needed to be achieved on reducing the negative influence of gangs in the DJJ. The DJJ is still in the very nascent stages of a revamped gang intervention model. There has been affirmative progress to improve mental health services but there was broad agreement that more progress was needed.

Several of those interviewed raised concerns about the old and crumbling facilities that were not designed to create a very effective treatment milieu. The "useful life" of the older places such as OHCYCF and VYCF was judged to be not very much longer. Few in the DJJ felt that there would be additional investments in the facilities by the Governor or the Legislature. The best guess is that the worst problems in the DJJ infrastructure would be repaired and efforts should be made to humanize the current facilities. It was hoped that future elected officials would tackle the replacement of the DJJ institutions. Many of those interviewed called for reducing the size of the living units even further than the Farrell limits and further enhancing the ratio of treatment staff to youth

The OSM and Court experts pointed to needed further reforms in the implementation of the IBTM. Training in all of the core ingredients of the IBTM still required a more diversified and intensive outreach to staff. In particular, it was noted that there was a need for the top managers to more fully understand the IBTM. There was support for the IBTM in theory but it

was felt that top leadership needed to increase their knowledge and ability to train and mentor others.

Some of the weakest links in the IBTM implementation process were needed improvements and simplification of the needs assessment process and improvements in staff ability to deliver high quality cognitive behavioral training and anger management groups.

A new substance abuse program was piloted from December 2012 to May 2013. In September 2013, the DJJ conducted training for trainers with staff who completed the pilot. The substance program was implemented statewide in December 2013, with the first cycle completed in June 2014.

Staff need more training in the operational details of the case management and better tracking of treatment resources for individual youth was needed. Several of those that I interviewed stressed the need for a better integration within the IBTM of counselors, educators and mental health staff. The incentive process and the reinforcement system have really just been launched and there is need for more practicing and adjustments of this core component of the IBTM. Some DJJ staff urged that there should be more opportunities created for youth to play positive leadership roles in a wide range of DJJ programs and services.

DJJ is making admirable steps forward to reintroduce reentry services and to better youth for successful return home. Reentry services must begin earlier in the DJJ process and be tightly connected to the IBTM. Some of my interviewees suggested that the length of stay in DJJ should be shortened further and that there is need for less secure housing options for those youngsters approaching release.

The OSM, the Plaintiffs' lawyers and most of the Court experts believe that the DJJ should further restrict and, perhaps, eliminate the use of chemical restraints – at least for the mentally ill youth or in single youth incidents that presented no imminent threats to the life and safety of youth and staff.

The youth advocates called for better access of the DJJ residents to legal advisors on the range of topics. They also called for continued improvements in the grievance process and the ability of young people to get their concerns heard and acted upon.

Moreover, most of the interviewees were concerned about sustaining the progress made in DJJ into the future. There were worries that future statewide elected officials would abandon the reforms based on public fears about youth crime and violence; what if youth arrests started to increase? It was also expressed that future state budget problems might put closing down the

DJJ back on the table. These DJJ close observers stressed the need for current leadership to aggressively broadcast the "good news story" about the DJJ changes.

Most of those that I spoke with urged that there be stronger coalitions established with county juvenile and criminal justice officials who should be very invested in the continuation of a successful state juvenile corrections agency. It was recommended that the DJJ could offer training and technical assistance to counties in effective policies and practices to treat and educate the most troubled young people. The media and civic groups should be cultivated as powerful allies of the DJJ. The research community should be encouraged to evaluate the effects of various aspects of the DJJ.

A different aspect of sustaining the reforms is to cultivate the next generation of DJJ leadership. Due to state personnel rules, many current DJJ leaders will retire in the next five years or less. DJJ needs to design and implement a process to identify the potential future facility and statewide leaders. There should be high quality training for this next generation of leaders in the latest research and also the best methods to institute and maintain progressive reforms. University-based programs in public policy and management should be asked to assist in this endeavor.

6. How the dramatic DJJ reforms were achieved?

"I get by with a little help from my friends"

Moving from the fairly objective recounting of what occurred, we redirect the narrative to the more subjective and judgmental analysis to identify what led to the successful transformation of DJJ. Reasonable and knowledgeable observers are likely to disagree about the right ingredients of the "reform stew". Interestingly, there was, in fact, remarkable consensus among the diverse interviewees that I polled as to what helped DJJ move from being one of the worst juvenile corrections agencies, to one of the better ones.

The push for major change in the DJJ came initially from a dedicated group of youth advocates who raised grave concerns about the decline of the California youth corrections system in the 1990s and the early years of the 21st Century. This group included organizations such as Books Not Bars, the Haywood Burns Institute, the Center on Juvenile and Criminal Justice, the Commonweal Institute, the National Council on Crime and Delinquency, the National Youth Law Center, the Youth Law Center, and the Youth Justice Institute. Relying on research and policy viewpoints from federal agencies and other states, these advocates documented the

deterioration of DJJ programs and services. Their vocal critiques of DJJ convinced many in the media and, more importantly, in the Legislature that urgent actions were required.

The calls for reform were mostly ignored by DJJ and the state youth agency hunkered down to defend its tenuous status quo. The proponents for reform pointed to very high rates of recidivism, the growing length of stay of DJJ youngsters that exceeded that of any other state, serious crowding, reports of high levels of institutional violence and the escalating costs of operating the state facilities. Because the advocates were given very limited access to DJJ facilities or data, they often relied on stories that were passed by former residents and by former staff of the state juvenile facilities.

In 2000 the newly established Office of the Inspector General (OIG) conducted a series of investigations of DJJ in the wake of a series of suicides and riots at several facilities. The OIG pointed to problems of rampant gang violence in the facilities, the prevalence of drugs and other contraband in the facilities, frequent use of solitary confinement and excessive UOF that bordered on torture of some DJJ youth. The OIG noted evidence of the breakdowns in health care, mental health and education services. These OIG reports received little immediate action by Governor Gray Davis but he did appoint new leadership for DJJ.

The Legislature under the guidance of Senator Gloria Romero held a series of high profile hearings based on the OIG reports. The United States Department of Justice Special Litigation Unit conducted a special inquiry into the treatment of youth at NACYCF.

Simultaneously the Youth Law Center filed successful lawsuits challenging the absence of adequate on-site health care services and major deficiencies in special education and the DJJ school programs. While these cases took years to resolve, the litigation opened up the agency to levels of outside scrutiny that was not previously possible. In 2003 the Prison Law Office (PLO) filed a comprehensive lawsuit covering virtually all aspects of the DJJ. The PLO had achieved great success in its challenges to the conditions of confinement in the state prisons and enjoyed strong credibility in the Governor's Office and the Attorney General's Office. The litigation was settled and the parties negotiated a detailed set of remedial plans and the Court appointed a Special Master and Court Experts to monitor the remedial agreements. Most of those interviewed for this paper asserted that the lawsuit was a necessary but not sufficient force for reform. These interviewees felt that meaningful reforms would have taken decades to achieve without the lawsuit. Further, the lawyers at the Prison Law Office were genuinely improving the lives of young people in the DJJ. They could navigate the delicate and complex role of lawyers for troubled youth –what national youth law expert Mark Soler referred to as being both "warriors and healers". The PLO was firm in its focus on implementing the Farrell orders, but they evidenced great flexibility and the ability to collaborate and compromise. PLO

attorneys Donald Specter and Sara Norman were “hands on” reformers who got to know and appreciate the staff and the youth in the DJJ.

The Farrell consent decree allowed the DJJ to request substantial additional funds from the Legislature at a time of overall state budget austerity. The consent decree established a clear structure that defined the outcomes to be achieved and timetables for progress. Moreover, the lawsuit resulted in a mechanism of outside accountability that included the Judge, who played a very active role in the case, the plaintiffs’ attorneys, the Special Master and the Court experts. These individuals conducted regular monitoring site visits to all DJJ facilities, assembled massive amounts of information about DJJ operations, and generated public reports on the evolving conditions of the state juvenile facilities.

For its part, the DJJ needed to create an internal cadre of managers that would track the reforms and generate internal and external assessments of progress. Attorneys for the parties, the OSM and the Court experts conferred on a weekly basis and there were settlement compliance conferences before the judge on a quarterly basis. These byproducts of the Farrell case created a new level of transparency and accountability that supported the change process. Reports authored by the OSM and the Court Experts, as well as Court hearings, were open to the public and generated additional media coverage about the conditions in DJJ and the challenges faced by its youthful residents.

The lawsuit also offered state officials political cover as they liberalized and humanized the conditions and programs within DJJ. The more conventional “tough on crime” voices were still powerful in DJJ, the media and the Legislature. However, the Farrell consent decree allowed the DJJ leadership to argue that they had no choice in the matter. While the initial reforms may have been based on the lawsuit, the current leadership and staff have shifted the perspective towards viewing these changes as the right thing to do to achieve better outcomes and to reduce recidivism for DJJ’s youth.

The Farrell consent decree introduced a set of nationally respected outsiders, including the OSM and the Court Experts, who offered their experience and knowledge of the latest research and professional opinions. Most important, DJJ did not have to search for a new mission and vision; the Farrell consent decree provided the basic framework for the organization. The challenge for the DJJ was to embrace that new philosophy at all levels of the organization and to give it life.

The Legislature and the Governor also played a major role in the DJJ reforms beyond providing additional funds. There were several major laws enacted that dramatically reduced the DJJ

population and ended the severe crowding.[18] These legislative actions diverted large numbers of youth, especially non-violent property and drug offenders and parole violators, to local programs and mandated the early discharge of some DJJ youth who had previously served their entire statutory time in DJJ facilities. Other new laws reduced the use of "time adds" by staff as punishment for youth and curbed some of the most arbitrary decisions by the Juvenile Parole Board. The upper range to which youth could be housed in DJJ was reduced from 25 to 23 years of age. Moreover, the Legislature granted substantial funding to counties to manage youth who were formerly sentenced to DJJ.[19] The most current research in the field of juvenile justice suggested that a smaller and better resourced DJJ would be less violence prone and produce better outcomes for youth.

The role of leadership of DJJ

The CYA had been fortunate from its very creation of having outstanding leadership. In particular the former head of California's juvenile corrections agency, Allen Breed, was regarded as an internationally celebrated expert on enlightened and progressive juvenile justice and corrections policy. But after Allen Breed was appointed by President Jimmy Carter to run the National Institute of Corrections, the leadership situation at CYA was never quite the same.

From 1980 to 2014, there had been almost 20 formally appointed directors or temporary heads of DJJ. Only a few of them had come up through the CYA agency structure and possessed even basic preparation for the job. The majority of those who joined the parade of DJJ leaders had backgrounds in policing and adult corrections. They were often outsiders that had to win support within the agency to accomplish their agendas. Few of them stayed around long enough to establish a sustained leadership style and direction. Most of the staff who observed this revolving door of directors, assumed that more changes were soon likely to occur and there was a reluctance to become too closely attached to the current office holder. The ever changing directorship reduced the clout and credibility of the DJJ director in the Department of Finance, the Legislature, or the broader juvenile justice professional world.

In 2010 CDCR Secretary Matthew Cate asked Michael Minor to assume the leadership of DJJ. Minor had already completed a long career and was eligible to retire. Director Minor had been promoted through various jobs as a Youth Corrections Officer and Youth Corrections Counselor and was Chief of Security at NACYCF during one of its most troubled periods. He also was

[18] Sue Burrell, "The Legislatures Role in Juvenile Justice Reform; A California Example" NCCD Blog, April 7, 2014.
[19] Sue Burrell op cit.

assigned to be the superintendent at several DJJ facilities, often after the major problems had overwhelmed others in leadership positions at those places. Immediately before being named Director of DJJ, Minor was in charge of all of the DJJ facilities in Northern California.

At the time of his interview with Secretary Cate, Michael Minor made clear that he did not want to take on the assignment to shut down the DJJ. He shared with the Secretary his support for the basic direction of the Farrell consent decree and that CDCR maintain the organization. Director Minor was assured that the goal was to make the DJJ a treatment model to be proud of, as well as working to close the lawsuit. At the end of a distinguished career in corrections, Minor said that he would rather "go fishing" than preside over a failed agency. He convinced staff that "on his watch" there would be no more facility closures and massive staff layoffs, factors that had created a sense of hopelessness among staff and fear of future uncertainty for DJJ youngsters.

While there are volumes written about the attributes in leadership in the public and private sector, there are a few major factors that are reiterated in these academic treatises.[20] Great leaders are not just good managers—they possess a vision of where they want to take the enterprise. Second, leaders inspire trust and confidence in those around them and they can clearly articulate their vision. Leaders are persuasive and can recruit others to their cause. Leaders know how to delegate authority and hold others accountable. In the words of President Ronald Reagan, they understand the dual principles of trust but verify.

Leaders are agile learners who quickly absorb and evaluate new information. True leaders understand that organizational success is not the product of the "great leader" but must be shared and celebrated with many employees. Most of all, leaders are persistent and possess patience. They understand that fundamental organizational transformations take time to realize and to be sustained. Great leaders take their work very seriously but are humble and can listen to criticism and disagreements without rancor. They are honest brokers who know how to achieve effective compromises among people who must work together to succeed.

Michael Minor possessed a natural instinct for almost all these traits of a great leader. He had honed these leadership skills in a career at the CYA and the DJJ. Moreover, he adapted his hands-on knowledge of the youngsters in the DJJ and its staff to forge his own responses to the implementation of the Farrell consent decree. He was a respected and experienced administrator who was immediately present at all of the DJJ facilities to meet with youth people and with employees to listen to their fears and concerns and hopes for the future.

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[20] Tom Peters and Robert H. Waterman**, In Search of Excellence, Lessons From America's Best Run Companies** New York City: Harper Collins 2006, and Phillip Selznick, **Leadership in Administration: A Sociological Interpretation,** Berkeley: UC Press, 1984.

The Court, the OSM and the Court experts applauded the selection of Minor as the DJJ's director. They respected his intelligence, sincerity and willingness to absorb new ideas. He was not wedded to the "way that we have always done things" mentality that had hamstrung the DJJ for several years after the Farrell remedial plans were approved by the Court. Minor was an excellent and skillful communicator who quickly established his bona fides in the Governor's Office, the Legislature and among important constituency groups. He projected a willingness to learn and to give a fair hearing to conflicting views – but he also was decisive and firm when critical decisions had to be made.

Virtually all of my interviewees gave ample credit to Minor for consolidating past successes and accelerating momentum going forward. Some of his management colleagues were careful not to diminish past DJJ leaders, but they were very clear that Minor made a big difference in the pace and intensity of the remedial plans.

Other strategies for making the Farrell remedial plans a reality

Central to Minor's leadership style was his ability to identify top managers from within the organization and permit them to translate the broad contours of reform into the discrete operational details of the facilities. Directors of the DJJ in the recent past had relied heavily on outside consultants and their colleagues from other states. Michael Minor focused his trust on small cadre of experienced insider staff that he had known over the years. These strategic staff middle managers brought with them detailed knowledge of how DJJ functioned on a daily operational basis. These management allies were generally supportive of the new reform direction, but could also politely confront the OSM and the Court experts if they believed that some of the new concepts were unworkable. Many of this core team had begun their careers at the DJJ as direct care workers as counselors or corrections officers. They were skillful at convincing the remaining direct care workers that the changed policies and practices would neither endanger the youth or their co-workers, and they were excellent at translating the general road map of the consent decree to specific implementation activities and systems. DJJ is a para-military structured bureaucracy and does best when the details are specified in advance and staff can rely on clearly defined processes and channels of authority to accomplish their tasks.

The new management staff created a strong sense of continuity and credibility of the reform agenda with the agency's past. They were trusted by fellow staff and could leverage longstanding positive work relationships to enlist others in their mission. They understood the daily challenges faced by the front line staff and could also anticipate problems. It was very helpful to have a core group of top staff that possessed extensive experience in basic details

such as budget development, procurement of needed services, hiring, union requirements and personnel rules.

Virtually all of my interviewees from within DJJ placed great value on the expertise and skill of this new management team. This group was credited with accelerating the pace of reform and winning over other DJJ staff to the changes. This group was the central strategy by in which DJJ top managers achieved widespread buy-in with the Farrell reforms and they were instrumental in modeling the new DJJ culture.

While sometimes teamed up with the OSM, the Court experts and a limited number of outsiders such as the group from the University of Cincinnati, the inner management group provided most of the training of other staff in the new methods. They became versed in the central elements of the IBTM and provided strategic coaching to others. Director Minor relied on this group to develop measures of the success of various reform components and this group worked alongside the Court experts and OSM to audit the Farrell mandates.

The management team described above led pivotal reform components such as revising the UOF process, minimizing the use of limited programs, establishing new "business rules" governing staffing patterns, and substantially recreating the DJJ approach to gang behavior in its facilities. These managers made frequent onsite visits to the facilities to confer with the local management staff and to gauge the obstacles to achieving the Farrell remedial plans. These Headquarters staff would work together with the facility staff to design "corrective action plans" to advance the reforms in instances in which there were major issues standing in the way.

Other essential people in the reform process were the facility superintendents and local top managers. The uneven success of the Farrell remedial plans at different DJJ facilities was directly related to the knowledge and skill of the local leaders to translate the plans into daily activities. The facilities at the OHCYCF and NACYCF emerged as the leading edge of the reforms; the VYCF experienced great difficulties in managing change. Leadership at the northern facility complex had all worked together in very collaborative and positive manners with each other and with the new Headquarters team. At the VYCF several of the superintendents were replaced after laudable efforts by Headquarters to improve their performance. Managers at the VYCF expressed strong verbal support for the Headquarters policy directives, but compliance was often superficial or token. The level of trust between the southern and the DJJ Headquarters had been problematic for years.

Minor and his team began to spend substantial time at the VYCF. They participated in training, mentoring and auditing the operations there. The short travel distance from Sacramento to Stockton made interaction relatively easy with managers at the OHCYCF and the NACYCF;

whereas being present at the VYCF meant flying down to the Los Angeles area and often staying there for several days. Early attempts by Headquarters to stay connected to the managers at the VYCF relied on emails and voice and video conferencing. These methods proved of only limited value. In recent months Director Minor replaced the superintendent at the VYCF with a member of his close-in management team. Other members of that team continue to work at VYCF on a regular basis. This enhanced effort at better direct communication and joint problem-solving between Headquarters and facility staff has produced substantial progress in meeting with benchmarks of the Farrell remedial plans, especially in the arears of reducing UOF, eliminating the use of solitary confinement and reducing room confinement. The OSM and the Court experts have also devoted a substantial amount of hours auditing and increasing the level of fidelity with the core elements of the IBTM at VYCF

There are two additional strategies that were mentioned by the persons that I interviewed, First, DJJ utilized the approach of pilot testing some of the large scale reforms before rolling these out statewide. The use of testing and refinements was especially important for the more complex changes required in the areas of the Sex Offender Behavior Treatment Program, the IBTM and improvements in the education and mental care sectors.

Earlier DJJ administrators were determined to implement large scale changes at every facility simultaneously. They felt that it was problematic to continue the old practices with a large segment of the youth population. Further, there was perceived pressure to show results in light of the substantial budget enhancements given to the DJJ. It was all possible that the rapid implementation of Farrell reforms would blunt the ongoing calls among youth advocates to close down the entire youth corrections system.

This aggressive approach to reform was not very successful. Instead, the DJJ employed a tactic of piloting some of the largest innovations – first in a single living unit, next in a series of other living units and eventually moving to a second facility. The pilots were begun at the OHCYCF which was judged to be most in tune in the philosophy of the Farrell reforms and where there had been a tradition of strong local management.

The pilot approach had major advantages. Primarily, it permitted the DJJ to experiment with different methods and to evaluate the strengths and weaknesses of various aspects of the program and policy design. The pilot approach created a group of staff who had actually lived with the new program and could be used as effective trainers of other staff. Piloting allowed for rapid modifications in the policies and procedures being tested on a small scale. Moreover, the piloting strategy allowed the DJJ to move forward without having to be completely blocked by existing union work rules and agreements. While the pilot testing approach may have slowed the initial realization of some of the Farrell reforms, this strategy made the expansion of the reforms go more smoothly in the near term.

Another strategy that proved very valuable was a decision initiated by the OSM and endorsed by the Court experts to conduct the auditing of the remedial plans within a collaborative framework. The central idea was that the Farrell consent decree required that the DJJ take over self-monitoring of the remedial plans in the future. The joint audit teams were believed to create opportunities for this handoff of responsibilities.

The joint auditing process was highly structured. Approximately 45 days before a scheduled site visit to a facility, the DJJ audit team would provide a detailed measurement of all the elements that required monitoring. This report would include all of the backup data that were employed by the DJJ team to make their conclusions. The Court experts had already explained to the DJJ auditors the nature of the evidence that was required.

The OSM and the Court expert would review these pre-audit materials and requested additional information as needed. These pre-audit reports were closely scrutinized for areas of partial or non-compliance as well as for the reasons given for less than full compliance. The Court expert would sample the data for areas deemed to be in full compliance to double check the quality of the internal DJJ audits. Over time, the Court experts would also examine changes in ratings and the rationale for these changes. The internal auditors, the OSM, and the Court expert would confer about the pre-audits in advance of the site visits.

The collaborative audit teams would be on-site for the actual audits. At this time, supplemental data was collected and additional interviews were conducted with staff and the Court expert and OSM interviewed a significant sample of DJJ youngsters and staff. All open living units were visually inspected by the audit team. An informal written and oral briefing was given to the facility mangers and to Headquarters staff shortly after the onsite work was completed. Later, the OSM and the Court Expert filed a formal audit report and received feedback from the Plaintiffs' and Defendant's legal representatives as well as other members of the DJJ management team.

The process produced a very significant level of agreement among the agency auditor and the outside Farrell monitors. Most important, the joint audit process allowed members of the team to learn from each other's diverse experiences and areas of expertise. This solidified the goal of working together to successfully meet all of the requirements of the Farrell consent decree. It fostered a spirit of candid communication and a sincere effort to consider many perspectives within the implementation process. Many great ideas surfaced for improving the quality of the audits and there were agreements that some very complex areas such as improvements in the review of UOF, the grievance system and the care of disabled youth would demand follow ups and more in-depth monitoring.

In general the joint teams worked very well together. In some of the highly specialized areas involved in the auditing of health care and education issues there was a need for the Court experts to play a larger role in the initial assessments. This process worked well and permitted a very efficient handoff of the primary auditing role to the Office of Audits and Court Compliance, with the proviso that the parties, the OSM or the Court experts could play a larger role in the monitoring process as needed in the future.

Great ideas whose results were underwhelming

Not every reform strategy meets its expected goals, even if those ideas that would appear obvious. I asked each of my interviewees to tell me what "great ideas" did not pan out or failed to meet their expectations. Sometimes these concepts came directly from the consent decree and other times the reform activities were promoted by the parties, the OSM or the Court experts. When the results were less than expected, the DJJ often revamped its approach in these areas. There was remarkable consensus among the people with whom I talked about the ineffective change models.

The interviewees explained that they had all assumed that the massive input of staff training on a wide range of pertinent topics would advance the Farrell reforms. Indeed the remedial plans specified a tremendous amount of new training for virtually all DJJ staff that was to be delivered very quickly. At the beginning of the Farrell case, training was primarily offered by a joint Academy with CDCR and was almost exclusively focused on security and safety issues. It was assumed that training in a range of treatment techniques per se was a key to reform.

Initially the DJJ struggled with the pure logistics of scheduling and organizing these training sessions. Training was offered at a central location and staff had to adjust work schedules to facilitate the absence of staff that were undergoing the training. Further, the quality of the training was, at best, uneven. Further, staff frustrated because they were being prepared for programs and systems that did not yet exist and might not be operational for years. Moreover, staff promotions, transfers and retirements meant that many of the staff who had these costly educational experiences were no longer functioning in the jobs for which they were being prepared. Agency policies and procedures were in flux and not entirely consistent with the training being offered. Supervisors were not organized to reinforce and model the principles of training in daily activities.

The training was scattershot without a planned approach to how and when the training should be delivered was needed. The DJJ has now moved to establishing a clear training plan with realistic timetables. DJJ is also working to see that the training is delivered proximate to the time when new programs and policies are introduced. The DJJ is relying less on the joint CDCR

Academy and is utilizing its own internal training staff. Outside substantive consultants are required to use a "Training for Trainers" format so that DJJ staff would become more comfortable and expert in the core training areas. Also, the DJJ has learned the need for top administrators and mid-level managers to learn the materials before it is presented to a larger number of front line personnel. It is also very beneficial to deliver more interdisciplinary training experiences that include education and health and mental health care personnel along with security staff. The list of areas for training has been streamlined and the scheduling of various training is more closely aligned to the schedule guiding the implementation of the component of the remedial plans. DJJ is revising its training method to be more participatory and less didactic. New ways of assessing the achievement of learning objectives will include a major focus on demonstrating mastery of the content and skills, not just the number of staff who put their names on sign-up sheets.

Another area of very limited returns for the reforms was the amount of time devoted to disagreements over the proper risk and needs assessment system to adopt. There were also weeks spent on a lack of consensus including the exact treatment curriculum to use as part of the IBTM. Initially DJJ relied on outside consultants and a small group of managers to specify its version of the IBTM. Several of the Court experts felt left out of this process and felt that the choices made by the DJJ leadership were not the best ones. After months of work by the DJJ and its consultants, there was only the skimpiest written description of the IBTM.

The Court experts demanded a fuller, research-based model, together with an operations manual and training curriculum for the IBTM. The plaintiffs' lawyers asked for an order for the Court experts and the DJJ to deliver the design of the IBTM and the related implementation tool. The Judge helped negotiate an apparent agreement in which the Court experts and their staff worked with the DJJ to produce the requested IBTM materials. This joint drafting team could never reach consensus and months went by with little or no progress seen on the IBTM.

The product of the joint group was very vague and generic in its tone. Responding with extreme frustration, the parties and the Court returned to the original plan that the DJJ would author the IBTM design with input from the Court experts and the OSM. The lengthy dispute weakened whatever trust may have existed among the parties and the Court experts and finally led to the resignation of the Special Master and two of the Court experts. This "era of bad feelings and bruised egos" stalled the commencement of the IBTM for almost two years.

In hindsight this argument over the most proven evidence-based tools and curriculum materials seems to have missed the essential spirit of the reforms. The differences among competing assessment systems or treatment curriculum were relatively small and unlikely to shape the overall direction of the Farrell reforms. Moreover, this battle lost sight of the core principle that DJJ managers and staff had to comprehend and embrace the reforms. The conflict delayed

gaining of staff buy-in and stymied efforts to improve services for youth. In the end, the IBTM model emerged out of a reading of the research literature, the treatment style that best fit the DJJ management style and the considerable adaptation and refinement that happened as the IBTM was piloted in real living units with actual DJJ young people.

Another early implementation dilemma was created as the parties negotiated about staffing levels and the building of data-based accountability systems before it was clear how the reforms would be fully implemented. This decision resulted is the creation of large amounts of time devoted to documenting activities and youth contacts. Staff complained that they were chained to their computers entering information that might never be looked at, rather than increasing the amount of time that staff could devote to one-on-one counselling and personal interactions with the DJJ youngsters. There were also periods in which many new staff were hired without a clear plan on how they would be utilized or how the living unit teams would function. This drove up the per youth costs of DJJ and raised questions as to whether the agency had "priced itself out of the market". As with training, more is not always better. A simple lesson of this experience is to not staff up until you are clear about their job descriptions and responsibilities. Moreover, don't construct complex and difficult data collection and reporting systems until you have specified the desired outcomes and agreed on the appropriate metric for those outcomes.

The levels of violence in the DJJ facilities seemed to decline as a direct result of the living unit sizes being substantially decreased. Other remedial plan components that set up '"Violence Reduction Committees" had fare less impact on youth safety. For a time it appeared that almost every problem in DJJ was met with a special task force at Headquarter or new committee at each facility. Over time these committees met sporadically and included a number of surrogates for the top managers. Staff devoted time to writing up the group deliberations, but few important actions or changed practices emanated from the expanding number of staff groups. In the end, the DJJ decided to combine and consolidate the work of these staff committees.

While these good faith reform tactics never met their fullest potential, the overall achievements at the DJJ were notable. Many of the key ingredients of positive change did produce the desired results. In the best of cases, the time that it takes to reshape a major state bureaucracy is considerable. But, some of the organizational insights discussed by my interviewees might have shortened the duration of the reform process. Major organizational reform does take considerable patience, focus and persistent leadership. The very complexity of the enterprise and its perilous political context explain why these successes are not witnessed very often.

7. Lessons learned about reforming juvenile corrections systems in other states

Besides the very substantial DJJ transformation, there are lessons to be gleaned from parallel efforts in four states that were well documented by outside researchers. I will briefly review the major findings of those case studies. It is worth noting that most of the major findings of the case studies in these states are mirrored in the observation and interviews describing the California success story.

Closing the Massachusetts reform schools and routinizing the continuum of care

The most dramatic reform in the history of juvenile justice was the closure of all of Massachusetts state juvenile facilities in the early 1970s.[21] There had been threats of federal investigation of the abuses in Massachusetts reform schools, but this was an era before there were major civil rights challenges to juvenile corrections. The strategy of change in the Bay State was the rapid closure of all the state's secure facilities and the transfer of youth to a diverse network of community-based placements and alternatives. This radical strategy was adopted after more modest efforts to create therapeutic communities in the reform schools were sabotaged by the corrections officer union. The Massachusetts Division of Youth Services Commissioner Jerome Miller surrounded himself with a group of trusted top level managers who helped plan and execute the closures. Miller provided the broad vision and left the operation details to his colleagues. [22]

Miller was masterful at outreach to the media and to the most powerful groups in the state. He enlisted the aid of professors at Harvard Law School, the state Bar Association, influential women's groups and the Governor. He helped the DYS youth tell their personal stories and elicited great sympathy for their plight and maltreatment by the corrections officers. He was able to obtain a substantial grant from the Office of Juvenile Justice and Delinquency Prevention to defray the initial costs of setting up the network of alternatives.

The dramatic closure of the reform schools led to a political reaction designed to protect the jobs of traditional state employees and avert the closure of facilities that were important to the economy of local communities. A new Governor asked Miller to resign and many of the reforms were blunted by legislative budget decisions and the opposition to reform of many of the judges.

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[21] Jerome Miller, **Last One Over the Wall: The Massachusetts Experiment in Closing Reforms,** Columbus, Ohio, The Ohio State University Press, 1998.

[22] Yitzhak Bakal, **Closing Correctional Institutions: New Strategies for Youth Service,** Lexington MA: Lexington Press, 1973

Over the next decade, the DYS had a series of Commissioners that carefully and deliberately moved the reforms forward. These later leaders of the DYS brought with them strong political ties and detailed knowledge of the Legislature, the judiciary and the state budget process. There were also subsequent Commissioners with very strong credentials in adult and youth corrections. These corrections professionals introduced policies and practices that were consistent with progressive thinking in the field and they played down the political and public confrontational style that was Miller's forte.

Despite the reaction to the closures, Massachusetts did not reopen the older reform schools and the state continued to focus its attention on strengthening the community based system. Research and evaluations supported the promising results in the reshaped DYS and national foundations and OJJDP sought to replicate the Massachusetts experiment.[23]

Creating and sustaining the Missouri Model

One of the earliest replications of the Miller vision was in the Missouri Division of Youth Services. There had been repeated investigations of child abuse of the state's reform school at Boonville. In 1983 the legislature voted to close Boonville and to move to a decentralized system of smaller facilities emphasizing therapeutic interventions rather than harsh punishments. Youth in the Missouri DYS lived in dormitories in facilities that resembled college campuses, not jails. Missourians viewed their youthful residents as students and citizens, not prison inmates. Over the next several years, the "Missouri Model" became the desired template for enlightened juvenile corrections practice.

A major reason for the sustained success of the Missouri DYS reforms was the political skill of its leader, Mark Steward, who built a strong and steadfast constituency for reform among the Legislature and the judges. Steward was able to articulate the new vision in concepts that appealed both to liberals and conservatives in the "Show Me" state. For liberals, the new system offered more humane treatment of youth and less incarceration; for conservatives the system appeared to be less costly and emphasized teaching individual accountability to the youth. Decentralizing the location of the Missouri DYS facilities created economic benefits for the many rural communities that hosted the new programs. It is especially notable that the major reinvention of juvenile corrections in Missouri survived with little challenge during changing state political leadership that spanned the ideological spectrum.

[23] James Austin, William Elms, Barry Krisberg and Patricia Steele, **Unlocking Juvenile Corrections: Evaluating the Massachusetts Department of Juvenile Services**, San Francisco: NCCD, 1991.

Noted juvenile corrections authority Richard Mendel has produced the most detailed and persuasive description of the Missouri DYS model. [24] Mendel places great importance on the decision to downsize the population of the facilities. He also notes that the Missouri DYS created a culture dedicated to continuous improvements and to engagement with the outside community; the Missouri Model depends on a strong and hopeful vision of the potential for youth rehabilitation. The agency articulated and reinforced an organization culture that rejected punishment as the dominant behavior management tool and replaced it with a caring and empathetic approach to its young clients. Mendel believes that the Missouri Model requires that there be highly motivated staff that are willing to engage the youth whenever and where these connections are needed. The staff are taught not to fear the youth and to seek safety through relationships with them, not via coercive practices. Missouri makes preparation for aftercare the central focus of all programs and highlights the necessity of very individualized educational and treatment services. Quality case management is the lynchpin of the Missouri system.

The role of staff in reforming the New York State Juvenile Corrections System

A somewhat different analysis of the dynamics of juvenile corrections change involves the New York State Office of Children and Family Services. (OCFS).[25] Professor Cox describes in some detail the perceptions of staff to juvenile corrections reform. She helps us understand how staff might be better enlisted to support change efforts.

In the period beginning in 2007, New York State closed a large number of juvenile corrections facilities that were located around the state. There were several staff layoffs and reductions in facility management personnel. Most of these institutions were located in upstate rural communities and their closure exerted a big economic impact on this region.

Some of these closures were responsive to a deep fiscal crisis faced by the state and by a trend of declining juvenile arrests and fewer youth being sent to OCFS facilities by the courts. The cost of operating the OCFS placements was approaching $275,000 per youth on an annual basis. Besides the severe budgetary pressures, there were reports of brutal and abusive practices in the facilities. The United States Department of Justice began an investigation under the auspices of the Civil Rights of Institutional Act (CRIPA). This investigation centered on five OCFS facilities and the US DOJ demanded changes to stave off federal civil rights enforcement. The OCFS agreed to a comprehensive agreement to remedy the deficiencies and some of the specific facilities were closed.

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[24] Richard Mendel, **The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders,** Baltimore, MD: the Annie E. Casey Foundation, 2010.

[25] Alexandra Cox, **Juvenile Facility Staff Responses to Organizational Change,** New Paultz, NY: The State university of New York, 2013.

The Governor recruited a noted child legal rights advocate Gladys Carrion to reform the New York State System. Ms. Carrion bought in a new management team of trusted professionals from other states to manage the closures and to fix the inadequate treatment of OCFS youth.

There was intense staff opposition to the new management team and claims that the program and policy changes had generated a wave of youth violence and staff assaults. A video tape of youth attacking staff at one OCFS institution was taken by a dismissed employee and broadcast on a local New York City television station and the video ultimately went viral on the Internet. The employee union staged work stoppages to protest against the new management team. Members of the legislature and state Auditor General conducted an investigation. The relationship between Commissioner Carrion and the OCFS staff remained strained until she left in 2013 to head up New York City's child welfare and juvenile corrections agency.

Against the background of this intense staff resistance to reform, OCFS was still able to meet most of the requirements of its agreement under CRIPA. There were many improvements in the quality and quantity of rehabilitative services for OCFS youngsters. Other litigation was held off as OCFS made steady progress to reduce the UOF, eliminate unnecessary solitary confinement, introduce trauma-informed therapy for its young people and upgrade mental health and education services.

Alexandra Cox observed that in New York as in other locales, the critical nature of the work of frontline staff was often overlooked or undervalued. The front line staff were often victimized by myths that they lacked basic cultural sensitivity with the largely urban and youth of color who were the inmates of the OCFS facilities. In fact, over half of the OCFS direct care staff were African Americans and many came from the same urban communities as the OCFS young people.

Opposition to reform and program closures was explained away by vested economic interests due to the loss of wages and fringe benefits. Staff were sometimes viewed as too punishment oriented and unwilling to truly embrace a treatment philosophy. Interview conducted by Cox revealed that staff resistance to change was rooted in a sense of their being excluded in the planning and design of reforms. Changes in policies and procedures were perceived as confusing, ill-conceived and subject to nonstop revisions. The staff wanted to be part of meaningful discussions about reforms and to offer their practical advice on how to best effectuate the desired results.

Uncertainty as to jobs, changing local management assignments and the future existence of these facilities led to a profound sense of being disrespected and treated unfairly. These staff felt they were victim of the stereotype that they did not support treatment. Professor Cox found that there was actually a significant group of OCFS personnel that wanted to advance

treatment goals for youth. This group wanted a larger role for reentry and educational services for the youth and not just social and emotional therapy.

Professor Cox noted that staff felt unsafe if they perceived a loss of control. As the OCFS changed its policies on UOF, disciplinary practices and isolation, the staff wanted alternatives and tools to better manage disruptive youth behavior and defiance of their authority.

Bedlam in Arizona

The last juvenile corrections case study that I examined was produced as part of the tracking of CRIPA reforms undertaken by the Arizona Department of Juvenile Corrections (ADJC).[26] It revealed a familiar story of abuse and neglect of the youth that caused condemnation of the agency by outside youth advocacy groups and many members of the Legislature. However a surge in the number of suicides by youth and one attempted suicide by a staff member heightened the demand for immediate action. There were also instances in which staff had brutally assaulted one of the youth residents and at least one staff member was indicted for having sex with an underage ADJC resident.

The U.S. DOJ conducted an investigation under CRIPA. Resistance to change was strong among the corrections workers and middle managers at ADJC. The Governor Janet Napolitano established a special task force to examine the causes of the crisis in ADJC and brought in new leadership.

Many ADJC staff agreed that the CRIPA reforms were needed but they lacked confidence that the agency would be given sufficient resources to implement these changes. There was suspicion that the impetus for reform would fade as the CRIPA agreement was slowly put into operation.

As progress to change the organization was too slow, Governor Jan Brewer threatened to defund the ADJC and transfer its youth to privately run programs. The combination of strong outside pressure by advocacy groups and the U.S. DOJ combined with a real possibility that the entire system would close down, produced the impetus of sped up reforms.

Key to the advanced reform momentum was a forceful and influential new Director of ADJC, Michael Branham who built an internal management team devoted to change. Branham had a past career in law enforcement not in juvenile corrections, and some were concerned that his

[26] Scott H. Decker, Melanie Taylor and Charles M. Katz, **A Case Study of the Response of the Arizona Department of Juvenile Corrections to the Civil Rights of Institutionalized Persons Act Consent Decree,** Phoenix, AZ: School of Criminology and Criminal Justice, Arizona State University, 2013.

police background would send ADJC backwards. But Branham, and his deputy Dianne Gadow, were generally credited with changing the culture of the organization to meet the objectives of the CRIPA consent decree. Branham instituted data-driven accountability systems and created quality assurance processes to sustain the positive changes. There were many more checks and balances that ensured that young people in ADJC were being accorded the care that they were entitled to by law and common morality. Even as Director Branham retired, another leader with a strong background in corrections came in and continued Branham's vision and protocols

Branham immersed himself in agency operations and spent substantial time at the facilities and in the living units. Similar to California DJJ Director Michael Minor, Branham put a high value on transparency and shared the results of the CRIPA monitoring reports throughout Arizona. The level of compliance with the CRIPA agreement rose quickly as ADJC articulated the value of the CRIPA reforms to judges, legislators and the law enforcement community.

Compliance with the requirements of the CRIPA agreement was not uniform in every area. Strides forward were accomplished in discovering and punishing misconduct by staff. Educational services improved but progress in providing adequate medical and mental health care lagged behind.

8. Reforming California juvenile corrections: concluding observations

There are several policy conclusions that should be drawn from this study and analysis. First and foremost, large and constructive improvements can be actualized even in the most troubled juvenile corrections systems. These reforms do not happen overnight and sustaining new methods of treating youth takes patience and a steadfast focus on the goals to be achieved.[27] Central to the humane care of troubled youth is a fundamental shift in the organization culture away from containment, confrontation and coercion and towards empathy, basic knowledge about adolescent mental and social development, and supportive relationships between staff and young people.

Leadership is essential to promoting and expanding the needed culture shift. Staff needs to feel valued and included in the change process. Effective leaders broadcast their vision and rely on others to flesh out the operational details and day-to day reality of this vision. There must be systems of accountability and checks and balances for youngsters and agency personnel. The Leader should be committed to transparency and skilled at establishing and nurturing strong allies for the reforms and there must be sufficient resources dedicated to the human care of

[27] At one Court hearing, the S&W Court expert (me) opined that it should take no more than three years to meet all of the obligations under the Farrell consent decree ---I was way off in my estimate of the time needed for reform.

troubled youth. Creating and nurturing an atmosphere of trust among the many individuals who will be involved in the reforms is a must.

Litigation or related civil rights enforcement is a valuable predicate for change. Few troubled bureaucracies change spontaneously. However the legal route must be tempered with ultimate attention to improving the care of youth, not just court victories.

Outsiders including Special Masters, Court experts and renowned national juvenile justice figures can add great value by exposing the juvenile corrections agency to the latest research and best professional opinion. They can also create a structure of accountability and standards of performance that are difficult to generate internally.

Change needs to be planned, managed and monitored closely. There must be clear lines of authority and responsibility for reform and these must be grounded in the chain of command. It is unwise to try to fix everything that is broken all at once. Pilot testing new policies and programs is a very important strategy.

Making progress in upgrading the basic care of youth including medical, dental, and mental health services can lay the foundation for the culture shift that is necessary. The conditions of the living units and the physical plant of institutions clearly communicate what value the adults place on the young people that they serve. It is often promising to start by upgrading the education program because these services are vital to the future success of all of the young people in juvenile corrections.

The preeminent need to develop and assist young people in realistic plans to return home is the centerpiece of high quality juvenile corrections programs. Youth who can see the way back to the community will be more enthusiastic customers of treatment and educational services.

Lastly, we return to the principle that smaller is better. Living units must be made even smaller and the large reform school will likely be a memory in the not too distant past. Smaller facilities promote greater safety and permit the sorts of positive role modeling and counseling that staff want to offer and that the youth desperately need.

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