I. INTRODUCTION

The Special Master submits for filing the Thirty-First Report of the Special Master. This report reviews the *Farrell* Mental Health Expert Dr. Bruce Gage's second Mental Health comprehensive report for his 2014 round of audits (site visits December 2014) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plans. The Mental Health 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 a brief overview of the status of youth population, programs and staffing issues followed by a discussion of the transfer of monitoring to Defendant of the *Safety and Welfare Remedial Plan* and a review of progress in the remaining safety and welfare items that the parties have agreed will not be transferred. The Special Master discussed the status of the remaining education items in her last report. Based on this information, the parties have stipulated to the transfer of monitoring of the remaining education items to Defendant. As such, there is no need for another review of these items. An update on the implementation of the Integrated Behavioral Treatment Model (IBTM) is provided next, followed by an analysis of progress in implementing the Mental Health Program.

II. YOUTH POPULATION, PROGRAMS AND STAFFING

A. Overview

At the Courtôs request, in her twenty-ninth and thirtieth reports, the Special Master 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 her twenty-ninth report with respect to youth population and programs. However, in her thirtieth report, the Special Master identified an issue pertaining to a shortage of staff in ñpostò positions that may impact Defendantôs reform efforts. The Special Mater wishes to update the Court on this issue as well as the issue of succession planning for senior administrators at the facilities and at the Central Office (CO).

B. Staff Shortage

As noted in the Special Masterôs thirtieth report, all three Defendant facilities have staff shortages in ñpostò positions, which include Youth Correctional Counselors (YCC) and Youth Correctional Officers (YCO). Shortages in post positions caused by unfilled vacancies, staff on extended leave status, vacation, sick leave, and training assignment require constant use of overtime, sometimes involuntarily, to fill behind vacant posts. During the Special Masterôs site visits to the facilities, managers and staff alike constantly brought to her attention that the practice of excessive use of overtime over an extended period causes staff fatigue and other conditions that may adversely

impact the safety and security of the living units as well as the quality and quantity of services to youth**.**

In addition, the parties agreed to a set of ñBusiness Rulesò that call for specific levels of staffing for certain classifications at each type of living units. It is implicit that the staffing level must be maintained to carry out the program elements and essential functions of the living unit. Besides shortages in post positions, approximately 12%[1] of all Parole Agent (PA) 1 and Casework Specialist (CWS) positions authorized under the Business Rules were vacant as of the end of January 2015 because of unfilled positions and staff on Industrial Disability Leave (IDL) or Long-Term Sick Leave (LTS) statuses. Staff members in these classifications are essential for planning, managing, and coordinating the casework functions in the living units. Defendant sometimes appoints YCCs to temporary out-of-class assignments to staff these functions. While such out-of-class assignments promote and enhance staff training and development, placing inexperienced staff in these positions impacts the quality and consistency of casework in the living units while further exacerbating an already critical shortage situation in the YCC classification. The following tables provide the number of vacant positions and staff on IDL/LTS at each of the facilities as of the end of January 2015:[2]

[1] Percentage based on four vacant positions and two staff members on IDL/LTS out of 50 authorized PA/CWS positions.
[2] Source: DJJ RO6 Vacancies provided in the email of February 11, 2015 from Associate Director Tammy McGuire.

Table 1
N.A. Chaderjian Youth Correctional Facility (NACYCF) – Vacant positions and staff on leave as of January 31, 2015

Classification	Authorized	Filled	Vacant	IDL/LTS
YCO	88	88	0	1
YCC	88	86	2	8
PA1	8	8	0	0
CWS	10	9	1	0
Total	194	191	3	9

Table 2
O. H. Close Youth Correctional Facility (OHCYCF) – Vacant positions and staff on leave as of January 31, 2015

Classification	Authorized	Filled	Vacant	IDL/LTS
YCO	41	37	4	1
YCC	60	52	8	4
PA1	8	8	0	0
CWS	5	4	1	0
Total	114	101	13	5

Table 3
Ventura Youth Correctional Facility (VYCF) – Vacant positions and staff on leave as of January 31, 2015

Classification	Authorized	Filled	Vacant	IDL/LTS
YCO	66	62	4	2
YCC	86	84	2	10
PA1	14	13	1	2
CWS	5	4	1	0
Total	171	163	8	14

In her thirtieth report, the Special Master acknowledged that Defendant management is well aware of this issue and is actively engaged in addressing it. While the hiring process for YCCs and YCOs is lengthy, Defendant apparently is on schedule to conduct a YCC/YCO Cadet Academy in April 2015 and complete hiring of approximately 50 YCCs and YCOs by July 2015.[3] In addition, a new PA1 hiring list has been established in February 2015 and Defendant has begun the hiring process for this

[3] *See* email of February 11, 2015 from Associate Director Tammy McGuire forwarding a document entitled ñVacancy/Succession Planning.ò

classification. Defendant has also initiated the testing process for CWS positions in February 2015.[4]

C. Succession Planning for Senior Leaders and Managers

Based on the current retirement formula, an overwhelming number of individuals in senior management positions at the facilities and at the CO are eligible for retirement within the next two years. At the CO, most individuals at or above the Program Administrator level (Director, Deputy Director, Associate Director) are at the near retirement age and a similar scenario exists at the facilities that include Superintendents, Assistant Superintendents, and Program Administrators. In general, there is little financial incentive for these senior leaders and managers to continue working beyond their retirement-eligible age.

Defendant is aware of this situation and is taking steps to address it. Defendant has and will continue to pursue ñdelegated testingò to establish a hiring eligibility list for classifications that are governed under civil service rules and regulations such as Program Administrator, Supervising Casework Specialist, and Captain. Delegated testing enables Defendant to conduct the tests on its own volition rather than relying on CDCRôs Office of Workforce Planning, which should streamline and expedite the hiring process to some extent. However, it is only one aspect of the lengthy process of identifying, recruiting, placing, and training qualified individuals into key leadership positions. In addition, certain high-level positions that are exempt from civil service rules are not totally within Defendantôs control and may require additional time to complete the appointment process. Given the criticality of stability and consistency in leadership, especially in the

[4] *See* the email dated February 27, 2015 from Associate Director Tammy McGuire.

current reform environment, the Special Master believes this is an issue that merits continued and focused attention on the part of Defendant.

III. SAFETY AND WELFARE

The parties have stipulated to the transfer of monitoring of the *Safety and Welfare Remedial Plan* to Defendant. Many of the issues in the *Safety and Welfare Remedial Plan* speak to the central concerns of the lawsuit. The transfer of most elements of the *Safety and Welfare Remedial Plan* to Defendant for monitoring is an indicator of the great progress Defendant has made in addressing some of the most difficult and intractable issues in this case.

A. Overview

One of the key concerns that resulted in the lawsuit was the excessive amount and type of force used against youth. Defendant did not have an effective behavioral management program but rather relied on a punitive disciplinary system to control rather than to shape youth behavior. As has been documented in the last three reports of the Special Master,[5] the total number of incidents of force used against youth has dropped to a reasonable level and the number of incidents of force used against a single youth has dropped precipitously. The use of chemical agents against youth with a mental health designation is now infrequent. The use-of-force review process continues to be an effective forum to review potential ways to avoid the use of force and to review when force is used if it complies with department policy.

Plaintiff decided to make site visits to identify possible concerns that they believed need to be addressed before bringing this issue to closure. Plaintiff made site visits to OHCYCF on December 4, 2014, to VYCF on December 19, 2014, and to

[5] *See* OSM 28, pp. 61-68; OSM 29, pp. 42-46 and OSM 30, pp. 33-44.

NACYCF on December 23, 2014. During the site visits, Plaintiff interviewed youth and staff, reviewed the facilityôs monthly use-of-force reports, and attended and observed the facility's Force Review Committee (FRC) meetings.[6] Subsequent to each site visit, Plaintiff provided feedback to the Superintendent on the results of their site visits. In addition, Plaintiff attended the Departmental Force Review Committee (DFRC) meeting on November 21, 2014. Plaintiff also provided feedback to Defendantôs executive staff and Superintendents on January 22, 2015.

Plaintiff found the review processes at OHCYCF and VYCF to be sound, as the cases analyzed if the level of force used was necessary, when force is used if it conformed to departmental policy and how the use of force could be reduced in the future. This observation is consistent with the findings of the Special Master in her previous reports.[7] However, while Plaintiff did not identify any specific deficiency in the cases reviewed during NACYCFôs FRC meeting, concerns were raised that NACYCFôs review process is not as consistent as the other two facilities and its monthly reports contain little analyses on the appropriateness of force used in individual cases, how force is used, and what could done to reduce the use of force. In her previous report, the Special Master found the force review process at NACYCF to be sound[8] and thus Plaintiffôs latest observation might have been caused by process or procedural lapses or changes in staffing or composition of the FRC members.

The Special Master obtained and reviewed the facilitiesô monthly use-of-force reports for December 2014 and January 2015. The monthly reports show the number of

[6] Reports and cases reviewed by Plaintiff were redacted and there were no discussions of any potential personnel actions during meetings where Plaintiff was present.
[7] *See* OSM 28, pp 65-66, and OSM 30, pp38-39
[8] *Ibid*

incidents that occurred at each facility is within a reasonable range. Moreover, she found all three facilitiesô reports contain sufficient and competent analyses of trends and patterns for meaningful review and monitoring of use-of-force practices at the facilities. In addition, on February 25, 2015, the Special Masterôs Deputy attended the FRC meeting at NACYCF and found the participants to be well prepared and discussion among the multi-disciplinary staff to be interactive and with appropriate focus on youth triggers and means to reduce future incidents. It appears Plaintiffôs feedback regarding the lower quality of the NACYCF review process has been addressed.

Moreover, as identified in previous Special Masterôs reports, additional and effective quality assurance measures exist, particularly oversight by the CO administrators through the DFRC review process.[9] Under the DFRC review process, all facilitiesô use-of-force cases are reviewed by a staff member in the CO and a sample of cases are selected for review by the DFRC. The Safety and Welfare Expert and the Deputy Special Master both routinely participated in past DFRC meetings and found it to be highly engaging and effective in identifying systemic issues that require policy or procedural modifications. The DFRC also routinely identifies deficiencies in cases reviewed by the FRC and returns the cases to the facilities for additional action. Thus, any shortcomings in the facilitiesô review process over an extended period undoubtedly will be identified and rectified through the DFRC review process.[10] When attending the DFRC on November 21, 2014, Plaintiff also commented positively about the thoroughness of the DFRC review process. In response to a suggestion from Plaintiff,

[9] *See* OSM 30, p. 39.

[10] DFRC in the past has repeatedly identified deficiencies in cases reviewed by VYCFôs FRC and additional training was provided that resulted in drastic improvement in VYCFôs review process.

Defendant has instituted a protocol of having representatives from each of the facilities participate in DFRC meetings on a quarterly basis starting March 2015.

Although Defendantôs use-of-force practice is very sound and in compliance with the *Safety and Welfare Remedial Plan* and the *Mental Health Remedial Plan*, the Special Master urges Defendant to continue to explore means to reduce use of chemical agents in the mental health halls. Both the Special Master and the Mental Health Expert believe that chemical agents should only be used as the last resort in the mental health halls. A review of recent data shows most cases involving use of chemical agents in mental health halls were youth engaged in one-on-one fights. Such incidents meet the criteria for immediate use of force and staff has the discretion to use chemical agents as one of the force options. However, staff appear to have relied exclusively on chemical agents in one-on-one fights, which may not always be necessary when other force options are available. For use-of-force incidents involving use of chemical agents against youth with a mental health designation, Defendant might wish to consider requesting staff to explain in their use-of-force reports why a chemical agent was believed to be the best force option under the circumstances. Defendant could also use the FRC and DFRC processes to identify situations that staff should have considered other options before resorting to use of chemical agents against youth with a mental health designation.

Defendant is to be congratulated for creating an effective use-of-force review process and for the consistent demonstration of limiting use of force to only situations with imminent risk of harm. The Special Master encourages the CDCR to review the outcomes achieved by Defendant for possible broader application in the agency.

B. Transfer of Issues for Continued Monitoring

While overall monitoring of the *Safety and Welfare Remedial Plan* has reverted to Defendant, the parties stipulated that three audit items remain outstanding and thus require further monitoring. One of the items is the IBTM. Previously, the parties agreed to transfer monitoring responsibility from the Safety and Welfare Expert to the Mental Health Expert.[11] The other two items are the Behavioral Treatment Program (BTP) and facilities improvement.[12] The Special Master has agreed to assume monitoring responsibility for these items.[13] The status of each of the two outstanding items is discussed below.

BTP Overview

The *Safety and Welfare Remedial Plan* prescribes the BTP model to provide intensive behavior treatment intervention for those youth exhibiting violent disruptive behavior who do not meet the criteria for intensive mental health treatment. The goal of the BTP is to help youth address these behaviors quickly and to facilitate rapid transition back to their sending units. Based on their previous site visits, both the Plaintiff and the Special Master agree that Defendant has made significant progress on this issue. A key concern for Plaintiff remains a small group of deeply entrenched youth with very lengthy stays in BTP units, particularly at VYCF. Another concern is the lack of meaningful treatment activities in some of the BTP units.

Defendant continues to make substantial progress toward implementing an effective BTP model. While the average daily population fluctuates, the numbers of youth at each of the facilities remains low. The decrease in population is a result of two

[11] The IBTM is discussed in Section IV below.
[12] *See* OSM 30, p. 51.
[13] *Ibid*.

factors. First, the core units are learning to resolve youth problems in more effective ways and thereby reducing referrals to the BTP. Second, the BTP staff typically is able to rapidly transition newly placed youth out of the BTPs. The issue remains how to deal with a small group of deeply entrenched youth with very lengthy stays in BTP units, particularly at VYCF.

BTP Population and Length of Stay

At OHCYCF, the BTP units housed 12 youth as of February 17, 2015, 11 of whom had length-of-stay (LOS) of 39 days or under while the remaining youth with a LOS of 96 days. When the Deputy Special Master visited the unit on February 25, 2015, the youth with LOS of 96 days was approved for transition to a core unit in NACYCF and the unit staff expressed confidence that they will be able to successfully transition the other 11 youth out of BTP before they reach 60 days of LOS.

The BTP at NACYCF housed 13 youth as of February 17, 2015 and nine had LOS of 33 days and under. The BTP unit staff told the Deputy Special Master that they are confident that these youth will be transitioned back to their sending units before 60 days. Of the remaining four, the youth with the longest LOS (320) was in transition to a core unit. Another youth with LOS of 109 days expressed the desire to integrate with the other youth after having repeatedly declined to do so in the past and the staff is optimistic that he will soon be ready for transition. The two other youth were placed in the BTP after repeatedly assaulting staff and the County District Attorneyôs Office filed charges. Both will reach age 18 before June 2015 when they are to be transferred to adult institutions and show little inclination to respond to staff intervention efforts.

Youth with lengthy LOS remain a challenge at VYCF. All 10 youth in the BTP unit had LOS of 60 days or more as of February 17, 2015. The disproportionate number of youth with lengthy LOS, in part, is caused by fewer BTP referrals in recent months. VYCF had a total of four BTP placements in December 2014 and January 2015 and two of the youth transitioned out as of February 17, 2015. It should also be noted that, between February 1, 2015 and February 16, 2015, VYCFôs BTP had successfully transitioned out six youth with LOS of 60 days or more, including one with LOS of 251 days and another one in excess of 700 days of combined stay in BTP units at VYCF and at NACYCF.[14] Of the 10 youth in BTP as of February 17, 2015, the facility has initiated the transition process for one youth with a LOS of 451 days and has plans to transition five other youth in the near future.[15]

Table 4
BTP Youth Population
As of February 17, 2014[16]

	Under 60 Days	Over 60 Days	Total
OHCYCF	11	1	12
NACYCF	9	4	13
VYCF	0	10	10
Total	14	9	33

Plaintiff also expressed a concern about the negative consequences of placing youth in an isolated setting over an extended period. In the past, the Special Master had similar concerns about the BTP units, particularly the VYCF BTP, that was functioning as a lock-up unit rather than treatment unit. While Defendantôs Program Service Day (PSD) schedule calls for youth to be out of their room at least 44 hours per week while

[14] Based on comparison of BTP monthly report for January 2015 and additional data forwarded in an email of February 24, 2015 from Program Administrator Alicia Ginn.
[15] *See* Behavior Treatment Program Summary ï 02 23 15 forwarded by Superintendent Mark Blaser via an email of February 24, 2015.
[16] Based on BTP data forwarded in an email of February 24, 2015 from Program Administrator Alicia Ginn.

engaging in structured activity based on evidence-based principles, the Special Master had questions about whether this requirement has been constantly followed based on her observations and youth interview results during her site visits.

The BTP units are no longer functioning as lock-up or detention units where youth are spending an overwhelming portion of their time being confined to their rooms. Recent weekly PSD data suggest that, with the exception of certain youth at NACYCFôs BTP, an overwhelming number of youth in the BTPs are spending most of their time out of their rooms. At OHCYCF, the average daily out-of-room time for each youth is more than 10 hours as the BTP mostly operates in a fully integrated setting. At VYCFôs BTP, the daily average is more than eight hours per youth despite most youth in the unit having lengthy stays and often being segregated by program groups. The Special Master believes the data is consistent with her observations during her recent site visits.

At NACYCFôs BTP, the average weekly out-of-room time lags far behind the other two facilities. For the week of February 2 to February 8, 2015, BTP youth at NACYCF averaged 47 out-of-room hours in comparison to 59 hours and 85 hours at VYCF and OHCYCF, respectively. For the following week, NACYCF average was 44 hours in comparison to 67 hours and 74 hours at VYCF and OHCYCF, respectively. During each of the two-week period, approximately 50% (seven of 14) of youth did not meet the minimum threshold of 44 out-of-room hours per week. In comparison, at the two other facilities, only one youth at VYCF did not meet the minimum threshold during one of the periods reviewed.

Defendantôs CO staff monitor the weekly PSD data and require justifications when a youthôs weekly out-of-room hours fall below the minimum 44-hour threshold. In

light of the significant disparity of hours between NACYCF and the other two facilities, Defendantôs CO staff should conduct further inquiries and youth interviews to quantify the cause of the disparity and seek possible solutions if this condition exists over an extended period of time.

While youth in general are meeting the threshold for out-of-room time, questions remain regarding to what extent such time is devoted to structured activities that are designed to support and reinforce a reduction in aggressive behavior. Activities such as individual counseling, attending BTP intervention groups, and attending school certainly meet this criterion. However, too often during her site visits, the Special Master observed youth either alone or as a group in the dayroom with little or no staff interaction or intervention. Such unstructured activity adds little value toward the core mission of the BTP, which is to provide intensive treatment and services to promptly address a youthôs aggressive and violent behaviors. Unstructured activity time should be an earned privilege that is provided only after demonstration of a youthôs ability to engage in structured activities without resorting to physical aggression with all unit staff and youth.

It is apparent that many staff members do not have the experience, knowledge, and skills necessary to engage youth in meaningful and structured activities. Some staff members likely are unaware that they are expected to engage youth in structured activities or have an understanding of what constitutes a structured activity.

The Special Master and the Mental Health Expert have reviewed the final version of the BTP Program Guide (discussed later), which should be finalized and issued in April 2015 after review and comment by Plaintiff. The Program Guide prescribes various program elements and requirements that, if properly followed, would accomplish

the BTP goal of delivering intensive and meaningful services designed to reduce aggressive behavior in youth. As it proceeds to implement the Program Guide, Defendant should incorporate provisions for monitoring, mentoring, modeling, and coaching of staff members for engaging youth in meaningful structured activities in accordance with behavior management principles.

Table 5
Weekly Youth Out-of-Room Hours
Week of February 2 – February 8 2015[17]

	Low	High	Average	Youth with Under 44 hours
OHCYCF	75	94	85	0
NACYCF	14	72	47	7
VYCF	34	71	59	1

Table 6
Weekly Youth Out-of-Room Time
Week of February 9 – February 15, 2015[18]

	Low	High	Average	Youth with Under 44 hours
OHCYCF	68	84	76	0
NACYCF	25	67	44	7
VYCF	47	73	67	0

BTP Workgroup and BTP Program Guide

While Defendant has clearly made significant improvements in the delivery of services to youth in the BTPs and is more rapidly transitioning youth from the BTPs, both the Plaintiff and the Special Master are disappointed with the slow progress of the BTP Workgroup. The workgroup was established on February 12, 2014, and is 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

[17] Data based on weekly PSD reports provided by Program Administrator Alicia Ginn via an email dated February 25, 2015.
[18] *Ibid.*

intervention and case planning in an integrated setting that promotes the rapid and safe transition of youth out of the BTP. The work plan calls for revising the existing BTP Program Guide to clearly define and describe the program and its key components/elements. Full implementation of the program guide and the work plan was supposed to be completed near the end of 2014.

Approximately seven months later on September 24, 2014, members of the BTP workgroup held a meeting that was also attended by Director Minor, the Plaintiff, the Mental Health Expert and the Special Master. 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.

The final draft of the program guide was not completed until five months later when it was forwarded to the Mental Health Expert and the Special Master for review and comment on February 24, 2015. It is anticipated the program guide will be forwarded to Plaintiff for review and comment in March 2015.

The Special Master believes staff members on the workgroup were extremely diligent in their attempt to produce a quality product in a timely fashion. She offers the following observations as lessons learned in the program guide revision process:

- An outline defining the format, structure, and general content of the program guide should be developed and reviewed by senior leaders and perhaps by outside stakeholders before fully proceeding with the process. In preparing the first draft, the BTP Workgroup essentially followed the same format and structure of the former program guide that was deemed to be obsolete and not particularly user friendly. Had the workgroup received more clear guidance

and direction on what the final product should look like, it could have avoided some of the false starts and unnecessary delays experienced in the process.

- Senior leaders at the CO and at the facilities should be more involved in the earlier stages of the process to provide policy guidance and directions. Many of the issues in the program guide involve policy considerations that are beyond the purview of the workgroup members. Some of the decisions were not made until the final phase of the program guide when the CO administrators and Superintendents became fully engaged in reviewing the program guide. Had these policy decisions been made earlier in the process, they could have provided more clear guidance to the workgroup and thus facilitated more timely completion of a quality product.

Facilities Plan

In her thirtieth report, the Special Master noted that there is a lack of clarity regarding how much more work is needed to resolve this issue and that it is highly subjective and difficult to ascertain without knowing what a unit should look like. The goal of facilities improvement is to modify the units to make the milieu more consistent with the therapeutic goals of the IBTM. The nature of such modifications will vary dependent upon facility design.

The Special Master suggested one approach might be for Defendant to develop a model unit at each facility for discussion and concurrence before proceeding to other units. Another approach would be for Defendant to prepare artist renditions of what the units would look like for consideration and concurrence.

To date, Defendant has not taken any action with respect to the two approaches identified by the Special Master. To resolve this issue, Defendant may wish to identify alternative approaches for consideration.

C. Next Steps

While Defendant is nearing completion of the BTP Program Guide,[19] the next important step is full implementation of the guide that, among other things, includes processes and procedures for BTP referrals and exits, BTP program elements, and a BTP-specific Behavioral Management System. The Special Master suggests Defendant immediately develop a work plan to implement the various components of the program guide as expeditiously as possible. Both the Special Master and the Mental Health Expert are available to provide advice and consultation when needed. Similarly, Defendant should provide the Special Master with a proposal for facility improvements.

IV. INTEGRATED BEHAVIORAL TREATMENT MODEL

Progress in the IBTM continues in a planned and focused way. Defendant continues to collaborate with the Mental Health Expert when making program changes. The CO IBTM team continues to provide guidance and leadership in designing and implementing system changes. Despite some staffing challenges, the volume as well as the quality of activities is impressive.[20] The quality of products produced keeps improving.[21] Rotations of unit staff into the team continue to expand the knowledge base of facility staff as these staff return to their units.

[19] The final draft of the program guide was submitted to the Special Master and the Mental Health Expert for review on February 24, 2015.

[20] *See* IBTM vacancies. There are currently three vacancies that are being recruited for. In the interim, support is being provided by PAs in the facilities.

[21] Examples include the revised level system, the training and quality assurance plans, and revisions to training and quality assurance tools. For more specifics, *see* OSM 31 IBTM Team Outputs that catalogs activities for this reporting period.

The Assessment Process

Defendant has begun the process to engage a contractor to refine the California Youth Assessment Screening Instrument (CA-YASI).[22] Upgrading the software platform and interface will allow for narrative assessment results reports, improved case planning and streamlining the current assessment.[23] In addition, work will be done to test for reliability between staff who use the assessment.[24] Another contract element related to assessment is the training and certification of a cadre of trainers who can teach staff how to conduct an assessment with fidelity. The contracting process is protracted so this work will not be initiated for several months. Defendant continues to train and coach staff in how to use the CA-YASI and it continues to be used for initial classification for unit assignment.

Case Management Process

The Mental Health Expert noted in his recent comprehensive report that ñcase planning targets and action steps remain largely generic throughout and are not timely at NACYCF.ò[25] He has also counseled Defendant that expertise in case management skills will improve in part through training and coaching and in part when the Reinforcement (RS) and Level Systems (LS) are fully implemented.[26] In effect, when staff are provided with clear tools and mechanisms for shaping behavior, it is easier for them to understand how to develop goals and action steps that are behaviorally grounded. This is not to say

[22] Information regarding the elements of the contract is outlined in an e-mail dated February 13, 2015 from Assistant Director, Anthony Lucero.
[23] The California version of the YASI added more elements that lengthened the assessment. Current managers believe the assessment, if shortened, would be just as effective and easier for staff to administer.
[24] *See* OSM 29, pp.10-13 for a discussion about this issue and the challenges in ensuring that reliability among assessors is monitored.
[25] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.4.
[26] These themes were emphasized in exit meetings during the 2014 IBTM audit and in meetings with the CO IBTM Team.

that more training and coaching are not needed. To that end, Defendant continues to develop better training and coaching strategies for developing case management skills.

Defendant also continues the difficult work of teaching staff case management skills by revising and improving the Case Management Protocol that provides a concise guide for case conceptualization, how to prioritize domains, develop goals and give feedback. Excellent examples of goals and action steps are provided in an attachment to the document.[27] The revisions to the document demonstrate increased understanding of the CA-YASI domains by the CO IBTM Team.

In addition, Defendant has revised the training materials for case management. The PowerPoint material and the trainerôs guide are excellent. The materials will be used in training for executive, management, custody and treatment staff.[28] Defendant also has an impending contract with a vendor to develop a coaching module for the case management training that provides supervisors and trainers the resources needed to coach unit staff in effective case management practices. The vendor will also provide an advanced refresher for the IBTM CO Team and case management trainers. The plan for contract services is well designed and addresses both gaps in existing systems as well as refinements and enhancements to the case management system.

Cognitive-based Behavioral Therapy (CBT) Resource Group Delivery

Defendant has significantly improved accurate reporting of group delivery and rescheduling. The Special Master pointed out in her last report that the monthly reports

[27] *See* Effective Case Planning IG 02-19-15.
[28] *See* Draft Training Plan (2) Amended.doc, p.5.

for some units, most notably the BTPs and the intake unit, failed to provide data needed to track resource group delivery.[29]

For the most part, this issue appears to have been remedied.[30] Most units are now reporting data that allows for accurate tracking of resource group delivery. The report that indicates if and when groups were delivered, how many youth were in attendance and the completion rates were filled out accurately by most core units.

While the reporting has improved notably, there continues to be challenges with the data regarding interactive journals. The BTP units and several core units at NACYCF are examples of the failure to indicate the start date of the journals and sometimes the expected number of groups to be delivered.[31] Without this data, tracking is difficult. That said, the tracking at the BTPs has improved significantly overall. Of the three facilities, NACYCF has the most room for improvement.

Behavioral Management System and Level System

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 Disciplinary Disposition Management System (DDMS) that provides a framework for when punishment and/or negative consequences must be applied. The RS has been in place for approximately 18 months, the level system is in the final stages of development and the DDMS will be undergoing minor modifications when the LS is implemented.

[29] OSM 31, pp.10-11.
[30] *See* the reports from OHCYCF including: OHC Amador Intervention Group Summary June-Sept. 2014, OHC Amador Intervention Group Summary Oct2015-Jan 2015.pdf, for an example of how one unit is reported.
[31] *See* NAC Kern (BTP) Intervention Group Summary June-Sept 2014.pdf and NAC Merced Intervention Group Summary Oct 2014-January 2015 as examples of still not accurately reporting. It should be noted that both units' reporting has improved since the last reporting period.

The best way to understand the use of the RS is to observe and interview staff and youth on the units. Since that was not done in this reporting period, comments will be limited to how often the RS is recorded as being used and not consistency or alignment with policy. The data for this reporting period on the RS show a clear pattern of consistent use. Most amazing is the increase in use by security staff. This increase is most notable at NACYCF.[32] Clearly the system is being used differently at different facilities. OHCYCF has a consistent pattern of a lower number of positive checks by all disciplines. VYCF shows the most use of the RS by mental health practitioners. Such differences are not necessarily problematic but should be studied.[33] Prior to the upcoming IBTM audit, Defendant should explore the extent to which the system is being used generically or to support specific goals and action steps in a youthôs case plan.

The development of the LS is finally coming to a close. Defendant has had the Mental Health Expert and the Special Master review the proposed model. While minor modifications may be made, the core principles of the system have been adopted. Defendant intends to create a training sequence that would start with the developmental stages of the adolescent, discuss the RS and LS as well as how these behavioral management tools integrate into case management practices.[34]

Quality Assurance

Defendant's Management staff has met with the Office of Audits and Court Compliance (OACC) to discuss how the current auditing and corrective action planning

[32] Comparing Positive Behavior Reinforcement Checks 6-2014---9-2014 and Positive Behavior Reinforcement Checks 10-2014---1-2015, there is a notable increase.
[33] *See* OSM 28, pp. 28-29 for a discussion about this issue.
[34] *See* Re Case Planning. The final documents that describe the components of the LS should be ready for dissemination soon. The Level System PowerPoint (2-18-2015) overviews the elements of the system. Feedback offered by the Mental Health Expert may result in some minor modifications to this material.

process can best be coordinated. Defendant is fortunate that the OACC staff have remained stable and that the experts assigned to the *Farrell* lawsuit trained most of the auditors. Who has authority to monitor corrective action plans needs to be determined. It is the Special Masterôs opinion that the OACC auditors are a valuable resource for such a function.

Defendant has developed a thoughtful draft quality assurance plan that has been critiqued by the Mental Health Expert and the Special Master. One aspect of the plan focuses on supporting managers' and supervisors' ability to effectively observe and to critique resource group delivery as well as implementation of other elements of the behavioral management system. Assessment of managers' and supervisors' facilitation skills is the first step in this process.[35]

Managers have been critiqued in their delivery of SOW. Review of the Proficiency Observation Forms[36] indicates that honest assessments of strengths and weaknesses of the managers and supervisors are being provided by the CO IBTM Team.[37] Remediation is indicated where needed. The goal of this process is to ensure that managers and supervisors are skilled enough to provide not just accurate observations regarding the delivery of IBTM services to subordinates but also to create a cadre of master trainers and coaches. Defendant is to be commended for the development of such a thoughtful and valuable learning process for managers and supervisors. The managers and supervisors are the key ñkeepersò of the culture and the more they understand and can support the IBTM, the faster it will be fully implemented and maintained.

[35] *See* the Quality Assurance Proficiency Schedule.
[36] *See* Skill of the Week QA Form (Monday-Final) for an example of the QA form used by observers.
[37] For examples of observations of managers and supervisors *see* NAC QA Proficiency 8, NAC Proficiency 13, OHC QA Proficiency 9, OHC QA Proficiency 10 and OHC QA Proficiency 11.

There is a synergy that develops as the different elements of the IBTM are put in place. Each part of the system reinforces other parts of the system. The quality assurance efforts help staff develop greater depth and understanding of the IBTM. The LS system helps counselors understand what goals and action steps youth need to work on. When the level system is put in place, it will become easier for staff to develop effective case plans. A common language is beginning to permeate most activities in the facilities.

The momentum is building regarding understanding and ownership of the IBTM. It is becoming the norm. It will not be long before the culture of the facilities will truly be one of IBTM.

Two areas of concern for the Special Master have been the Juvenile Justice Administrative Committee (JJAC) and Parole Board hearings. These ñhearingsò have not aligned with a behavioral health model. Rather than focusing on criminogenic needs and risk management, the focus in these settings has been on criminal offense. That too is beginning to change. The recently appointed Parole Board Chair is collaborating with experts in structured decision-making models for release decision makers. Structured decision-making models can provide a consistent methodology that considers factors relevant to future recidivism rather than rely solely upon the individual beliefs and biases of committee and board members. The Special Master looks forward to learning about these thoughtful efforts that can take advantage of the vast array of information that the IBTM will soon be able to provide to decision makers.

V. MENTAL HEALTH

The Mental Health Expert, Dr. Bruce Gage, conducted a round of site audits in December 2014. The site visits included NACYCF, VYCF and CO. Dr. Gage completed

a draft of his comprehensive report and the Special Master submitted it to the parties on February 18, 2015. After receiving feedback from the parties, the final version was sent out March 15, 2015.

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

Consistent with the rating system of other *Farrell* remedial plans, Dr. Gage assigned ratings of substantial compliance, partial compliance, and non-compliance to each of the audited items. The following table provides a summary of the ratings at each of the facilities and at the CO. There is improvement in the number of items in substantial and partial compliance and a decrease in non-compliant items. Clear progress is evidenced in the implementation of the mental health program since the last reporting period. The Mental Health Expert suggests that, if Defendant continues on its current trajectory, many of the items that are marked partially compliant will easily achieve substantial compliance status by the next audit round.[38] The Special Master concurs with this assessment.

[38] *See* Mental Health Expertôs reply to DJJôs comments on audit ratings for NACYCF and VYCF.

Table 7
Summary of Compliance Rating Percentages[39]

	NACYCF	VYCF	CO	Cumulative
Substantial Compliance	57%	68%	70%	64%
Partial Compliance	25%	31%	30%	28%
Non-compliant	18%	1%	0%	8%

The percentage of items found to be in substantial compliance has increased between the two audit rounds at the two facilities and at the CO. The increases range from 15% at NACYCF to 18% at both VYCF and CO.

Table 8
Comparison of Percentage of Items in Substantial Compliance Rating Percentages

	Round 1[40]	Round 2[41]	Increase
NACYCF	42%	57%	15%
VYCF	50%	68%	18%
Central Office	52%	70%	18%
Cumulative	47%	64%	17%

A. Current Progress

In contrast to his last report, Dr. Gage noted that the mental health youth population has stabilized, as has the mental health leadership. Dr. Gage noted that the overall trend is ñclearly in a very positive direction.ò[42] There have been changes in some of the Psychologists in the mental health units.[43] These changes, in combination with greater development of the IBTM, have ñhelped to bring stability to the agency generally and mental health specifically.[44] Making programmatic changes as challenging as implementing a mental health services delivery model fare far better in a stable

[39] *See* email of March 2, 2015 from Nancy Marker, Research Manager, Quality Assurance Section.
[40] *See* OSM 29, p.30.
[41] *See* the email dated March 2, 2015 from Nancy Marker, Research Manager, Quality Assurance Section.
[42] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.1.
[43] This impact is discussed later in this section.
[44] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.1.

environment. Progress since the last reporting period appears to be in part a reflection of the more stable environment and in part because of the diligence of the mental health implementation team.

Dr. Heather Bowlds has been Associate Director of Mental Health since October 2014. Dr. Bowlds now oversees all behavioral health programs.[45] Having the programmatic oversight of the IBTM, Sexual Behavior Treatment Program (SBTP) and the mental health program combined under one person may enhance the integration of mental health and SBTP with the IBTM. SBTP and mental health both require a strong clinical focus. Bringing the programs under one administrator should help maintain this focus and improve fidelity and integration of both clinical and IBTM program elements, including case planning. It will also promote sharing of program components where appropriate.

One of the greatest impediments in the mental health program has been the significant divide between Psychologists and other unit staff. Relationships were often poor and typically there was little evidence of coordination between treatment and case management staff. Even in those instances where there were collegial relationships between the Psychologists and the unit staff, it was typically unclear who had decision authority with a youth when it came to goal setting. Unit YCCs and PAs are not privy to the treatment plans and notes of the Psychologists and Psychologists struggle to influence the case plans. Lack of clarity regarding issues such as confidentiality has resulted in distrust (and to some extent still does). While Psychologists participate in case conferences and JJAC hearings at most facilities and often share their opinions,

[45] The Special Master is not aware of a formal announcement of this change but was informed by Director Minor and corroborated by Dr. Bowlds that this is indeed the case.

comments often have little to do with actual mental health treatment issues but focus on case management issues.[46]

In a short time, Dr. Bowlds has begun to resolve the structural and interpersonal challenges between the Psychologists and the unit staff. Dr. Bowlds has begun to work through the establishment of clear policy on issues like confidentiality to help the mental health unit staff understand the differences between treatment and case management functions. As observed by Dr. Gage, the collaboration between mental health and other staff is much stronger and there is very little divisiveness. The sense of partnership and mutual respect is notable. This is a testimony to the quality of both the leadership and the staff.[47]

Psychologists are also showing a greater understanding of the IBTM with some even co-facilitating groups. Progress in this regard could be expedited substantially by ensuring the Psychologists are trained in the CBT and behavioral management systems of the IBTM. All Psychologists should have to complete the following training: Cognitive Behavioral Primer, Anger Interruption Training (AIT) and Counterpoint (CP). Only three Psychologists have completed any of these.[48] Recognizing that turnover in Psychologists may explain some of this, there are many Psychologists who have been with Defendant for years and have not completed any of the training. Just as the unit staff need to be trained in Trauma-Focused Cognitive Behavior Therapy (TF-CBT), so do the Psychologists need to be trained in the IBTM CBT. This supports the use of a common language between the unit staff, Psychologists and youth.

[46] Some of the issues DJJ managers have faced in creating cohesive teams in the mental health program are discussed in OSM 30, pp.31-35.
[47] Mental Health Audit Comprehensive Summary February 2015 final amended (2), pp.1-2.
[48] *See* Copy of Training for the Psychologists at NYCYCF and VYCF 2-19-15.xls.

Defendant has made notable progress in several areas of the Mental Health Implementation Plan.[49] In the thirtieth report of the Special Master, four issues of the eight key areas identified in Defendantôs plan were not completed. They are: developing an evidence-based mental health treatment program, a program guide for unit operations, the policies and procedures to guide all mental health programs and the development of quality assurance outcomes and measures. During this reporting period, the Mental Health Program Guide has been completed and significant work is underway in the remaining three areas. One area that has been completed, intake procedures, still has a few deficiencies that need to be remedied.

Developing a Treatment Program

As noted above, work has begun on clarifying the differences and overlap between the roles of mental health treatment providers (largely Psychologists) and the unit staff. The Mental Health Expert noted that there remains work to do on clarifying roles, reporting relationships, and other elements of the organizational structure. The good news is that mental health services are moving away from being only a response team to the crisis of the day to a structured program that is based on referral, assessment and treatment.[50]

There remains work to be done on defining the role of mental health in forensic functions such as DDMS and JJAC. Participation varies across facilities and the role of the Psychologist in such meetings is not clearly defined.[51]

Finally, there continues to be a bit of problem finding and maintaining a full complement of Psychologists who are trained in cognitive-based behavioral approaches

[49] *See* Mental Health Implementation Plan Summary 5-23-13.
[50] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.2.
[51] *Id*, pp.1-2.

with youth. For the most part, Defendant has been able to maintain staffing of Psychologists consistent with the agreed-upon business rules. What has been challenging are the cumbersome contracting and hiring processes, making it difficult to backfill positions vacated by staff out on leave. When all positions are filled, the staffing is sufficient.[52] All other staffing including laboratory, pharmacy, and consultative services are sufficient. There is not sufficient psychiatric staff at NACYCF.[53]

The actual structure of the residential mental health program has improved largely due to the incorporation of the current elements of the IBTM.[54] In addition, the Psychologists are now facilitating the TF-CBT. Group observations during the audit indicate largely adequate to good facilitation of the curriculum. The numbers of the groups held for the reporting period are as follows:

- NACYCF: Merced staff facilitated 16 group sessions and one individual session. Sacramento unit staff facilitated 13 group sessions and 20 individual sessions.
- VYCF: Al Alborado staff facilitated 15 group sessions and two individual sessions. El Toyon staff facilitated 13 group sessions.[55]

In the past, the reviews of treatment plans in the medical reports where they were documented overwhelmingly showed such poor quality that it would be inaccurate to indicate true treatment planning was being done. There was typically a diagnosis and some notes but not a treatment plan. Progress notes were sporadic and poorly done. At the time of the mental health audit, there were a few integrated treatment plans in use in the mental health residential units, but there was demonstration of clearer goals, treatment modalities and occasionally good formulations. Treatment planning had improved even

[52] The Special Master agrees with the Mental Health Expert the addition of recreational and occupational therapists could enhance the quality and nature of the mental health program.
[53] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.4.
[54] *Id.*, p.2.
[55] *See* Marc-Aurele Info Request.

without an agreed-upon treatment plan format. Progress notes have also improved and demonstrate use of the intended modalities. There remains room for improvement in treatment planning and documentation.

Since the audit, an Integrated Mental Health Treatment Plan format has been finalized and implemented at all facilities.[56] The newly implemented treatment plan will, if fully implemented, address many of the Mental Health Expertôs concerns regarding treatment planning.

The outpatient program is working well except at NACYCF where the lack of staff resulted in no outpatient services to the core units. The outpatient program at OHCYCF was not audited but will be reviewed in the next audit round.

Finally there remains a lack of available licensed mental health care (hospital level) for minors. Defendant has continued to try and negotiate contracts for such services but to no avail.

Program Guide

Defendant distributed the final version of the Mental Health Program Guide on January 6, 2015.[57] Defendant worked closely with the Mental Health Expert to develop a coherent and clear description of the type of services to be provided, how service delivery works in core units and the BTP compared to mental health living units, how documentation of services is to be recorded and how mental health services are aligned with the IBTM. The guide provides a framework that describes the mental health programôs goals and objectives, entrance and exit criteria, program elements, transfer and

[56] *See* MH TX Plan
[57] *See* Mental Health Service Program Guide or PoP 1021

referral processes, case and treatment planning and documentation, staff roles, alignment with the IBTM and quality assurance mechanisms.

Legal and medical requirements always make the development of mental health programs more complex than behavioral health programs. The complexity often results in staff confusion especially regarding roles and documentation. Defendant has developed a document that, to the extent possible, describes in plain talk how the program should work.

Completion and distribution of the Mental Health Services Program Guide does not mean all the elements described in the plan have been implemented. It is the document that describes a fully implemented program that Defendant can use to guide the remaining steps in implementation. Case planning targets and action steps remain largely generic and are not timely at NACYCF.[58]

Policies and Procedures

Defendant is very close to having revised all the policies and procedures needed to fully implement the mental health program. The current implementation team has done an excellent job of synthesizing many overly complex, conflicting and confusing documents into a manageable number of policies that are easier to read, understand and that integrate into a coherent direction for the program.[59] The Mental Health Expert has done an excellent job of providing guidance and expertise to the Mental Health Implementation Team.

In chronological order, the policies and procedures are listed by completion date.

[58] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p.4.
[59] Both the Mental Health Expert and the Special Master have opined that the mental health policies are still too complex and long. It appears that this is in some measure an artifact of the CDCR policy and procedure format process.

- July 21, 2014: Mental Health Services Policy. This policy incorporated nine formerly separate policies. It includes:

    - Acceptance and Rejection Criteria,
    - Mental Health Levels of Care which include Licensed Facilities,
    - Forensic Evaluations,
    - Community Re-entry of Youth with Mental Health Treatment Needs, Communication with Counties,
    - Mental Health Referrals,
    - Principles of Mental Health Assessment, and
    - Treatment, Mental Health Documentation, and Mental Health Evaluations.

- December 26, 2014: Treatment Confidentiality Policy[60]

- January 6, 2015: Mental Health Services Guide[61]

- February 19, 2015: Informed Consent Policy[62]

Staff training for the Mental Health Services Guide was held in early February and training on the Informed Consent Policy was held on February 26th.[63] Three policies remain and they are nearing completion. The Suicide Prevention Assessment and Response (SPAR) policy has undergone a review process by the Mental Health Expert and internal stakeholders and is now being reviewed by legal counsel. Internal stakeholders and the Mental Health Expert have reviewed and commented on the Psychopharmacological Treatment Policy. The last policy that requires modification, the Involuntary Medication Policy, is still in the drafting and internal review processes.

Quality Assurance Outcomes and Measures

Defendant has outlined a clear quality assurance system in the Mental Health Program Guide. Most of the systems have yet to be implemented because the program elements are still in the implementation stage. Documentation regarding self-harm that

[60] *See* PB14-08_TreatmentConfidentialityPolicyandForms.pdf
[61] *See* PoP 1021; PB 1407_Appendix; PB 1407_Appendix2;PB 1407_Appendix3.
[62] *See* PB15-01_InformedConsentFor MentalHealthTreatment_PolicyBulliten.pdf.
[63] *See* MH Update Bowlds.

lead to suicide prevention measures has improved but it still requires further improvement. The Mental Health Expert will continue to monitor progress in this area.

Intake Procedures

While it is true that Defendant has created intake procedures for the mental health units, there remain a few areas in the intake process that are not satisfactory. The initial assessment of a youth is the foundation for his or her treatment plan. This assessment is perhaps one of the most critical steps in developing a meaningful treatment and case plan for a youth. The failure to develop a robust initial assessment must be addressed to ensure the development of effective treatment and case plans.

The Mental Health Expert again noted that the agreement to replace standardized assessments (Voice Diagnostic Interview Schedule for Children [V-DISC] and the Massachusetts Youth Screening Instrument [MAYSI]) with a semi-structured interview has not happened and that the CA-YASI is still not incorporated into the initial assessment. Defendant dropped the standardized assessments well over a year ago but never created the semi-structured interview.

> The semi-structured interview intended to replace previously used structured assessments (MAYSI, V-DISC) has still not been fully implemented. This needs to be completed to assure a thorough initial assessment. The YASI, a rich source of information, is also not being included in psychological assessments, often because it is not completed by the time the psychological assessment is done.[64]

Defendant has also fallen behind ensuring timely completion of intakes and in some instances not having the intake done prior to a youth being placed in a unit. In light

[64] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p. 5.

of the low numbers of youth in the system, the failure to complete the CA-YASI timely so that it can be incorporated into the psychological assessment is inexplicable.[65]

Once the semi-structured interview is implemented, Defendant will have a broad range of detailed information available. What is lacking is a process for integrating and distilling it into a succinct and usable formulation that can guide the treatment of the youth. Little progress has been made on integrating the input of the various components of the intake. Defendant has developed an excellent guide for such integration in the Clinic Case Conceptualization Guide.[66]

As with so many processes, despite the guide being ready for implementation in December of 2014, the required labor notice delayed implementation. Discussions with labor are ongoing regarding program changes. The Assistant Director of Mental Health has provided and has planned more training with the Psychologists to review polices and to continue to work on clarifying roles and team structures.[67]

The initial case review (ICR) is also an important element of the intake process. This issue has been written about primarily in the context of ensuring the rights of disabled youth.[68] This review consists of a meeting of a newly arrived youth with a member of the Parole Board, a disability representative, an educator, a Psychologist, the youthôs Casework Specialist, the Supervising Casework Specialist and a Parole Agent III.

[65] Defendant has added an additional .5 Psychologist to help with the intake backlog but it remains unclear if the intake system does not require structural changes to ensure these issues are addressed.
[66] *See* Clinic Case Conceptualization.
[67] Unfortunately labor negotiations appear to have eliminated the possibility of implementing a peer review process in mental health. Peer review is used in mental health and medical settings as a quality assurance process and creates a forum for professionals to learn from one and other. It is considered a best practice and to not use it in mental health programs in CDCR only serves to undermine the development and implementation of high quality services.
[68] *See* OSM 22 pp. 30-31.

The meeting can be an opportunity to help a youth adjust to the culture of a facility, create a therapeutic alliance, and to understand the program requirements.

Both the Special Master and the Mental Health Expert have observed these meetings. As noted by the Mental Health Expert in his one observation, the meetings are not treatment focused but are called hearings and are run like a hearing with no presentation of an integrated case formulation and targets for treatment.[69] One has to ask why would there be any type of a hearing with a youth who has just entered a facility? What is the purpose of a hearing? Why use the format of a hearing? If the goal is to frighten or intimidate a youth, it seems an appropriate format. If there is any treatment purpose, it cannot be met without each ICR member reviewing a complete intake packet, discussing it together in advance of meeting with the youth, reaching agreement on desired meeting outcomes and using a motivational interviewing approach with the youth. The current hearing clearly is not consistent with the IBTM.

The ICR should be a step in the intake process that exposes a youth to the principles of the IBTM and helps staff and youth begin to develop a plan for the youth to achieve case plan and treatment goals. The Special Master recommends Defendant work with the Mental Health Expert to define the purpose of the meeting, who should attend and to restructure the meeting to align with the principles of the IBTM.

VI. CONCLUSION

The Special Master is extremely pleased that the parties have agreed to transfer monitoring of the *Safety and Welfare Remedial Plan* to Defendant. Defendant has implemented systems that have been sustained over time and that have resulted in force being used only in cases of imminent harm. The use-of-force review process is an

[69] Mental Health Audit Comprehensive Summary February 2015 final amended (2), p. 6.

excellent quality assurance mechanism and is a forum for not just oversight but for learning.[70]

A system that once relied in many cases on brute force to control youth now appropriately limits use of force to only those instances where imminent harm to youth or staff exists. Defendant has been rigorous in providing remediation opportunities for staff to learn how not to rely on force to prevent violence but rather, their most effective tool, their interpersonal skills. For those staff members that risk violating the use-of-force policy, Defendant has been equally rigorous in initiating disciplinary processes.[71] Defendant has created a safe environment for youth and staff where both can learn and grow.

Of the three items that were not transferred to Defendant from the *Safety and Welfare Remedial Plan,* the IBTM, BTP and facilities improvement, two have demonstrated significant improvement during this reporting period. Both the IBTM and the BTP have made progress.

The CO IBTM Team and the facility staff have continued to enhance the training and quality assurance mechanisms for the CBT resource groups. The RS is now a routine part of unit practices as is SOW. The level system, the last key element of the behavioral health plan, has recently received supportive approval from the Mental Health Expert. In some facilities, newly appointed SYCCs who understand and are committed to the IBTM

[70] While there are many people who have contributed actively to the development of the use-of-force review process, two staff members have been key to the success of this work. Deputy Director Anthony Lucero never lost sight of the goal of the process and through his active engagement helped others see the value of it. Captain Jeff Plunkett modeled for custody staff that their job is not just when force is necessary to follow agency policy and procedure but to understand how to prevent the use of force and when it is used to ask questions regarding what if anything could be done differently. Director Lucero and Captain Plunkett are to be commended for modeling the way for other staff.

[71] Director Minor has been diligent in respecting the rights of staff and pursuing all available avenues of recourse to discipline and punish staff members who knowingly and willfully use excessive levels of force and to provide training and corrective action where needed.

are dramatically changing staff perceptions of behavioral management strategies.[72] Defendant is seeking the help of outside consultants to refine systems. It appears the majority of staff no longer resists the concepts of the IBTM but want to know how to fully implement them.

The Mental Health Program is showing similar signs of progress. With policies and procedure revisions almost complete, the Mental Health Guide being implemented, continual discussion of roles and responsibilities of the unit teams being clarified, and the treatment plan format being finalized, the treatment and case management teams are beginning to function more as a unified whole. Understanding of case formulation and its integration into treatment and case plans are beginning. Youth in the units can demonstrate understanding of treatment goals.

Defendant has also created excellent training and quality assurance plans that are nearing finalization. The plans have undergone several reviews with the Special Master and the Mental Health Expert. Elements of the plans are already being implemented.

Plaintiff has rightly opined that to achieve substantial compliance, Defendant must demonstrate the ability to sustain the *Farrell* reforms. Defendant is demonstrating the capacity to do this by implementing not just the reforms but the systems that will measure their effectiveness over time.

The Special Master respectfully submits this report.

Dated: March 30, 2015

Nancy M. Campbell
Special Master

[72] This is most notable with the recent promotions of four talented SYCCs at VYCF. This phenomenal group of talented young supervisors is earning the respect of long-term staff at the same time that they are shifting the culture from a moral accountability model to a behavioral health model.

Mental Health Audit Comprehensive Summary

December 2014 Audits

INTRODUCTION

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

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

Since the last mental health audits in early 2014, there have been a number of developments in DJJ that have helped to bring stability to the agency generally and mental health specifically. The dramatic population changes have slowed, bringing both less change and movement of both the youth and staff. This has allowed teams to gel and the youth to be more consistently engaged. The Integrated Behavior Treatment Model (IBTM) has also continued to develop, bringing about some of the expected reductions in mental health crises because of the growing the ability of the program staff to manage more of the day-to-day problems and because the IBTM provides a more supportive and behaviorally sound environment for the youth. This has allowed mental health staff to better focus their resources on the youth with mental health needs that go beyond the capacity of the IBTM to meet their needs.

While there have been some continued changes in mental health leadership, these changes have been less dramatic and disruptive and the mental health staff are functioning more and more like a team within their ranks and are also participating more actively in the IBTM.

There have also been a number of changes in mental health staff, with mixed impact on the mental health program. But these changes appear to be settling down and the mental health staff themselves are better understanding and settling into their roles as both treatment providers and partners in the IBTM. The appointment of Dr. Bowlds as the head of mental health, with her experience and involvement with the IBTM, has helped this process along.

The mental health program itself is developing well and is progressively better organized. DJJ has adopted some sound evidenced-based approaches and processes for transfer of mental health youth are functioning more effectively. The quality of services and documentation is improving. While there are areas of difficulty, the trend is clearly in a very positive direction.

ORGANIZATIONAL FUNCTIONS

While there is clear improvement here, this still requires some attention in specific areas.

Relationship Between Mental Health and Other Staff

On the units, these relationships have improved dramatically in almost all settings. The collaboration between mental health and other staff is much stronger and there is very little

divisiveness. The sense of partnership and mutual respect is notable. This is a testimony to both the quality of leadership and the staff.

It is important to note that this has not come at the expense of abandoning appropriate boundaries. In fact, a clarification of the roles and boundaries has been more help than hindrance. As mental health staff grow into their roles in the IBTM and other staff accept their participation, teamwork and collaboration naturally improved. But mental health staff have also maintained appropriate confidentiality in their treatment of youth. By focusing their mutual communications on salient youth behaviors, the details of work in therapy can remain confidential. And because mental health staff have growing clarity about who is getting treatment and who is not, especially on core units, it is easier for them to know where and how to draw the boundaries of confidentiality.

The structure of mental health services is also improved. There is greater clarity about who is in treatment and who is not (though there remains work to do here). This is both due to efforts to provide specific courses of treatment to those in need of services and because of an intentional move away from a crisis-driven approach to mental health to an approach that emphasizes referral, assessment of need for services, and provision of needed services. In short, the delivery of care is being better managed and is driven by clinical assessment of need rather than responding to the crisis of the day. Despite this, crisis services, when needed, continue to be timely and focused.

It still remains to clarify the organizational structure. Mental health, IBTM, and security (and other services) are all well and appropriately represented in Executive and unit management but this is not well laid out in organizational charts or policy (or other means of formally specifying the relationships between different positions or departments). It is important to be cognizant of the difference between formal administrative chains of command and the relationships between the different chains of command. While the chains of command for different departments may not converge until the level of the superintendent or even headquarters, the different chains must explicitly understand how they relate at levels below this convergence. One example pertinent to mental health and facility leadership is that the superintendent does not directly administratively supervise mental health staff (the Senior Psychologist) but mental health still needs to be represented within facility executive management.

With regard to case planning, mental health involvement is much improved, especially at VYCF. NACYCF has also improved but it remains somewhat spotty. Accordingly, case plans show somewhat more attention to mental health related behavioral problems and barriers to change. There is room for improvement but also clear progress.

<u>Policies</u>

DJJ has been reworking its mental health and associated policies. Some are finalized, others are nearly finalized. The mental health policies and the Mental Health Services Guide are all improved. The Mental Health Services Guide is comprehensive and well-targeted. While some of the policies remain unduly complex, procedural, and redundant, they are a substantial improvement over past policies. They are more internally consistent and consonant with existing law and recent changes in law (which itself is unduly complex in California) and practice.

The pending informed consent polices address a substantial lack from the previous audit. They address the legal changes with regard to involuntary psychotropic medications, the mechanism for getting judicial consent for certain minors, and informed consent for therapy. Implementation of the new judicial consent has proven somewhat problematic. While some of the problem lies with certain jurisdictions' own struggles to implement the law, there have been challenges internal to DJJ that need to overcome. This is not seen as a major issue as adaptation to such statutory provisions requires new procedures that take some time to smooth out.

The role of mental health in forensic functions such as DDMS, JJAC, and parole board hearings has been clarified to a great degree though has not been fully implemented, primarily at NACYCF. At VYCF, there is regular participation by a non-treating psychologist at JJAC, parole board hearings and at DDMS hearings involving mental health youth and psychologists are active participants. At NACYCF, psychologists do not participate in DDMS hearings, with the Senior Psychologist "signing off" on the results of the hearing after the fact. They do participate in JJAC and parole board, though the extent of participation seems to vary. Greater clarity regarding the role of psychologists at these meetings would be welcome. Here again, it is reasonable for treating psychologists to provide a summary of treatment progress but if what is wanted is more on the order of a risk assessment or other forensic opinion, the participant should be a non-treating psychologist. Clearly, a treating psychologist would not be needed in cases where there was no treatment. Most likely, the role would be best played by a non-treating psychologist, especially if routine participation is to be expected.

Staffing

Mental health staffing is mixed. There are easily sufficient psychology positions when filled. At VYCF, the coverage has been generally adequate though there has been a good deal of covering for absent staff owing to illness and vacancies. But it has not severely affected service delivery except to some degree on the female unit, though that is now improved. At NACYCF, staffing problems have resulted in lack of coverage on some core units and has probably contributed to the back-sliding seen in the intake process.

Psychiatric coverage at NACYCF remains inadequate. This has resulted in some follow-up not being timely.

Licensed Psychiatric Technician (LPT) positions are adequate and reasonably well-filled.

DJJ continues to have virtually no ancillary clinical staff such as Occupational Therapists and Recreational Therapists and few Social Workers. While these job classes are not required by the remedial plan, the first two especially could be a great benefit on the residential units and Social Workers would be able to provide assistance in continuity of care and provision of some services such as family engagement. This would aid DJJ in being able to deliver evidence-based services on the residential mental health units.

Ancillary Services

Ancillary services such as laboratory, imaging, electrophysiology, and medical consultation are adequate. The formulary, though now reduced is sufficient, again given that non-formulary requests are generally honored. There is now a clinical pharmacist available for consultation.

RESIDENTIAL MENTAL HEALTH SERVICES

The vast majority of mental health youth continue to be housed on residential mental health units. Those that are not almost uniformly have been on such a unit and have transitioned appropriately to other units.

The services and structure of the residential mental health units has started to be developed but has some way yet to go. While not finalized at the time of the audit, there is now a program manual that provides sufficient detail and guidance in terms of clinical services to be offered. DJJ has largely implemented Trauma Focused CBT which is to remain the centerpiece of its mental health program. There are plans currently in the works to implement medication education as the first step towards the development of rehabilitative services. This can pave the way for other specialized services such as mental illness awareness, relapse prevention, social skills (which may need to be different than or augment those provided in IBTM modules), and specialized community transition services including accessing community services and family engagement.

The units are more structured than previously, primarily owing to the IBTM. There remains no level system beyond the Youth Incentive Program and it is unclear whether the impending DJJ level system will be sufficient to address the unique challenges and needs of the youth on the residential mental health units. The systems developed need to provide highly structured activities designed to promote socialization in a safe environment, including recreation. Unstructured program time should be minimized, especially for those youth who are struggling or who have decompensated. As noted previously, the program also needs to be designed to promote medication adherence and treatment engagement. This is likely to require a level or privilege system that is consistent with but augments the general level system being developed.

A unified Treatment Plan for the residential mental health units that is shared by all clinical staff is being developed and has been implemented to some degree at VYCF. It is a reasonable approach and format.

Case Plans have improved but continue to be fairly generic in most instances. There has been some improvement in the degree to which Case Plans address mental health issues such as youth limitations or specific behaviors related to symptoms, but most still do not. But few Case Plans are frankly inconsistent with the mental health needs of the youth. At NACYCF, Case Plans on the residential units were frequently not completed timely.

Psychotropic prescribing remains sound, though as noted above psychiatric availability at NACYCF is inadequate at present. Treatment groups under the TF-CBT are being run and those observed were of high quality. Individual therapy is much better focused in most instances and progress notes reflect implementation of intended treatment most of the time as well.

One clear marker of improvement is that the youth are almost uniformly able to articulate what they are working on in treatment. And many are even able to distinguish what they are working on in terms of their mental health Treatment Plan and their Case Plan.

OUTPATIENT MENTAL HEALTH SERVICES

Outpatient psychiatric services are generally sound at VYCF. Psychotropic prescribing remains very solid at both institutions, though less timely at NACYCF.

At NACYCF, staff shortages have substantially undermined outpatient services on the core units. There were essentially no such services at the time of the audit. Staffing is set to improve and this should turn things around. But this is one area of notable backsliding.

Psychotherapy services at VYCF are dramatically improved. There are better assessments with targeted treatment plans based on formulations which in some cases are quite good. Most treatment is now goal-oriented. There remains minimal group therapy, but as noted before, this may not be a big problem but could provide a more efficient and effective means of providing treatment for some disorders.

OTHER MENTAL HEALTH SERVICES AND FUNCTIONS

Licensed Mental Health Care

The lack of availability of licensed mental health care is a significant problem for DJJ that has, if anything, worsened. It is important to state again that DJJ has been making reasonable efforts to secure contracts and agreements in order to be able to provide services to the seriously ill, but there are gaps in the available services. DJJ continues to have no provision for minor youth needing more than acute level services and even acute level services have been challenging to obtain. There was a youth at NACYCF in need of such services but DJJ had not been able to secure such services at the time of the audit, apparently due to the criminal history of the youth, despite the fact that the youth was not presenting any significant acting out behavior.

Screening

Both pre-admission screening and post-admission screening continue to be adequate and reliably done.

Initial Psychological Assessment

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

More problematic, many initial psychological assessments are being done quite late. DJJ has already made some staffing changes to address this problem.

The assessments still generally result in no formulation or summary of the results that can be used to guide either treatment or case planning, though those done at VYCF (primarily with the

female population) show real improvement in this regard. There is still no evidence that the results of the psychological assessment are being used to help formulate Case Plans. The comments from the last Comprehensive Summary bear repeating. These assessments can provide important information about sources of risk, barriers to treatment, and protective factors. But perhaps most importantly, they can help the teams identify specific targets of intervention specific to each youth within the domains of risk identified by the YASI. For example, a youth may have problems with aggression/violence for a variety of reasons. And while general CBT approaches may be of value to nearly all such individuals, focusing on the particular nature of the risk (e.g. traumatic brain injury, mental illness, trauma) can be of vital importance in many cases.

It is important to make another point, which is that the Initial Case Review needs to be looked at. While auditors only attended one of these, it was highly concerning. It was called by the person chairing it "a hearing" and it was run like a hearing. Most of the time was spent asking the youth to recount the crime and there was virtually no mention of treatment goals. The psychologist's participation consisted entirely of stating that there were no mental health conditions needing treatment. There was no evidence that there had been any coordination between staff members in terms of developing a shared view of what was going on with the youth or that this was even something that should be done. The youth's participation was minimal and he was barely invited to speak. This meeting should be designed to develop a clear case conceptualization and launch the youth into treatment. Perhaps others are run differently, but if not, substantial reworking is needed.

Psychologists' IBTM Functions

As noted at the top, psychologists are much more engaged with the IBTM at both NACYCF and VYCF. Some are assisting in IBTM groups. Many are providing assistance and guidance with the Reinforcement System and are more active on the units.

Use of Force

Use of force in general remains down, including with mental health youth. There have been some questionable uses of force on mental health youth but these are being addressed appropriately. The review process is clearly helping in this regard but there have also been changes in staff attitudes and behaviors that have helped as well.

Self-Harm

It is much easier to track the chain of events leading to placement of a youth on suicide precautions largely owing to the improved documentation of psychologists, especially at VYCF. Evaluations of such youth by psychologists are timely and of good quality with the reasons for changes in status clearly documented.

Most of the informatics problems have been resolved as well.

While there is little doubt that observation of the youth is occurring per policy, in many instances the documentation (check sheets) could not be located. Those that were located were complete and consistent with the youth's status. This is relatively simple to fix and is not anticipated to present a problem.

Respectfully submitted,

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3/14/15