

CALIFORNIA DEPARTMENT OF  
CORRECTIONS AND REHABILITATION  
DIVISION OF JUVENILE JUSTICE

**MENTAL HEALTH REMEDIAL PLAN**

August 24, 2006

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# Section 1

## OVERVIEW / SUMMARY

### BACKGROUND

On November 19, 2004, a Consent Decree was entered into in the case of *Farrell v. Allen* by the plaintiff, Margaret Farrell, a taxpayer in the State of California, and the defendant Walter Allen III, Director of the California Youth Authority, now the Division of Juvenile Justice (“DJJ”) within the California Department of Corrections and Rehabilitation (“CDCR”). The Consent Decree required the defendant to file remedial plans in all areas of deficiency identified by experts for the Court by January 31, 2005. In January 2005, based on DJJ’s decision to reform California’s juvenile system to a rehabilitative model based on a therapeutic environment rather than simply address the deficiencies identified by the expert reports, the parties stipulated to extend the dates for the filing of remedial plans.

Pursuant to the agreed upon time extension, DJJ filed its proposed Mental Health Remedial Plan on December 1, 2005. Both parties agreed that the plan submitted by DJJ lacked details sufficient for implementation.

By agreement of the parties, national experts William Arroyo, M.D., Kimberly Hoagwood, Ph.D, Richard Shaw, M.D., and Hans Steiner, M.D. were retained to review and revise the Mental Health Remedial Plan in consultation with the parties and the mental health experts serving under the Consent Decree. The experts also consulted with Gail Wasserman, Ph.D. and with the Consent Decree Sexual Behavior Treatment expert, Barbara Schwartz, Ph.D. Christopher Murray organized and coordinated revisions for the experts. The experts affirmed the planning reflected in DJJ’s initial version and refined and strengthened the Plan by revisions which are reflected in this document

### PLAN ORGANIZATION

Starting with Section 3, each section of this Plan begins with a brief description of **The Issue**. This is followed by a **Discussion** section wherein details concerning deficiencies and required changes are presented. Each section concludes with an **Action Plan**. A plan for monitoring for compliance, including Standards and Criteria and identification of Actions Necessary to Achieve Compliance, will be filed with the Court by December 15, 2006.

### RELATIONSHIP TO PREVIOUSLY FILED PLANS

As necessary, DJJ will work with the *Farrell* Consent Decree experts in the areas of medical care, education, disability, sexual behavior treatment, and safety and welfare in order to reconcile the previously filed plans with any conflicts in this Plan. In the interim, as inconsistencies between this Plan and any of those plans are identified, DJJ will notify plaintiff’s counsel, the Special Master and the appropriate Consent Decree expert(s) to convene a discussion to resolve the discrepancy. If discrepancies are not resolved by agreement, either party may invoke the dispute resolution procedure under paragraphs 48 and 49 of the Consent Decree.

### RESOURCES NEEDED FOR PLAN IMPLEMENTATION

Reference throughout this Plan to numbers and types of staff reflect DJJ’s and its expert consultants’ judgments at the time the Plan was filed as to the numbers and type of staff necessary for successful implementation. References to positions are working titles rather than

specific job classifications. DJJ will adjust staffing levels and types of staff when such changes are necessary to achieve programmatic compliance. DJJ will not be found in non-compliance based solely on the number or type of staff in a particular program or function where DJJ is in programmatic compliance.

Before it makes substantial reductions in the staffing set forth in this Plan, DJJ will provide at least sixty days notice to plaintiff's counsel and the Special Master. This notice will demonstrate that the proposed reduction will not hamper DJJ's progress towards programmatic compliance in any area covered by this Plan. Changes in types or classes of staff that result in reducing qualifications of significant numbers of staff are deemed a "reduction" in staff for purposes of this paragraph. Any dispute between the parties over reductions, whether reductions are substantial, or whether reductions are likely to hamper DJJ's progress towards programmatic compliance, will be resolved pursuant to paragraphs 48 and 49 of the Consent Decree.

## Section 2

# PROGRAM STATEMENT

### MISSION STATEMENT

The primary goal of the Division of Juvenile Justice is to enhance community safety by providing a safe, secure, productive, and accountable system in which staff, local stakeholders, victims, the community, youth and their families work toward returning youth to the community as responsible and productive citizens. The mission of DJJ is defined by law:

*“To protect society from the consequences of criminal activity and to that purpose community restoration, victim restoration, and offender training and treatment shall be substituted for retributive punishment and shall be directed toward the correction and rehabilitation of young persons who have committed public offenses.”*

-Welfare & Institutions Code Section 1700

Enhancing community safety refers to both immediate and long-term safety. The Division of Juvenile Justice (DJJ) will place youth in secure facilities that provide rehabilitation/treatment aimed at reducing risk and increasing protective factors. Long-term safety will require ongoing efforts with local stakeholders to determine strategies to most efficiently and effectively protect communities and rehabilitate youth.

The specific mission of Mental Health Services consists of providing comprehensive and integrated forensic and Mental Health Services to juveniles served by DJJ. Mental Health Services include: screening, diagnosis, psychometric assessments, psychotherapeutic and pharmacotherapeutic treatment, consultation services to direct care and other staff; as well as leadership of clinical programs operating within a continuum of care in a variety of settings. Selection and delivery of services will follow existing evidence based standards of mental health care.

### PHILOSOPHY OF CARE

The philosophy of mental health treatment is based on principles of developmental psychopathology. This model includes the following principles:

1. The primary goal of mental health care in the juvenile population is to address issues that are interfering with adaptive functioning and to help restore the youth to a normative path of development.
2. Psychopathology in youth must be considered in relationship to developmental issues. Behavior in adolescents must be interpreted in the context of the youth's chronological and developmental age with consideration for the youth's level of social and emotional maturity.
3. Psychopathology in youth must be considered in the context of the individual's social, family and educational environment, both with respect to factors that promote maladaptive functioning, and with respect to factors that need to be a focus of mental health treatment.
4. Models of treatment that are based on work with adult patients must be adapted to incorporate developmental issues that are relevant in the assessment and management of youth with psychopathology.
5. Assessment and treatment of youth will take into account both strengths and weaknesses of the individual.

## **TREATMENT PRINCIPLES**

Principles of mental health treatment in the juvenile population include the following:

1. Assessment and treatment of individuals will be multimodal and address individual, family, educational and environmental factors.
2. Treatment will be individualized wherever possible according to the specific needs of the individual.
3. Families, when available, will be considered to play a key role in the rehabilitation of youth and prevention of recidivism and will wherever possible be incorporated in the youth's mental health treatment.
4. There will be a continuum of mental health treatment that addresses the intensity of the individual's mental health needs while ensuring placement in the least restrictive treatment environment.
5. There will be a system of ongoing monitoring and assessment of treatment progress.
6. Wherever possible, treatment will be founded on evidence based practices.
7. Mental health treatment will be provided by mental health staff with training and expertise in mental and behavioral health, especially as it pertains to youth.

## **FAMILY INVOLVEMENT**

Treatment outcomes for mentally ill youth are enhanced by successful involvement of parents, guardians, and/or other significant adults in the youth's life. Opportunities to solicit and engage families exist throughout the youth's commitment to DJJ. This includes intake and assessment, treatment, transition to the community, and parole.

## **CONTINUUM OF CARE**

The continuum of mental health services has two primary dimensions: time and intensity. The temporal dimension refers to continuity of services from intake and assessment through transition to the community and services while on parole. The intensity dimension refers to the delivery of services at different levels of intensity as determined by level of staffing, capacity to control behavior and target systems, and the amount of therapy time. Treatment levels, in decreasing order of intensity, are: inpatient (including acute and intermediate care), residential, and outpatient.

As noted in the 2001 report to Governor Davis, *The Assessment of the Mental Health System of the California Youth Authority* (Steiner, et. al. 2001), "While morbidity is high, we expect that extensive rather than intensive intervention will be the basic model to address most [mental health issues in DJJ]. Finally, we expect that most children will require multi-modal, carefully coordinated intervention, targeting multiple deficient domains. The main principle governing treatment will be that the [youth] be allowed to function in the least possible restrictive environment which is capable of ensuring safety and personal growth."

## **EVIDENCE BASED TREATMENT / EVIDENCE BASED PRACTICE**

The phrase "evidence based treatment" refers to interventions consistently supported by scientific evidence that demonstrate improved patient outcomes. "Evidence based practice" is a treatment approach that provides practitioners with a publicly accountable decision making process based on scientific research. This treatment approach involves research-based, generally structured and manualized practices that have been examined using randomized trials or other controlled designs measuring both the efficacy and effectiveness of the practice [Hoagwood,

2006]. However, it is important to note that there are very few evidence based mental health treatments that have been validated within the juvenile justice populations. There is a strong need for evidence based practices that have been developed in the general population to be piloted and evaluated within the DJJ population as part of the longer term development of the mental health plan.

This Remedial Plan provides a strategy for moving DJJ mental health services to an evidence based treatment and evidence based practice approach.

### **INTEGRATED TREATMENT**

As described in the Safety and Welfare Plan, all youth in DJJ facilities will be involved in cognitive behavioral treatment interventions related to the behavior and criminogenic factors that contributed to their commitment to DJJ. The principles of cognitive behavioral treatment permeate all components of the continuum of care.

Under this Remedial Plan, the mental health team possesses (or will possess following appropriate training) the expertise to help guide the development of interventions under the Integrated Behavior Treatment Model, to develop curriculum and provide training, and to provide coaching/consultative services to treatment team leaders and direct care staff involved in the day-to-day provision of treatment services to youth in non-clinical settings.

DJJ recognizes that it is important for all staff - including administrators, living unit staff, educators, security staff, mental health providers, integrated behavioral treatment providers, and other program providers within DJJ - to collaborate in the development of the Integrated Behavior Treatment Model.

## **Section 3**

# **ORGANIZATIONAL STRUCTURE**

### **THE ISSUE**

Mental Health Services requires a close relationship with Health Care Services. Its psychiatrists are clinically supervised by the Medical Director and it relies on nursing, pharmacy, records, and other Health Care Services personnel and support systems. It provides direct care to youth in residential mental health programs and through outpatient mental health services. Mental health staff also provide training, consultation, and coaching to direct care staff who are not in the Mental Health Services chain of authority but who deliver treatment services under the Integrated Behavior Treatment Model.

The relationship of Mental Health Services, Health Care Services, and Integrated Behavioral Treatment Services, as well as the role of mental health leaders in central office and at facilities, is described below.

### **DISCUSSION**

Like implementation of the Safety and Welfare Remedial Plan, implementation of the Mental Health Remedial Plan requires creating the capacity for change by creating strong central office leadership and employing dedicated staff to guide and facilitate transition to a reformed mental health system in DJJ facilities.

#### **Statewide Leadership**

##### Authority

The authority for the establishment and operation of the California Department of Corrections and Rehabilitation, Division of Juvenile Justice, and the appointment of the Chief Deputy Secretary for Juvenile Justice is set forth in Division 2.5, Chapter 1, Section 1700 et. seq. of the Welfare and Institutions Code. The Chief Deputy Secretary for Juvenile Justice is authorized to make and enforce all rules proper to the accomplishment of the functions of the Division of Juvenile Facilities, including those related to the medical, surgical, dental, and mental health needs of lawfully committed youth.

##### Program Services

DJJ will have a Director of Programs who reports to the Chief Deputy Secretary, DJJ. The Director of Programs has administrative responsibility for all program services in DJJ facilities, including, among others, Health Care Services, Mental Health Services, Integrated Behavioral Treatment Services, and Education Services.

The Medical Director directs all health care services for youth in DJJ. He or she is director of Health Care Services and reports to the Director of Programs. The duties and responsibilities of the Medical Director are described in the Health Care Services Remedial Plan.<sup>1</sup>

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<sup>1</sup> A different reporting relationship was described in the previously filed Health Care Services Remedial Plan. DJJ will convene a discussion between plaintiff's counsel, the Special Master, the Consent Decree Health Care experts, and the Consent Decree mental health experts to resolve the discrepancy. If this issue cannot be resolved by agreement, either party may invoke the dispute resolution procedure under paragraphs 48 and 49 of the Consent Decree.

The Mental Health Services Director/Chief Psychiatrist has responsibility for all services provided by mental health staff in DJJ facilities. This includes mental health staff providing direct care in residential mental health programs and in mental health outpatient services. This also includes supervision, either directly, or through the Chief Psychologists, of mental health staff providing training, consultation, and coaching to non-mental health staff who provide direct care under the Integrated Behavioral Treatment Model.

DJJ will also have a Director of Integrated Behavioral Treatment Services who reports to the Director of Programs. This person has administrative responsibility for the development of all core rehabilitation/treatment programs, including substance abuse/dependence treatment and sex behavior treatment programs.<sup>2</sup>

Because treatment on core rehabilitative/treatment units is based on the same principles and uses the same treatment model as residential mental health programs there is great overlap between the techniques and skills used by staff in core programs and staff in mental health programs. The mental health staff and the trainers in the Integrated Behavioral Treatment Model will have the highest level of expertise with the treatment model. Consequently, while administratively separate, the relationship between Mental Health Services and Integrated Behavioral Treatment Services must be very close.

To promote this close relationship, the Director of Integrated Behavioral Treatment Services will coordinate closely with the Mental Health Services Director and Mental Health Services staff to: (1) help develop the Integrated Behavioral Treatment Model, (2) provide training and ongoing consulting/coaching of non-mental health staff in use of the model, and (3) help maintain quality control and fidelity to the treatment model.

DJJ will continue to assess and modify, as needed, an appropriate organizational structure in conjunction with all of the Consent Decree experts.

#### [Integrated Behavioral Treatment Services Leadership](#)

The Integrated Behavioral Treatment Service is based on a behavioral health concept in which all youth are provided services to increase their emotional and behavioral control through application of the Integrated Behavioral Treatment Model (IBTM). The Director of Integrated Behavioral Treatment Services oversees program development and implementation and operation of all Integrated Behavioral Treatment Programs. This will be done in conjunction with the Chief Psychiatrist and Chief Psychologists who will have primary responsibility for issues involving mental health programs, clinical content, and supervision of mental health staff.

#### [Mental Health Services Leadership](#)

The Mental Health Services Director/Chief Psychiatrist will provide leadership and management of Mental Health Services, including supervision of mental health clinicians and clinical oversight and direction of mental health services. He or she will be responsible for developing

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<sup>2</sup> The role of the Director of Integrated Behavioral Treatment Services may be in conflict with some aspects of the Sexual Behavior Treatment Program Remedial Plan. If conflicts are found to exist, DJJ will convene a discussion between plaintiff's counsel, the Special Master, the Consent Decree Sexual Behavior Treatment expert, and the Consent Decree mental health experts to resolve any discrepancies. If the issue(s) cannot be resolved by agreement, either party may invoke the dispute resolution procedure under paragraphs 48 and 49 of the Consent Decree.

policies and procedures for the delivery of mental health services to ensure compliance with existing federal and state laws and regulations, and community standards. The Mental Health Services Director/Chief Psychiatrist will ensure that:

1. Supervision, training, and development of mental health staff are provided.
2. The quality of mental health care is monitored and continually assessed.
3. Ethical and professional standards of practices are implemented.
4. A system to evaluate the productivity of mental health care staff is developed.

If DJJ chooses not to use a Chief Psychiatrist as the Director of Mental Health Services in the future, the Director will be a clinician.

### Access to Care

Access to mental health care will be available to all youth in a timely way. Access will be determined by policy and clinical criteria. Access to care includes access to supportive services necessary to provide that care including nursing, pharmacy, laboratory and other diagnostic and ancillary services.

### Mental Health Policies and Procedures

The Mental Health Services Director/Chief Psychiatrist will provide leadership and oversight in developing and implementing:

1. Standard juvenile-specific mental health policies and procedures, treatment guidelines, and clinical programs, ensuring each will be commensurate with applicable community standards.
2. Standard policies and procedures regarding mechanisms for mental health delivery, including access to care, medication administration, initial screening, health records, and response to emergencies.
3. The mental health components of the Health Care Services Standards and Compliance Program.
4. The mental health components of the Health Care Services Quality Management Program, including peer review of mental health clinicians and routine monitoring of the process of care.

### Integrated Behavioral Treatment Model

The principles of the DJJ Integrated Behavioral Treatment Model are described in the Safety and Welfare Remedial Plan. These principles apply to all treatment programs, including mental health, sex behavior treatment, substance abuse/dependence treatment, and behavior treatment. Within this context, the intensity of services and treatment modality for each youth are governed by the principles of risk, needs, and responsivity.

The Chief Psychiatrist is responsible for the mental health components of the Integrated Behavioral Treatment Model. This includes responsibility for defining policies and procedures, standards, training requirements and curriculum, and quality assurance measures through a collaborative process with the Integrated Behavioral Treatment Services staff. DJJ will ensure that there is collaboration between education, custody, mental health, and other program services in development of the Integrated Behavioral Treatment Model.

### Resource Allocation and Tracking

DJJ will ensure that resources authorized by the legislature through the annual budget process are allocated and tracked through separate and distinct allotments for Health Care Services and that Mental Health Services is identified as a separate category.

Once budget allotments are made, only the Chief Deputy Secretary, DJJ can approve the transfer of spending authority or positions into or out of Health Care Services or Mental Health Services and obtain, as needed, authorization from CDCR administration and state governmental agencies.

### Recruitment, Hiring and Job Descriptions

Recruitment and hiring to fill authorized mental health positions will be the responsibility of the Mental Health Services Director or his/her designee in coordination with Human Resources.

Job responsibilities for mental health personnel will be established by division policy and be consistent with activities included in approved class specifications. Policy regarding clinical responsibilities of clinical staff will be determined by the Chief Psychiatrist or his/her designee consistent with approved class specifications.

### Organizational Structure

DJJ will develop and maintain a central office table of organization consistent with the principles outlined above and in the Safety and Welfare Remedial Plan.

### **Facility Leadership**

As set forth in the Safety and Welfare Plan, the superintendent is responsible for his or her facility. The superintendent's responsibility is to carry out division policy, ensure the safe and orderly operation of the facility, and ensure programs and services are provided to youth. Clinical mental health decisions will be made by the top level mental health clinician at the facility or his/her designee. Facility budgets, personnel decisions/evaluations, and program content for mental health are managed as noted above under "Statewide Leadership" (subsections "Resource Allocation and Tracking" and "Recruitment, Hiring and Job Descriptions").

The senior psychologist (or highest ranking mental health clinician) at each facility is a member of the superintendent's executive team and participates in regular briefings, facility committees, and other administrative meetings as appropriate. A protocol will be established to ensure that if staff interfere with the clinical and/or professional judgment of mental health staff, those issues are addressed at these meetings. If consensus is not reached, the issues will be referred up the appropriate chains of authority for resolution.

### Performance Evaluations and Disciplinary Action

Performance evaluations of all mental health personnel will be conducted in accordance with division policy by the supervisor at the appropriate level within the mental health chain of authority. The superintendent or his/her designee may, at the superintendent's discretion, provide input to persons completing performance evaluations of all mental health staff. If the superintendent believes that the top level administrators are not performing appropriately and/or in accordance with division policy, he or she will take the concern up the appropriate chain of authority.

The senior psychologist (or highest ranking mental health clinician) at each facility, or his/her designee, may provide written input in evaluations of non-clinical staff working in the mental health units and/or staff providing direct services in core program treatment units under the Integrated Behavioral Treatment Model.

Consistent with state, departmental, and division policy and applicable laws, the facility superintendent may initiate disciplinary or corrective action, as applicable, against any state or contract employee, except that disciplinary action with regard to clinical matters and professional ethics will be the sole responsibility of the Chief Psychiatrist or designee(s). Notwithstanding reporting relationships within the mental health chain of authority, the facility superintendent retains the authority to control access of all personnel to the facility and will consult with the Chief Psychiatrist or his/her designee whenever there is a question of permitting access to the facility of any mental health staff.

### Core Program Treatment Units

As part of the Integrated Behavioral Treatment Model discussed in the Safety and Welfare Plan, core program treatment units and other non-mental health treatment programs will have the capacity to provide group and individual treatment/teaching for emotional dysregulation, anger control, aggressive behavior, social skills, communication skills, and substance use education. Direct care staff in these units receive clinical oversight (but not administrative supervision) from qualified mental health professionals, including psychiatrists, psychologists, or social workers, who provide training and coaching in cognitive behavioral treatment and interventions.

### Working Conditions

Working conditions, including clinical responsibilities, hours, and primary place of employment, for mental health staff (i.e. staff within the mental health chain of authority) will be determined by the Chief Psychiatrist and Chief Psychologists, except that:

1. Hours for mental health coverage will be set by the Senior Psychologist in accordance with a coordinated Program Service Day schedule at each facility to ensure that all mandated and routine professional services are provided in a manner that minimizes intrusion of one discipline on another.
2. In units on temporary lockdown and during times of emergency, the Senior Psychologist will work with custody and medical staff to ensure that routine Mental and Integrated Behavioral Health services – such as the dispensing of medication and counseling – are provided on the unit or other location specified by the superintendent.

### Organizational Structure

DJJ will develop and maintain a table of organization for each facility consistent with the principles outlined above and in the Safety and Welfare Remedial Plan.

### **Treatment Team Leadership**

The treatment team leader roles and responsibilities will be defined in the development of the Integrated Behavioral Treatment Model. Regardless of the position/job classification designated for this role in mental health treatment units, the functional leadership, i.e., leadership based on the specific skill set needed to guide the team on a specific issue, will be given to the appropriate team member. For example, if the problem being discussed is primarily a diagnostic issue, the

functional leadership role will be taken by the mental health clinician; or, if the problem being discussed involves the structuring of the youth's day, the functional leadership will be taken by the unit supervisor. The use of designated and functional leaders in the team concept will allow the individual with the greatest skill to lead the team when necessary.

#### Mental Health Program Treatment Team

Mental Health Program living units will operate under the unit team concept.

The unit supervisor is responsible for supervision of one mental health program unit. This person provides oversight of the daily operations of the living unit, including staff supervision, scheduling, discipline, grievances, and reports. This person is the primary liaison between the living units and upper-level facility management.

The Clinical Psychologist provides mental health services for youth in the mental health program unit. The psychologist also provides training, coaching and consultation in cognitive behavioral treatment and interventions to direct care and other staff in these units. Additionally, psychologists in the mental health programs will provide direct services to youth, including individual and group therapy. Clinical Psychologists are part of Mental Health Services and report to the facility's Senior Psychologist.

The team psychiatrist will provide direct clinical services to youth, including individual therapy, group therapy, and evaluation, and provide input to Individual Change and Accountability Plans. The psychiatrist will have allocated time to participate in the team meetings and provide input on diagnosis and psychopharmacologic treatment options. Psychiatrists will provide education to team members on psychiatric practice parameters and provide input on measures used to measure the effectiveness of the symptoms treated.

The case manager is responsible for facilitating monthly case conferences of the multi-disciplinary team, conducting the majority of the risk/needs assessment, developing an Individual Change and Accountability Plan (ICAP) tailored to the risk and needs of each youth, coordinating and prioritizing interventions, documenting progress in the ICAP, communicating with parents, guardians, parole officers, and others, and providing weekly individual and/or group counseling.

The Senior Youth Correctional Counselor is responsible for the living unit schedule and supervising the Youth Correctional Counselors on the unit. The Senior Youth Correctional Counselor is accountable for the cleanliness, security, and order of the living unit.

Youth Correctional Counselors provide direct supervision, behavior management, skills training and maintain a normative culture on the unit. As part of the normative culture model, YCC's facilitate group meetings daily. YCC staffing will be sufficient to ensure that small groups or activities can be run simultaneously during the day or evening, as needed.

Nursing staff are critical members of the mental health team and provide mental health and medical support on the units, consistent with their classification and licensure. This may include medication administration, health and mental health education, maintaining the normative culture, and implementing the Integrated Behavior Treatment Model.

Licensed Psychiatric Technicians are responsible to support psychiatric nursing functions under the direction of the team psychiatrist that are consistent with their license and classification. They may provide group and individual counseling and education of youth in the areas of mental health signs and symptoms and utilizations of aspects of the integrated behavioral treatment model.

### Treatment Team Organization

Treatment teams are organized around the concept that the treatment team is responsible for addressing the behaviors and needs of the youth assigned to the team. Each team member is responsible for the progress and achievement of the youth. Teams will be multi-disciplinary and include input from living unit staff, treatment/rehabilitation service providers, education, medical, mental health, parole, family, and youth as appropriate and possible. Treatment teams make decisions and recommendations regarding individuals, but facility/central office teams make decisions that impact more than one youth or unit (e.g. priority for placement, jobs). Facility-wide services support team decision-making regarding each youth's behavior and monitor the effectiveness of the approaches used by the team in guiding the youth's development and conduct. Each team member has:

1. Technical or functional expertise and skill in implementing the DJJ Integrated Behavioral Treatment Model.
2. Problem solving and decision-making skills.
3. Good interpersonal skills.

Each team member requires all three skills for the team to be effective, but different members have different technical or functional skills, as appropriate.

Treatment teams are focused on goals tied to the division's mission; outcomes are to be defined by the program model.

### **ACTION PLAN**

1. DJJ will produce an organizational chart for central office consistent with the principles outlined in this section by September 1, 2006.
2. DJJ will produce an organizational chart for each DJJ facility consistent with the principles outlined in this section by October 1, 2006.
3. DJJ will institute a protocol at each facility, and for the Division, for resolution of disputes related to the exercise of clinical and professional judgment by mental health personnel. This protocol will be in place by July 1, 2007

## **Section 4**

# **SCREENING AND ASSESSMENT**

### **THE ISSUE**

In order to provide appropriate individualized treatment, case plans must be based on high quality assessment of risks and needs. In order to provide high quality assessments in an efficient manner, reliable screening tools are needed to identify those youth who need additional testing and/or clinical evaluation.

### **DISCUSSION**

#### **Goals of the Assessment Process**

Mental health assessment will be comprehensive and consist of instruments which address areas of strengths and limitations including major mental health diagnoses, adaptive functioning, personality, coping style, and family functioning. To the maximum extent possible, instruments will be standardized, have established validity in the juvenile and young adult population, take into account ethnicity, gender, and age effects, and be available in both hard copy and electronic format. As needed, DJJ will use interpreters or have the instruments translated into other languages. At minimum, instruments will be available in Spanish and English. Methods of assessment will be complementary and lead to:

1. A profile of symptoms and functioning that require immediate attention (e.g. homicidality; suicidality and/or self harming behaviors; potential for aggression and violence; psychosis; developmental delays; problems with self care).
2. Assessment of youth with regard to the mental health elements of the acceptance criteria developed in accordance with the Safety and Welfare Remedial Plan.
3. Comprehensive assessment of psychopathology (including psychiatric diagnoses, personality and traits relevant to criminological outcomes) and diagnosis-specific target symptom domains (e.g. depression, anxiety, impulsivity), cognitive and academic functioning, family history and functioning, capacity for collaboration and development of the treatment alliance.
4. A comprehensive and individualized case formulation which then drives a specific treatment plan.
5. The capacity for follow-up assessments at appropriate and specific time intervals to permit assessment of progress, persistence of problems, reasons for lack of progress, and re-calibration of specific interventions targeting the causal loops that precipitate or perpetuate maladaptive functioning.

To the maximum extent possible, mental health assessment will be integrated with, or complementary to, other DJJ assessment processes, such as assessment of criminogenic factors and custody classification based on institutional risk and risk to reoffend.

#### **Screening Instruments and Process**

All youth will be screened at a DJJ Reception Center prior to assignment to treatment programs. The Reception Centers will be staffed by representatives from among the following clinical disciplines: nursing, medicine, dentistry, social work, psychology, and psychiatry. As part of the DJJ's remedial efforts, youth identified as requiring mental health services will have their needs met in a timely manner. All youth receive medical, dental and mental health screening within

twenty-four hours of intake. This initial screening will also include a standardized screening for suicidality and psychosis. If the mental health screening raises concerns requiring further attention (such as a history of suicidal or parasuicidal behaviors, self-harming behavior, or history of psychiatric hospitalizations) then a mental status examination will be completed by a mental health clinician by the next business day. There will be an on call system that provides 24-hour access to psychiatric consultation for any emergent mental health care concern. Subject to same day review and approval by the on-call physician, all individuals who are prescribed psychotropic medications will continue using their medication and be seen by a psychiatrist no later than the next business day.

In all cases, it is essential to obtain and review previous medical records, psychiatric records, and prior psychological test results. Where clinically appropriate, and subject to laws and regulations governing who may have access to such information, school records and details of Individualized Educational Plans (IEPs) will also be obtained from the DJJ Educational Services unit and reviewed.<sup>3</sup> Health, mental health, and other records documenting prior treatments will be actively pursued with appropriate consent. Agreements with county agencies (especially probation departments) will be developed in order to acquire copies of treatment records in a timely fashion, either before or soon after arrival of youth at DJJ facilities. Specifically, to the extent necessary, the DJJ will require county agencies to include signed consent forms to allow DJJ staff to review relevant medical records.

Family and guardians are an essential part of the intake and assessment process. The assigned case manager will make contact with a parent or guardian contact either by telephone or in person within two business days of intake. Family members and guardians can provide historical information essential to completing an accurate and complete psychosocial history, developing treatment plans, identifying youth strengths, providing mental health information including medication history, etc.

Throughout the youth's treatment, treatment team staff will maintain contact with family and guardians for issues related to consent for medical treatment, maintenance of family contact, discussion of treatment goals, updates regarding the youth's treatment, and transition planning. However, pursuant to California Family Code, Sections 6924(d), mental health treatment or counseling shall not involve the minor's parent or guardian if, in the opinion of the mental health clinician, the involvement would be inappropriate (deemed to be potentially harmful to the youth). Additionally, youth age 18 and over may prohibit staff from contacting parents and guardians. Additional details for involvement of families are discussed in Section 6, "Evidence Based Treatment and Family Involvement."

### **Definition of the Mental Health Population**

#### **Psychiatric Morbidity and Comorbidity in Incarcerated Youth**

Several significant studies have indicated that the frequency of mental health disorders is significantly higher for delinquents than for comparable non-delinquent adolescents (Abram et al. 2004; Teplin et al. 2002; 2005). For example, Coccozza (1992) estimated that every year,

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<sup>3</sup> If any provisions in this Plan conflict with provisions in the previously filed Education Remedial Plan, DJJ will convene a discussion between plaintiff's counsel, the Special Master, the Consent Decree Education expert(s), and the Consent Decree mental health experts to resolve the discrepancy. If the issue(s) cannot be resolved by agreement, either party may invoke the dispute resolution procedure under paragraphs 48 and 49 of the Consent Decree.

150,000 juveniles who come into contact with the juvenile justice system meet the diagnostic criteria for at least one mental disorder. Previous studies have, on average, found high rates (around 60 percent) of morbidity including both internalizing disorders, such as anxiety and depression, as well as externalizing disorders, such as attention deficit hyperactivity disorder (ADHD), and high rates of comorbidity<sup>4</sup> (around 66 percent). Significant variations in the frequencies of psychiatric disorders have also been reported. For example, Friedman and Kutash (1986) uncovered a 10 percent rate of conduct disorder compared to a 100 percent rate uncovered by Timmons et al. (1997). Studies of comorbidity have suggested that the mean number of psychiatric diagnoses ranges from 2.7 to 3.1 disorders. Comorbidity may be a particular problem in incarcerated girls with one study suggesting that over 90 percent of this group have more than one psychiatric disorder and nearly 80 percent have at least three disorders. Clearly, this population is psychiatrically highly compromised, requiring comprehensive clinical involvement and attention. Table 4.1 summarizes the major findings regarding the prevalence of mental health diagnoses in juvenile justice populations.

**Table 4.1 Mental health diagnoses in juvenile justice populations<sup>5</sup>**

<b>Disorder</b>	<b>Prevalence</b>
Depression	2-13 % (Males); 14-36% (Females)
Suicide	10%; 34% (lifetime rate)
Anxiety Disorder	20-21% (Males) 31-59% (Females)
Posttraumatic Stress Disorder	16-32% Females > Males
Bipolar Disorder	1.5-3% (some studies report rate of 20%)
Borderline Personality Disorder	17.6%
Conduct Disorder	Present in the majority of incarcerated youth with exception of those incarcerated for single major offense or drug related offenses.
ADHD	1-18% (Males); 6-34% (Females)
Substance abuse/dependence	33-50% 25% abuse > one substance Use of alcohol (100%), marijuana (70%), cocaine (25%)
Psychosis	1-2% for schizophrenia 25-75% for psychotic symptoms (atypical psychosis, personality disorders, PTSD)
Autistic Spectrum Disorder	15% of individuals referred for forensic psychiatric investigation had pervasive developmental disorder (PDD)

<sup>4</sup> Comorbidity is the presence of more than one psychiatric disorder occurring in the same individual.

<sup>5</sup> Vermeiren R, Jaspers I, Moffitt T: Mental Health Problems in Juvenile Justice Populations. [Child and Adolescent Psychiatric Clinics of North America 15, 2](#), 2006, 333-351, 2006

[Background Data from DJJ Population Studies](#)

In the first results of the screening study carried out in DJJ facilities using standardized measures of psychopathology,<sup>6</sup> Steiner et al. (2002) found that 20 percent of boys and girls were in the clinical range on internalizing disorders, and 19 percent of boys and 30 percent of girls were in the clinical range on externalizing disorders (N = approximately 3,638; mean age = 16 years; 92 percent male; data collected 1997-1998).

Psychiatric disorders are commonly classified using a five axis diagnostic classification system referred to as the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition, Text Revision (DSM-IV-TR).<sup>7</sup> Using this classification system, major psychiatric disorders, such as mood disorders or posttraumatic stress disorder, are listed on the first axis, referred to as Axis I. There are a number of standardized psychiatric diagnostic interviews that are used to help identify the presence of a psychiatric disorder according to these diagnostic criteria. For example, Steiner et al. (2001) carried out a survey of the mental health diagnoses of the DJJ population using a variety of instruments.. The sample of youth surveyed between 1998 and 2000 was matched with the total population at the time of the survey as indicated in Table 4.2.

**Table 4.2 Comparison of Psychopathology in Previous Studies of Incarcerated Juveniles.**

Criteria	Georgia DISC-2	South Carolina DISC-PC 2.3	DJJ N=790	General Population
Mean Comorbidity		2.4 (2.7)	4 (2.1)	0
Mood (Mania/Bipolar & Depression)	19%	24%	12%	.5-6%
Anxiety	30%	33%	31%	8.7% AACAP
Psychosis		45%	4%	1%
Substance Use Disorders	30%	20%	85%	4.9% for alcohol dependence 1.9% for illicit drug dependence
Disruptive Behavior	35%	43%	95%	4-20%
ODD	13%		27%	2-16% DSM
ADHD	7%		10%	3-5% DSM
Conduct Disorder	29%		93%	2-9% under age 18, DSM

(DISC = Diagnostic Interview Schedule for Children)

**Preliminary Treatment Needs Assessment**

Within 48 hours of intake, each youth will be administered an initial mental health screening battery (Treatment Needs Assessment) to identify emergent mental health issues, as well as other treatment needs. Results will be reviewed by a psychologist no later than the next business day

<sup>6</sup> Youth Self Report, Achenbach, 1991

<sup>7</sup> American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000).

following completion of the instruments. These screening instruments will provide a clinical platform from which to begin a more intensive evaluation. The screening instruments utilized will assess if there are special mental health/psychiatric needs, social-emotional adjustment problems, suicidal ideation/self-harm potential, and cognitive deficits. If the screening instruments indicate significant mental health problems, clinical evaluation will be completed by a mental health professional to further assess mental health treatment needs.

To this end, DJJ will test the following standardized, validated instruments, as recommended by the experts:

1. The Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). The MAYSI-2 will be administered on day 1. (Reference: Grisso T, Barnum R: Massachusetts Youth Screening Instrument – Version 2: User’s Manual and Technical report. Sarasota, FL, Professional Resource Press, 2003)
2. A screening for suicidality using instruments such as the Suicide Ideation Questionnaires for youth and adults (SIQ-JR, SIQ and ASIQ),<sup>8</sup> or Suicide Risk Screening Questionnaire (SRSQ) developed by DJJ. Suicide risk screening to be administered on day 1.
3. The Voice Diagnostic Interview Schedule for Children (V-DISC) to make a preliminary diagnostic assessment for the presence of major DSM-IV-TR Axis I psychiatric disorders. While only validated for youth up to the age of 18, use of the V-DISC by Gail Wasserman (one of the experts consulted for this remedial plan) and her colleagues has also yielded good results with older youth as well. Based upon advice of the expert panel, DJJ will use the V-DISC on all youth upon admission to the reception center pending its validation on older youth or replacement by a screening instrument validated for youth over 18. This screening instrument will provide information on diagnosis and emergent risk issues and can also provide data for trend analysis, population review, bed utilization, etc. The V-DISC will be administered between days 2 and 4. (Reference: Wasserman GA, McReynolds LS, Lucas C, Fisher PW, Santos L. The Voice DISC-IV with incarcerated male youth: prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41:314-321, 2002)
4. DJJ will use or develop a structured clinical assessment to assess the presence or absence of psychotic disorders.

At its discretion, DJJ may use and test other instruments that are not among those recommended by the experts. If it chooses to do so, care will be exercised to avoid redundancy and testing fatigue by youth during intake.

The performance of these instruments will be critically examined for their efficacy, especially in youth aged 18 years or older. New data emerging from the scientific literature or data obtained from DJJ statistics may lead to the use of other more age appropriate instruments and the discontinuation of measures not found to be valid or useful within the DJJ population. Modifications will be made in consultation with Consent Decree mental health experts.

Indicators of mental health diagnoses or issues identified by the screening/assessment process may result in a referral for further assessment, including referral for a face-to-face individual

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<sup>8</sup> The SIQ-JR is for youth in grades 7-9; the SIQ is for youth in grades 10-12; the ASIQ is for adults. Reference: William Reynolds, PhD, Psychological Assessment Resources, Inc., Lutz, Florida)

mental health evaluation with a psychologist or a referral to a psychiatrist. Results of the assessment/evaluation may be used to determine the need for placement in a mental health unit and will assist in the development of treatment plans and provide the basis for further, more detailed, assessments.

When youth are identified as requiring mental health services or programs not available at a Reception Center and Clinic, the case will receive expedited processing that will be completed within fifteen working days. The Senior Psychologist at the Reception Center and Clinic will arrange for services to be provided in the interim prior to assignment to a treatment program.

### **Referrals and Clinical Evaluation**

The Initial Case Review (ICR) is conducted on all youth prior to leaving the reception center and clinics. Further assessment instruments that may be used either in the Reception Center or after assignment to treatment program include the following:

1. The Weinberger Adjustment Inventory (WAI) to assess coping and personality styles.
2. A Brief Family Strengths Assessment.
3. Intelligence testing.
4. A Risk/Needs Assessment to assess items such as the youth's risk for reoffending and risk and protective factors linked to criminal behavior. One example of such an instrument is the Washington State Juvenile Court Assessment (WSJCA) that assesses the following domains: Criminal History, School, Use of Free Time, Employment, Relationships, Family, Alcohol and Drugs, Mental Health, Attitudes/Behavior, and Skills.
5. A structured assessment of risk for violence. One example of such an instrument is the Structured Assessment of Violence Risk in Youth (SAVRY) that assesses the following domains: Historical Risk Factors, Social/Contextual Risk Factors, Individual Risk Factors, Protective Factors.
6. For individuals incarcerated for sex offenses, a structured assessment of risk factors for sexual offending.

All clinical screenings and evaluations will be placed in the Unified Health Record and will be considered confidential in nature. The information contained in the screening and evaluation reports may be presented by a mental health clinician during the Initial Case Review and may be used in the development of the Individual Change and Accountability Plan (ICAP). DJJ will develop policies and implement a system to provide hierarchical access to information. The policies and system will protect confidential information while ensuring ease of access to those with appropriate authorization.

The ICAP information is documented in the youth's field and unit file and in the Ward Information Network (WIN) by the assigned case manager. The ICAP is available to all members of the youth's Interdisciplinary Treatment Team for review and implementation.

### **Case Planning and Monitoring**

Ongoing and systematic monitoring of youth progress will be essential for ensuring that treatment/rehabilitation needs are being met; that the proper intensity of service is being provided; and that the overall goals of the mental health and integrated behavioral treatment program for DJJ are being met. Systematic and unbiased feedback on client progress is essential for quality improvement. A system to provide ongoing (at least monthly) assessment of treatment

progress is required. The goal is to provide direct care providers with a system that supports and enhances their decision making about their clients' progress.

The system will include at a minimum the following elements:

1. Assessment of youth symptoms and functional characteristics at baseline and six month follow-up intervals, as well as concurrently (at least monthly) while the youth is actively receiving treatment.
2. Focus on both treatment strategies and treatment outcomes.
3. Minimization of respondent burden and avoidance of duplication.

### **Consent for Treatment**

Every effort will be made to obtain consent from parents or legal guardians for youth under age 18 for mental health treatment within 24 hours of identification of need, including psychotropic medications, pursuant to applicable law and community standards of care.

Mental health and other treatment will be protected under the guidelines of the state and federal statutes that govern confidentiality and privilege of such information. In situations where parents or legal guardians are not available or refuse to give consent, appropriate consent through applicable legal procedures, including court order, will be obtained where necessary. In situations where there is a need for emergency treatment to protect the safety of the minor, treatment may be provided without consent in compliance with applicable laws. In such cases, clinical justification will be documented in the youth's medical record. DJJ will follow all legal requirements when prescribing psychotropic medication absent consent.

### **ACTION PLAN**

1. DJJ will develop tracking systems to document requests for, and receipt of, medical, psychiatric, and testing information from other facilities and agencies; successful and unsuccessful attempts to contact family members or guardians throughout a youth's stay in DJJ facilities; the type of screenings and assessments conducted; and the time such screenings and assessments were completed. These tracking systems will be in place no later than November 1, 2007.
2. In consultation with local governmental entities, DJJ will establish a policy and process to receive and share behavioral and assessment information about youth committed to DJJ by June 1, 2007.
3. The policy and process described in the previous action plan item will be implemented no later than December 1, 2007.
4. Effective immediately, DJJ will use the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2) at initial intake of all youth upon admission to the reception center.
5. Effective immediately, DJJ will use the DJJ Suicide Risk Screening Questionnaire for suicidality at initial intake of all youth upon admission to the reception center.

6. Effective July 1, 2007, DJJ will use the Voice Diagnostic Interview Schedule for Children (V-DISC) on all youth upon admission to the reception center pending its validation on older youth or replacement by a screening instrument validated for youth over 18.
7. By February 15, 2007, in consultation with the mental health experts, DJJ will use or develop and implement a structured clinical assessment to assess the presence or absence of psychotic disorders of all youth upon admission to the reception center.
8. By November 1, 2008, and periodically thereafter, DJJ will analyze the efficacy of screening and assessment instruments for youth under 18 and those 18 and older. On an ongoing basis, using these analyses and data from the scientific literature, DJJ will substitute improved instruments and discontinue the use of those found less effective.

## **Section 5**

# **LEVELS OF CARE AND PROGRAMMING**

### **THE ISSUE**

While there is a common treatment model that will be used across all settings in DJJ facilities, staffing ratios, staff skills and training, and the intensity of treatment interventions will vary based on the risk and needs of youth in DJJ facilities. Definition of mental health levels of care and of special rehabilitation/treatment programs is a key component of this Remedial Plan.

### **DISCUSSION**

#### **The Integrated Behavior Treatment Model**

Over the next three years, DJJ will modify its mental health levels of care and programming as described in this section. As the mental health system matures, program assessment will guide the development of levels of care and programs. As accurate data on mental health needs becomes available, future specialization and/or modification to levels of care and programming may be appropriate. (See “Future Needs Assessment,” below.)

Mental health levels of care will be guided by the same principles as articulated in the Integrated Behavior Treatment Model (IBTM) described in the Safety and Welfare Plan. In the Integrated Behavior Treatment Model, it is assumed that all youth in DJJ facilities need mental health and/or behavioral rehabilitation/treatment services. The IBTM will also require that all DJJ personnel – including those not trained or licensed as therapists – are therapeutic/rehabilitative in their interactions with youth and families. Consequently, while some youth in DJJ facilities will receive intensive mental health services from mental health providers, all youth will receive rehabilitation/treatment services consisting of behavioral programming in therapeutic milieus based on validated behavioral and mental health principles. Mental health professionals will provide clinical oversight, coaching and mentoring to direct care staff providing these rehabilitation/treatment services.

All direct care staff will be trained on the IBTM and able to work with youth on emotional regulation, interpersonal effectiveness, distress tolerance, behavior analysis, and as the need arises, aggression and self-harm behavior. Emergence of aggression and self-harm may lead to a more intensive level of mental health and/or behavioral services. Mental health symptoms that interfere with a youth’s ability to participate in, or benefit from, the core rehabilitation/treatment program will lead to formal mental health treatment at the appropriate level of care.

The treatment model used on core rehabilitative/treatment units will be the same model used on residential mental health treatment units. Youth Correctional Counselors will use the same basic psychologically-based therapeutic/rehabilitative approach whether they are working on mental health treatment units or core rehabilitation/treatment living units. Staffing ratios, personnel with more specialized skills, and the intensity of mental health treatment, differentiate mental health living units from core treatment living units.

Using an IBTM throughout DJJ will provide a common language and approach for understanding and changing youth behavior. It will simplify staff training and ease staff movement between units. System-wide adoption of an IBTM will facilitate continuity of care for youth moving between programs and living units.

## Mental Health Services

There will be three levels of care as shown in Table 5.1: Inpatient, Residential, and Outpatient.

**Table 5.1 Initial Organization of Mental Health Levels of Care**

		PROGRAM
LEVEL OF CARE	Inpatient	Within DJJ (Correctional Treatment Centers) and/or contracted with community hospitals and/or Department of Mental Health (including ICF)
	Residential	Intensive Treatment Program (ITP) Specialized Counseling Program (SCP) Intensive Behavior Treatment Program (IBTP)
	Outpatient	Core Rehabilitation/Treatment Program Substance Abuse/Dependence Treatment Program Sex Behavior Treatment Program Behavior Treatment Program

Outpatient mental health services (see below) will be provided to any youth whose mental health needs are not addressed in the program to which they are assigned. Although most outpatient services will be provided to youth at the Core Rehabilitation/Treatment level of care as defined in Table 5.1, outpatient mental health services are available to youth at all levels of care and programming.

Placement of youth within treatment programs will be based on institutional risk, individualized treatment needs, age, and other factors required by law.

## Treatment Hierarchy

DJJ will develop an Integrated Behavior Treatment Model based on the Washington State Juvenile Rehabilitation Administration (JRA) integrated model. The provision of services under the Integrated Behavior Treatment Model will be predicated on a treatment hierarchy similar to the JRA model, which has as its top priority the reduction and prevention of harm to self or others. In order of priority, the elements of the JRA hierarchy are:

1. Suicide ideation, threats or behaviors / self-injurious behavior
2. Aggressive ideation, threats or behavior
3. Escape ideation, threats or behavior
4. Treatment-interfering behavior
5. Research based risk and protective factors relating to recidivism
6. Quality of life issues<sup>9</sup>

<sup>9</sup> Quality of life issues include such things as being homeless, being unemployed or unable to maintain employment, being expelled from school, lacking friends or having inconsistent relationships, having excessive unstructured time, having anti-social peers, etc. Most of these elements are correlated with recidivism.

DJJ may add other elements to their hierarchy - such as the presence of psychotic symptoms or symptoms of acute intoxication.

### **Outpatient Services**

The outpatient mental health service is part of the integrated treatment delivery system at each facility. Outpatient mental health personnel provide outpatient services in response to referrals from youth, their families or staff and to youth discharged from residential mental health programs who require ongoing mental health services in a core rehabilitation/treatment setting. These services may be provided in the living unit by unit staff or by a nurse or mental health professional. Outpatient services may also be provided in the facility clinic.

Outpatient mental health services consist primarily of consultation, medication management, screenings, assessments, and crisis evaluations and referrals.

While other rehabilitative services are generally provided by non-mental health staff who are clinically supervised by mental health clinicians, mental health staff assigned to core rehabilitation/treatment living units may periodically assist in ongoing intensive needs resource groups, and in individual, group, and family therapy. Service provision will be prioritized using the treatment hierarchy described above.

### **Staffing Standards for Outpatient Mental Health Services**

Staffing for outpatient mental health services are:

- 1.0 Psychiatrist per 200 youth
- 1 Senior Psychologist per 7 Psychologists (minimum 1 per facility)
- 1 Office Technician per 4 clinicians

Staffing standards for core program rehabilitation/treatment units determine the number of psychologists providing outpatient services. (This varies from 1:24 in core Behavior Treatment Programs to 1:76 in regular core rehabilitation/treatment programs. See Safety and Welfare Remedial Plan, Section 6: “Convert Facilities to Rehabilitative Model,” for details.)

### **Integrated Behavioral Treatment Services Consulting and Coaching**

Consistent with the Integrated Behavior Treatment Model, direct care staff in core rehabilitation/treatment living units will have the capacity – through training, coaching, and consultation – to provide group, individual, and family treatment/teaching for emotional dysregulation, anger control, aggressive behavior, social skills, communication skills, and substance use education. Psychologists, or other mental health professionals, will provide clinical oversight, consulting and coaching to direct care staff.

In conjunction with other qualified trainers and IBTM staff, these consulting mental health clinicians (psychiatrists, psychologists, and social workers) provide training, coaching and consultation in cognitive behavioral treatment and interventions to direct care staff in non-mental health living units and program settings. For mental health clinicians assigned to core program rehabilitation/treatment living units, consultation will be their primary responsibility. Mental health clinicians in mental health units may spend more time providing direct services and less time providing consultation.

## **Forensic Services**

In order to avoid dual relationships, evaluations for forensic hearings that determine a youth's release date (such as Welfare and Institutions Code § 1800 hearings and parole board date hearings) will not be performed by mental health professionals already providing treatment to a youth. Instead, forensic evaluations will be provided either by mental health professionals who have no other relationship with the youth (such as professionals from a different living unit) or a dedicated forensic mental health service. These evaluators will be able to review progress of the youth through discussions with treating clinicians and accessing all relevant records pertaining to the youth. These records, among other things, will specify progress towards treatment and rehabilitation goals.

When a disciplinary review hearing involves a mentally ill youth, a determination will be made by a mental health clinician whether the behavior under review results from the youth's mental illness as defined by the policies referred to in the following paragraph. This determination will be made either by a mental health professional who has no clinical relationship with the youth or by someone from a dedicated forensic mental health service.

DJJ will work with the Consent Decree experts to develop policies and procedures regarding the involvement of youth with mental illness in the disciplinary process. Among other things, these policies will ensure that youth do not receive time adds for behavior resulting from a mental illness or its treatment. This policy will balance the need to involve clinical review in the determination of appropriate consequences while protecting the clinician's role with his/her patient. It is expected that acting out behavior resulting from a mental illness or its treatment will not result in punishment, but rather an adjustment to the youth's treatment plan.

As with other potential conflicts between remedial plans, if this provision is found to be in conflict with the Safety and Welfare Remedial Plan, the conflict resolution procedure outlined in Section 1 will be used.

Forensic services as discussed here do not include treatment summaries or annual reviews which may be completed by the assigned clinician.

## **Core Rehabilitation/Treatment Programs**

Living unit size, programs and staffing for the Core Rehabilitation/Treatment Program and the (non-mental health) Behavior Treatment Program is discussed in the Safety and Welfare Remedial Plan.

Admission and discharge criteria and program descriptions for the Sex Behavior Treatment Program are discussed in the Sexual Behavior Treatment Program Remedial Plan. Living unit size in sex behavior treatment programs will require reconciliation between the various remedial plans. This, in turn, will affect staffing patterns assumed in the Sexual Behavior Treatment Program Remedial Plan.

## **Substance Abuse/Dependence Treatment Program**

If the prevalence of substance dependence found in the DJJ population in 2001 is still reasonably accurate, there are likely between 800 and 900 males whose *sole diagnosis* is substance

dependence. Another 600 to 650 males likely have a *sole diagnosis* of substance abuse.<sup>10</sup> Fifteen to 20 females likely fall into each of these categories. Substance dependence, as opposed to substance abuse, generally requires long-term therapy along with relapse prevention. In addition, many more youth have substance dependence, or substance abuse, co-occurring with one or more mental health diagnosis.

The co-occurrence of substance use disorders with juvenile offenses is well documented (Stewart & Trupin, 2003; Teplin et al., 2002; Wasserman et al., 2002; Greenbaum et al., 1996). In many cases, substance use by youth is a primary contributor to juvenile delinquency (Duncan et al., 1997; Loeber & Strouthammer-Loeber, 1998). In other cases, substance use disorders exacerbate the intensity and frequency of other behavior problems (Moffit, 1993; Stewart et al., 1997). In all cases, substance abuse by youth and family members hampers rehabilitation and dramatically increases the likelihood of persistent offending (Myers et al., 1998; Stewart et al., 2001; Trupin & Boesky, 2001).

In consultation with national experts, DJJ will develop a Substance Abuse/Dependence Treatment Program that conforms to the principles underlying the Integrated Behavior Treatment Model and the proposed treatment strategy and philosophy outlined below.

1. Adopt a relapse prevention model that teaches youth skills to cope with high risk substance taking situations as well as situations placing youth at risk for illegal behavior and other risky behaviors (health, violence, victimization, etc). Excellent relapse prevention manuals based on cognitive behavioral and motivational principles exist and should be utilized in all aspects of treatment. An example is *The Kids Curriculum* developed by the Change Company.
2. Teach skills that can be practiced within all phases of DJJ placements such as:
  - a. Interpersonal effectiveness and social skills.
  - b. Emotion regulation and anger management skills.
  - c. Refusal and avoidance skills.
  - d. Self advocacy or support seeking skills.
3. Develop detailed descriptions of problem behaviors youth experience in the community. As youth are motivated to change they will provide increased factual details of places, people and situations that place them at risk of substance use, illegal behavior and mental health decomposition. *The Inventory of Drug Taking Situations* (IDTS) is a useful assessment tool in identifying general categories of high risk situations.
4. Teach and rehearse skills that can be used in community high risk situations using role plays, groups and rehearsed interactions with family members.
5. Identify a network of community based social supports for preventing relapse that includes natural supports (e.g. family, friends, neighbors, faith based community, ) and formal supports (e.g. parole officers, treatment providers, teachers). Assertively work to develop support for youth who identify no community supports.

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<sup>10</sup> See Table 6.2 in Section 6, Evidence Based Treatment

6. Create comprehensive relapse prevention plans that are developed and written in conjunction with youth, treatment teams, and with appropriate consent and in compliance with state and federal law, the primary members of the youth's community support network. Also with appropriate consent, and in compliance with state and federal law, disseminate relapse prevention plans to community providers, family members, and natural and formal supports prior to discharge.

Upon development of a substance dependence/abuse treatment program, placement will be based on criteria established in conjunction with national experts and may include screening or diagnostic tools, such as the pertinent sections of the Voice-Diagnostic Interview Schedule for Children (V-DISC), the Personal Experiences Inventory (PEI), American Society of Addiction Medicine (ASAM) criteria, or history provided by other informants. Youth who do not need this level of substance abuse treatment, but who have a history of substance use or abuse, will receive appropriate substance abuse treatment in their core rehabilitation/treatment unit.

DJJ will use evidence based substance abuse/dependence treatment programs, such as the National Institute of Drug Abuse Cannabis Youth Treatment Program for youth in need of such treatment.

The indented text below borrows heavily from the Washington State JRA *Integrated Treatment Model Report*, dated September 2002. Certain modifications have been made to make descriptions consistent with terminology used by DJJ.

Developmental levels of juveniles require modified interventions which differ from adult substance abuse/dependence treatment interventions. A heavy emphasis on motivating and engaging youth to invest in substance abuse/dependence treatment is necessary. The inclusion of identified motivation strategies as well as substance abuse-specific motivation strategies (e.g., Motivational Interviewing, Motivation and Engagement Therapy) must be well understood and employed by staff.

The focus of Substance Abuse/Dependence Treatment Programs will be primarily on skill acquisition through functional replacement of the effects of drug-taking behavior with skills chosen from the cognitive behavioral treatment (CBT) skill set used in the Integrated Behavior Treatment Model. Because youth use drugs and alcohol for different reasons, DJJ Substance Abuse/Dependence Treatment Programs will use behavioral analysis to identify the vulnerabilities, risks, antecedents and functions of drug using behavior. Some youths will require several behavioral chain analyses, each representing a different instance of using. Once the vulnerabilities, risks, antecedents and functions of the behavior have been identified, various skills from the CBT skill modules will be taught and strengthened. Thus, youth will learn the same skills to treat problem behavior in Substance Abuse/Dependence Treatment programming as other DJJ youth. As a result, staff will be able to coach and support youth in their treatment of substance abuse/dependence issues regardless of specific expertise in the substance abuse/dependence treatment area.

Skill generalization interventions are also a focus in the Substance Abuse/Dependence Treatment Programs. Abstinence is the goal of substance abuse/dependence treatment, but

following a relapse, work immediately shifts to getting clean again and remaining in treatment.

Thus, understanding the function of drug use and associated risk factors through behavioral analysis, developing skills for abstaining, or for reducing likelihood to use, and developing relapse prevention plans are the key elements of treatment focused on skill development and generalization.

Education about traditional “twelve-step” programs will continue in residential programs and as a community support for skill generalization after youth leave DJJ facilities. Plans to cope with cue exposure<sup>11</sup> to drugs and alcohol, and engaging in prosocial activities that are not compatible with substance use, will be addressed by residential staff, parole staff, youth and families together as key treatment planning and transition factors for youth receiving treatment in facilities. Involving families and care-givers in supporting treatment for their youth will be important for youth returning to the community.

Treatment protocols and curricula will be open-ended so that entry into a program, or transfer from another program, is not dependent upon fixed start and stop times for treatment.

Youth complete the Substance Abuse/Dependence Treatment Program after meeting criteria which will be developed in consultation with the Consent Decree mental health experts.

Presence or emergence of treatment interfering behavioral or mental health problems while in a substance abuse/dependence treatment program may lead to placement in more intensive treatment programs, such as a Behavior Treatment Program, Residential Mental Health Program, or Intensive Behavior Treatment Program.

Pending development of the Substance Abuse/Dependence Treatment Program under the IBTM, DJJ will continue its current specialized treatment programs and outpatient programs for youth in need of such interventions. As living units are converted to the IBTM, youth in those living units will be provided with skills, treatment, and therapeutic interventions which will assist those youth to address substance abuse/dependence behavior.

### **Residential Mental Health Programs**

DJJ will modify existing residential mental health programs by reducing unit size, increasing staffing, and implementing an Integrated Behavior Treatment Model. DJJ will also open an additional Intensive Behavioral Treatment Program. Initially, there will be three types of residential mental health treatment programs:

1. A smaller, more richly staffed Intensive Treatment Program (ITP)
2. A smaller, more richly staffed Specialized Counseling Program (SCP)
3. A smaller, more richly staffed Intensive Behavioral Treatment Program (IBTP)

Each facility with one or more residential mental health treatment programs will have a mental health program administrator.

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<sup>11</sup> In this context, cue exposure refers to situations which trigger the desire for drugs or alcohol.

Because of the high presence of mental illness in the DJJ population, it may be desirable or necessary in the future to add an intensive sex behavior treatment program and/or an intensive substance abuse/dependence treatment program for youth with co-occurring mental illness. Implementation of these other residential programs will be planned once better data are available to estimate actual levels of demand. If demand for one or both of these programs is small, other options will be considered.

### **Living Unit Size for Residential Mental Health Programs**

Approximately one year ago, DJJ's maximum population for ITP and SCP living units was 48. During this fiscal year, DJJ is reducing its maximum population for ITPs and SCPs to 30 and its maximum population in its IBTP to 20 youth (in the program) plus 5 youth mentors. DJJ will also increase staffing on ITPs and SCPs by 2 psychiatric technicians, 0.5 supervising case managers, and increase nursing coverage on ITPs from 5 days per week to 7 days per week. DJJ's plan to increase staffing and to reduce the maximum size of ITPs and SCPs to 30 and IBTPs to 20 (plus 5 youth mentors) is based on its current youth census and physical capacity.

By the end of fiscal year 2007-2008, DJJ will reduce living unit sizes to 24 on the ITPs and SCPs and to 16 (exclusive of mentors) on the IBTP. Based on the experts' position that the size of these living units must be further reduced, DJJ will work with the Consent Decree mental health and Safety and Welfare experts to determine the appropriate living unit sizes and staffing patterns for each type of mental health unit. DJJ will adjust living unit sizes accordingly by the end of FY 2009-2010.

Under the Safety and Welfare Remedial Plan, as new facilities are constructed, the size of residential mental health programs will be smaller than the new core rehabilitation/treatment living units. This reflects the judgment of DJJ's leadership, supported by all mental health experts that they have consulted, that small living unit size is essential to the provision of intensive mental health services. The actual maximum size will be determined through the planning process described in the Safety and Welfare Remedial Plan.

### **Factors Common to Residential Mental Health Programs**

#### Referral to a Residential Mental Health Program

Referral to a residential mental health program will be made by the youth's treatment team or outpatient mental health services personnel. The treatment team will include a mental health clinician.

Upon evaluation, if significant mental health issues are detected and the youth meets the criteria for placement in a residential mental health program, he or she may be recommended for transfer. Once referred, placement of a youth in a residential mental health program is not automatic, but subject to the acceptance process described below. DJJ will modify referral criteria in consultation with the Consent Decree mental health experts, incorporating assessment results as appropriate.

#### Residential Mental Health Program Acceptance Process

A centralized mental health team reviews referrals to residential mental health programs and makes a determination if the referral is consistent with entrance criteria and if the placement is appropriate. All beds and movement will be centrally coordinated. Placements will be consistent with decisions made through this acceptance process.

Due to the high risk/high need status of youth referred to an IBTP, referrals will be expedited and placement determination by the centralized mental health review team will be made within one business day after receipt of the placement recommendation of the treatment team.

#### [Waiting Lists for Residential Mental Health Programs](#)

The number of spaces in each residential mental health program is limited in order to ensure that there are sufficient staff to address the treatment needs of the youth in the program. If youth are referred to mental health programs when all spaces are filled, they will be tracked on a waiting list that is maintained by Mental Health Services headquarters staff. For any youth placed on a waiting list for a mental health program, headquarters staff will review the youth's record and discuss his/her condition and circumstances with the clinician from the treatment team that made the referral. Headquarters staff will use uniform criteria to prioritize youth for placement off of the waiting list as space in residential mental health programs become available. If a youth is approved for placement in an IBTP and a bed is not immediately available, the youth will be placed in an alternative residential mental health program no later than the day following the approval of placement. If no beds are available, all youth on mental health waiting lists will be managed in the most clinically appropriate manner possible, such as through the provision of more intensive outpatient mental health services in his or her core rehabilitation/treatment living unit.

#### [Residential Mental Health Program Team Organization](#)

Residential mental health programs will operate under the unit team concept using a multidisciplinary approach developed as part of the Integrated Behavioral Treatment Services model. (See Section 3 – Organization Structure, Treatment Team Organization)

#### [Treatment Plans for Youth in Residential Mental Health Programs](#)

Youth in residential mental health program living units will receive rehabilitation/treatment services, including appropriate educational and vocational programming, in the least restrictive manner possible. If, for any youth, safe delivery of the services cannot be accomplished through normal procedures, an alternative schedule or procedure will be developed. Within three working days of placement in a residential mental health program, a case conference will be held and the treatment plan developed. At 30 days, and monthly thereafter, a staffing will evaluate the need for continued stay in the program, refinement of the treatment plan, or recommendation for placement in an alternative treatment program. Treatment team meetings will be held at least weekly in accordance with the program service day schedule (see below).

#### [Review Process for Extended Lengths of Stay](#)

If a youth has been in an IBTP or SCP for four months or longer, or in an ITP for two months or longer, treatment team reviews of his or her progress will include at least one clinician who is not regularly involved in the youth's treatment. Ongoing participation by a clinician not involved in the youth's treatment will continue as recommended by the outside clinician. Copies of treatment team reviews requiring the presence of an outside clinician will be sent to the appropriate central office mental health staff.

#### [Exit Criteria and Process](#)

Upon admittance to a residential mental health program, the treatment team will establish specific goals and behavioral expectations to be met prior to transfer to a lower level of care unit.

These goals and expectations will primarily focus on the management of the symptoms and behaviors that resulted in referral to the program. A youth will be transferred to a less intensive level of care upon determination by the treatment team that the youth has met these goals and has demonstrated significantly diminished symptomatology (including, in the case of the IBTP, significantly reduced aggressive behavior) and increased stable control of behaviors for the period of time established in the youth's treatment plan.

When the youth has met treatment goals and behavior expectations in a residential mental health program, a plan for transition back to an appropriate living unit will be developed. Transition activities may include:

1. Regular visits to the designated receiving living unit.
2. School attendance in the receiving treatment program school area.
3. Attendance in small group meetings within the designated receiving living unit.

### Daily Schedule

Residential mental health programs provide safe, secure environments within which youth are engaged in constructive programmatic activities. In ITPs and IBTPs, this includes educational services on, or in classrooms adjacent to, the living unit. Youth in SCPs attend school in the facility's education area.

A Program Service Day Schedule will be developed for each residential mental health program to maximize out of room time and to ensure structured activity based on evidence based principles for 40 to 70 percent of waking hours. The program service day schedule will ensure that youth will be actively engaged in developmentally appropriate and rehabilitative activities with the expectation that they will spend minimal time in their rooms during normal waking hours.

### Treatment in Residential Mental Health Programs

Treatment in residential mental health programs is based primarily on cognitive-behavioral skills development and positive reinforcement for improvements in behavior and on access to appropriate mental health treatment and psychiatric intervention, including psychiatric evaluation and medication management, as needed. Program components emphasize cognitive and behavioral skill acquisition in anger control, emotional regulation, conflict resolution, effective communication, behavior analysis related to the maladaptive behavior, and individualized psychological services. These elements will be incorporated into DJJ's Integrated Behavior Treatment Model.

### School for Youth in Residential Mental Health Programs

Education is provided for all youth in residential mental health programs who do not have a high school diploma or GED. Using the same criteria as applied in core programs, education directed at gaining a GED rather than a High School diploma will be provided, when appropriate.

Education for youth in ITPs and IBTPs will take place on the unit in small classrooms consistent with the Education Remedial Plan. Staffing for the school area is described in the Education Remedial Plan. Youth in SCPs will attend school in the facility's education program area (see Education Remedial Plan).

### High School Graduates (and those with GEDs) in Residential Mental Health Programs

Rehabilitation/treatment in residential mental health programs will include meaningful post-secondary education through the use of remote learning and other strategies, or acquisition and practice of job-related skills as appropriate.

High school graduates may also be assigned to a part-time job within the living unit. As appropriate, this plan will include the same opportunities for work and work training as described in the Safety and Welfare Plan for youth in the core program.

### Substance Abuse/Dependence and Sex Behavior Treatment

In addition to intensive mental health treatment, youth in residential mental health programs will also receive sex behavior treatment and/or substance abuse/dependence treatment as needed and consistent with the treatment hierarchy.

### Implementation of Residential Mental Health Programs

Implementation of residential mental health program units will be phased in over time and will require facility modifications and/or the addition of modular buildings to ensure adequate space for treatment, recreation, and (for ITPs and IBTPs) education.

### **Intensive Treatment Program (ITP)**

The Intensive Treatment Program (ITP) is a residential mental health treatment program for youth displaying a wide range of psychological and psychiatric problems that require intensive mental health services and staffing in a sub-acute, rehabilitative setting. Some of these problems may include self-harm behavior and ideation, behavioral dyscontrol, emotional dysregulation, and psychiatric disorders. These youth require a full range of psychological, psychiatric and supportive services but are not an imminent danger to themselves or others and do not require an inpatient level of care in a licensed facility or the use of clinical restraints. The ITP is a treatment-focused program that utilizes intensive cognitive-behavioral and psychiatric interventions for youth to promote emotional regulation and increased behavioral control.

### Staffing Standards for ITP Living Units

ITP staffing patterns may change in future years as living unit size is reduced. In the first year of implementation, the staffing pattern on ITP units will be as follows.

- 1 Supervising case manager
- 1 Senior Youth Correctional Counselor
- 0.5 Psychiatrist
- 2 Case managers
- 0.5 Senior Psychologist, Supervisor
- 2 Psychologists, Clinical
- 2 Licensed Psychiatric Technicians (one per 2<sup>nd</sup> & 3<sup>rd</sup> watch, seven days a week)
- 2 Registered Nurses (one per 2<sup>nd</sup> & 3<sup>rd</sup> watch, seven days a week)
- 7 Youth Correctional Counselors
- 1 Youth Correctional Officer (1<sup>st</sup> watch)
- 1 Office Technician
- Educational personnel assigned pursuant to the Education Remedial Plan.

### Staff Schedule for ITP Living Units

The staff coverage schedule for ITP living units is to accomplish the following objectives:

1. The Clinical Psychologist's and case managers' schedules will overlap that of the two shifts of Youth Correctional Counselors. This will allow coaching, consultation, and treatment team coordination with YCCs.
2. The Senior Youth Correctional Counselor's hours will be such that he/she is able to provide direct supervision of all Youth Correctional Counselors at least once a week.
3. There will be no fewer than three Youth Correctional Counselors on the second shift seven days a week.
4. There will be no fewer than four Youth Correctional Counselors on the third shift seven days a week.

### ITP Referral Criteria

DJJ's criteria for referral to an Intensive Treatment Program include:

1. Treatment interfering mental health symptoms that cannot be managed at a lower level of care.
2. Mental status changes that interfere with functioning at lower levels of care.
3. Self-harm behavior or ideation, suicidal ideation.
4. Behavioral dyscontrol secondary to a mental illness.
5. Emotional dysregulation requiring increased support.
6. Marked decline in psychosocial functioning as the result of a mental disorder, including major impairment in school, peer relations, judgment, cognition, and/or affect.
7. Structured assessments of global functioning (such as the Child and Adolescent Functional Assessment Scale) may be used to assist in ITP versus SCP (see below) placement determinations.

### **Specialized Counseling Program (SCP)**

The Specialized Counseling Program (SCP) is a residential mental health treatment program for youth displaying a wide range of moderate psychological and psychiatric problems that require mental health services and staffing in a sub-acute, rehabilitative setting. Some of these problems may include minor self-harm behavior and ideation, behavioral dyscontrol, emotional dysregulation, and psychiatric disorders. Some of these youth may be less sophisticated and lower functioning (social, emotional, cognitive) than other incarcerated youth and may be vulnerable to abuse by others. These youth require a full range of psychological, psychiatric and supportive services but are not an imminent danger to themselves or others and do not require an inpatient level of care in a licensed facility or the use of clinical restraints. The SCP is a treatment-focused program that utilizes intensive cognitive-behavioral intervention and psychiatric interventions for youth to promote emotional regulation, social skills training/acquisition, and increased behavioral control.

### Staffing Standards for SCP Living Units

SCP staffing patterns may change in future years as living unit size is reduced. In the first year of implementation, the staffing pattern on SCP units will be as follows.

- 1 Supervising case manager
- 1 Senior Youth Correctional Counselor
- 0.5 Psychiatrist
- 0.5 Senior Psychologist, Supervisor
- 2 Case managers
- 1 Psychologist, Clinical
- 2 Licensed Psychiatric Technicians (one per 2<sup>nd</sup> & 3<sup>rd</sup> watch, seven days a week)
- 7 Youth Correctional Counselors
- 1 Youth Correctional Officer (1<sup>st</sup> watch)

#### Staff Schedule for SCP Living Units

The staff coverage schedule for SCP units is to accomplish the following objectives:

1. The Clinical Psychologist and Casework Specialists schedules will overlap that of the two shifts of Youth Correctional Counselors. This will allow coaching, consultation, and treatment team coordination with YCCs.
2. The Senior Youth Correctional Counselor's hours will be such that he/she is able to provide direct supervision of all Youth Correctional Counselors at least once a week.
3. There will be no fewer than three Youth Correctional Counselors on the second shift seven days a week.
4. There will be no fewer than four Youth Correctional Counselors on the third shift seven days a week.

#### SCP Referral Criteria

DJJ's criteria for referral to a Specialized Counseling Program include:

1. Treatment interfering mental health symptoms that cannot be managed at a lower level of care.
2. Mental status changes that interfere with functioning at lower levels of need.
3. Minor self-harm behavior or ideation, suicidal ideation.
4. Behavioral dyscontrol secondary to a mental illness.
5. Emotional dysregulation requiring increased support.
6. Moderate difficulty in several areas, including school, peer relations, judgment, cognition, and/or affect.
7. Structured assessments of global functioning (such as the Child and Adolescent Functional Assessment Scale) may be used to assist in SCP versus ITP placement determinations. (See ITP referral criteria, above.)

## **Intensive Behavior Treatment Program (IBTP)**

The Intensive Behavior Treatment Program (IBTP) is a behavior treatment intervention for youth exhibiting violently disruptive behavior that is determined to be driven by a mental illness. The Intensive Behavior Treatment Program is a more secure, behavioral treatment-focused program that utilizes intensive cognitive-behavioral and psychiatric interventions for youths who are not able to manage their aggressive behavior in a less restrictive environment due to their mental illness.

### Staffing Standards for IBTP Living Units

IBTP staffing patterns may change in future years as living unit size is reduced. In the first year of implementation, the staffing pattern on IBTP units will be as follows.

- 2 Clinical Psychologists
- 0.5 Psychiatrist
- 0.5 Senior Psychologist, Supervisor
- 2 Licensed Psychiatric Technicians (1 per 2<sup>nd</sup> & 3<sup>rd</sup> watch, seven days per week)
- 2 Registered Nurses
- 2 Casework Specialist or equivalent
- 1 Supervising Casework Specialist or equivalent
- 1 Senior Youth Correctional Counselor
- 7 Youth Correctional Counselors
- 3 Youth Correctional Officers (1 on first watch, 2 on 2<sup>nd</sup> and 2 on 3<sup>rd</sup> watch)
- 1 Office Technician
- Educational personnel assigned pursuant to the Education Remedial Plan.
- 1 Youth Correctional Counselor for every occupied classroom

### Staff Schedule for IBTP Living Units

The staff coverage schedule for IBTP units is to accomplish the following objectives:

1. The Clinical Psychologists' and Casework Specialists' schedules will overlap that of the two shifts of Youth Correctional Counselors. This will allow coaching, consultation, and treatment team coordination with YCCs.
2. The Senior Youth Correctional Counselor's hours will be such that he/she is able to provide direct supervision of all Youth Correctional Counselors at least once a week.
3. There will be no fewer than three Youth Correctional Counselors on the second shift seven days a week.
4. There will be no fewer than four Youth Correctional Counselors on the third shift seven days a week.
5. Every occupied classroom will have a teacher and a Youth Correctional Counselor.

### IBTP Referral Criteria

DJJ's initial criteria for referral to an Intensive Behavioral Treatment Program are that a youth has, or is suspected of having, a mental illness and one or more of the following behaviors within the last 90 days that is believed to be related to a known or suspected mental illness:

1. Battery on a staff member
2. Battery on a youth with a weapon

3. Serious battery on a youth without a weapon
4. Aggressor in a group physical attack
5. Aggressor in a group disturbance
6. Return from a CDCR adult facility where the youth was last assigned to a Security Housing Unit (SHU) because of aggressive or violent behavior and the youth has a history of receiving mental health services.

### **Inpatient Psychiatric Care**

Pursuant to state law and the Safety & Welfare Remedial Plan, DJJ will collaborate with state and local stakeholders to find appropriate mental health placements for youth with serious mental health disorders requiring long-term inpatient care. DJJ seeks to reduce, rather than expand, the number of youth in its care who require long-term inpatient mental health services. To the extent that such youth are discovered in DJJ, they will be returned to the committing court or referred to DMH or other treatment facilities outside of DJJ for inpatient care.

DJJ recognizes that, despite these efforts, some youth in its care will require inpatient services. For youth requiring inpatient services, DJJ will comply with state law and regulations requiring that inpatient health services be provided in licensed facilities. The inpatient level of care includes long term and short term acute, sub-acute and intermediate care that psychiatric units in hospitals provide, and sub- or non-acute care that is provided in skilled nursing or similar facilities for mentally ill persons who require 24 hour nursing and/or related services (*see* Title 22 California Code of Regulations §§ 79751 and 79753).

Currently, DJJ provides inpatient mental health care at its own 10-bed Correctional Treatment Center (CTC) at the Heman G. Stark Youth Correctional Facility, by Memorandum of Understanding with DMH, and by contract with community facilities for acute/crisis care. The MOU with DMH provides for 10 inpatient beds in DMH hospitals for youth 18 and older and 20 Intermediate Care Facility (ICF) beds at the Southern Youth Correctional Reception Center and Clinic. DJJ has two contracts with local community mental health facilities for acute and intermediate care for females. Additionally, if there is an emergency psychiatric situation, DJJ will send any youth to a local emergency room with appropriate mental health service capacity, regardless of whether DJJ has a contract with the hospital. DJJ will continue to provide these inpatient resources unless and until an alternative arrangement is approved by the Consent Decree mental health experts.

In consultation with the Consent Decree mental health experts, DJJ will reassess the adequacy of this combination of resources, and make plans and adjustments as necessary.

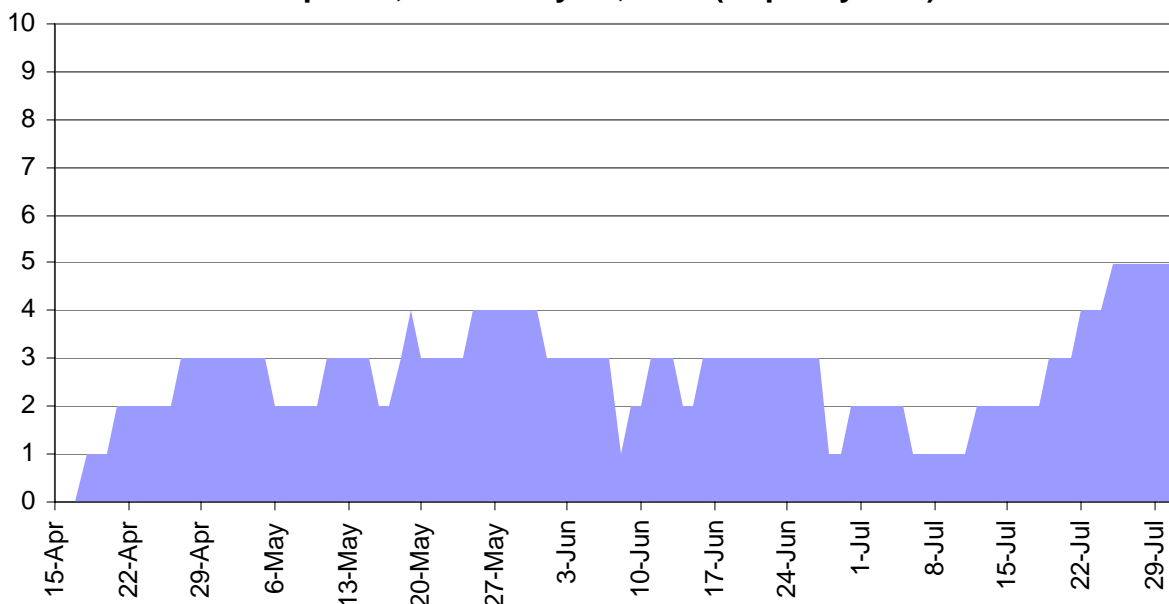
### **Acute/Crisis Stabilization Level of Care**

This level of care is characterized by the need for 24 hour per day nursing and mental health services in a licensed facility for youth who are in imminent danger to self or others that exceeds the ability of lower levels of care to maintain safety. Youth requiring clinically indicated restraints to maintain safety may be placed at this level of care. Clinical restraints – including restraint chairs – will not be used in any unlicensed facility. The anticipated average length of stay is relatively short - from a few days to a month - although exceptional cases may require longer stays.

DJJ's Correctional Treatment Center accepted its first mental health patient in April 2006. Most patients treated in the CTC have been from Southern California facilities (Heman G. Stark and SYRCC), but youth have been transferred from Stockton complex facilities to the CTC. DJJ will transfer youth from Northern California facilities to the CTC at Heman G. Stark when it does not have an adequate community facility option. The means of transport will be clinically determined by a treating or supervising clinician.

Between April 15 and July 31, the average length of stay of youth who have been released from the CTC has been 15.7 days. The following diagram shows the daily count in the CTC from the time it was opened through the end of July 2006.

**Daily Count - H.G. Stark Correctional Treatment Center  
April 15, 2006 - July 31, 2006 (Capacity = 10)**



#### Admission Criteria

Admission to acute inpatient psychiatric care will be based on:

1. Imminent danger to self.
2. Imminent danger to others as a result of a serious mental health disorder.
3. Marked impairment in psychosocial functioning and activities of daily living, requiring 24-hour nursing care.
4. Safety concerns, which are a result of a serious mental health disorder, requiring clinical restraints.

#### Discharge Criteria

Discharge from acute inpatient psychiatric care will be based on:

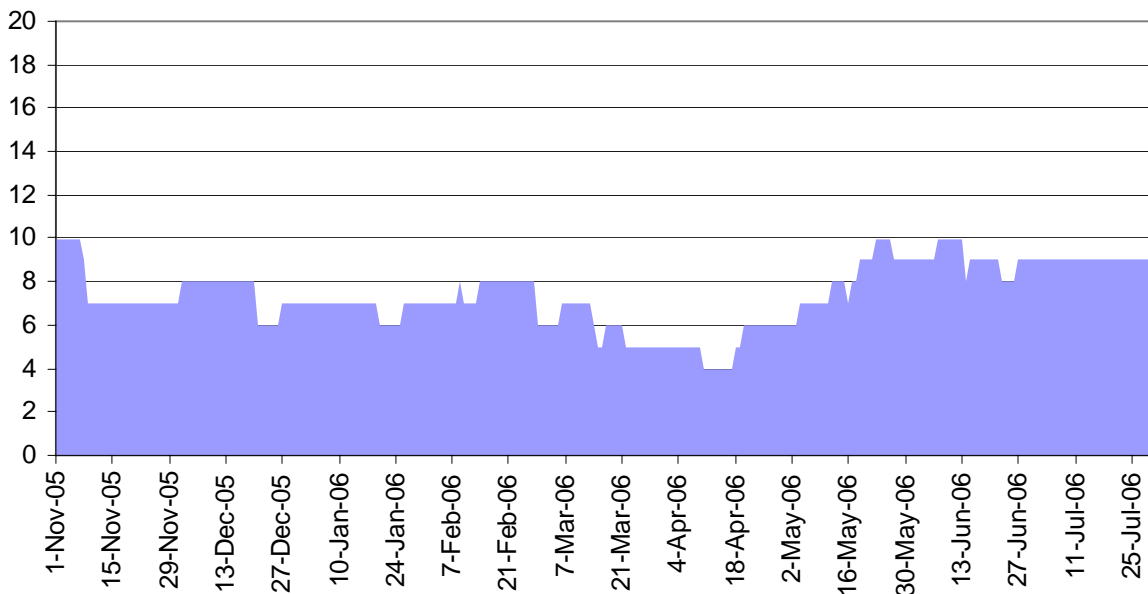
1. Stabilization of the crisis behavior, and
2. No imminent danger to self or others, and
3. Improved psychosocial functioning, consistent with placement in a lower acuity setting.

### Intermediate Level of Psychiatric Care

The intermediate level of psychiatric care, such as that provided by a hospital or an ICF, is characterized by the need for 24 hour per day nursing supervision or related mental health services in a licensed facility. (For example, as defined for an ICF, intermediate care means "beds designated for patients requiring skilled nursing and supportive care on less than a continuous basis." See 22 CCR § 73050.) This level of care is for youth who are not an acute imminent danger to self or others but who have severe and persistent mental illness that exceeds the ability of lower levels of care to maintain safely, and/or youth requiring more extensive and/or specialty evaluation than DJJ commonly provides in its residential mental health programs. Because it is licensed, clinically indicated restraints may be used at this level of care. The lengths of stay will vary. Evaluations will typically be associated with relatively shorter lengths of stay, while youth who are not responsive to treatment in lower acuity settings will have longer lengths of stay, generally measured in months.

DJJ currently contracts with DMH for 20 Intermediate Care Facility beds at Southern Youth Correctional Reception Center & Clinic. Between November 2005 and July 2006 the average length of stay in this facility was just under three months (83.5 days). The following figure shows daily population at the SYCRCC ICF during this period.

**Daily Count - SYCRCC Intermediate Care Facility  
Nov 1, 2005 - July 31, 2006 (Capacity = 20)**



### Admission Criteria

In general, admission to the ICF at SYCRCC will be based on:

1. The youth requires highly structured (staffed) inpatient care with 24-hour nursing supervision and enhanced staffing due to an active major mental illness, significant impairment in psychosocial functioning, stabilization or elimination of self-harm/suicidal behavior (which does not rise to the level of imminent danger to self), or stabilization of symptoms of a serious mental illness.

2. The youth would benefit from a comprehensive treatment program with an emphasis on skill development/psycho-social rehabilitation, with increased programming and supervision.
3. The youth would benefit from a comprehensive assessment for diagnostic clarification.

And in general, admission to DMH state hospitals will be based on:

1. The youth has a major Axis 1 disorder with active symptoms.
2. The youth's GAF over the previous 30-day period is 30 or less.
3. The youth is unable to adequately function and stabilize within the structure of the DJJ's mental health treatment programs.
4. The youth's psychiatric condition can potentially be remediated and stabilized within the state hospital treatment program.
5. The youth needs to be placed in conservatorship in preparation for parole.

Additional factors that may justify consideration for referral to the ICF, a DMH state hospital, or another facility offering intermediate psychiatric care include:

1. The youth requires further medical, neurological or neuropsychological consultation, evaluation or studies that cannot be provided in a less restrictive setting.
2. There are other medication issues requiring treatment in a subacute inpatient setting.
3. The youth requires complicated psychiatric medication management.

### Discharge Criteria

Discharge from intermediate inpatient psychiatric care (including the ICF, DMH state hospitals, and community mental health facilities) will be based on:

1. Improved functioning, with the ability to function in a less clinically structured environment.
2. The diagnostic, consultative, or trial treatment goals for referring the youth to an intermediate inpatient psychiatric facility have been met or no longer need to be pursued.

In addition to the intermediate care facility operated by DMH, contract beds are available through other providers for wards needing long term intermediate care. Treatment at an intermediate inpatient psychiatric facility can be for diagnostic and assessment purposes (requiring a relatively short length of stay) or for treatment of an active major mental illness (which may require a longer length of stay). DJJ contracts for such services with the DMH and community facilities and the above criteria are illustrative of the admission and discharge criteria DJJ has negotiated with contractors. Memoranda of Understanding (MOU), as agreed to by DJJ and DMH, outline the specific criteria and process for admission to, and discharge from, the DMH-run ICF at SYCRCC and DMH state hospitals. Additionally, prior to transferring a youth to a DMH facility, DJJ mental health staff confer with DMH staff regarding the appropriateness of the proposed transfer. When youth are under the care and treatment of DMH, they are provided care in accordance with DMH's policies and procedures, including in accordance with DMH's staffing ratios, treatment plans, and documentation systems.

## **Movement between Levels of Care and Programs**

Movement between levels of care and programs will be based on clinical judgment with centralized clinical oversight. As appropriate, the clinical judgment will take into account objective assessments using standardized and (where available) validated instruments. Data used to determine movement between levels of care may be obtained from:

1. Symptom/behavior specific instruments such as the Children's Depression Inventory (CDI), the Behavioral Assessment Rating Scale (BASC), the Structured Assessment of Violence Risk in Youth (SAVRY), the Substance Abuse Subtle Screening Inventory (SASSI) (Reference: Miller FG, Lazowski LE. The Adolescent Substance Abuse Subtle Screening Inventory-A2 (SASSI-A2) manual. Springville, IN: SASSI Institute, 2001), or a suicide risk assessment scale. These instruments are used in conjunction with guideline cutoffs for various levels of care.
2. Assessments of general functioning, such as the Child and Adolescent Functional Assessment Scale (CAFAS) (Reference: Hodges K. Child and Adolescent Functional Assessment Scale (3<sup>rd</sup> ed.). Ypsilanti: Eastern Michigan University, 2000), the Child and Adolescent Level of Care Utilization System (CALOCUS), the Vanderbilt Functioning Index, or the Strengths and Difficulties Scale (SDQ).
3. Instruments DJJ currently uses (such as the SPAN) that could be adapted to inform movement between levels of care.
4. Documented presence or absence of specific behaviors as applicable (such as suicidal/self-harm, aggressive or sexually inappropriate behavior).
5. Consistent youth self-report (beyond responses on specific assessment instruments) of urges of inappropriate behavior and demonstrated ability to immediately inform staff of urges and contract for safety.
6. Clinical impression, including input from any staff who have contact with the youth as well as information gained from clinical interview and assessment combined with results from above instruments and related data.
7. Treatment failure in current level of care.

Policies and procedures will be developed to guide and direct movement between mental health levels of care and programs. Elements of the policies and procedures for movement between mental health levels of care and programs will include:

1. Indications and processes for emergency transfer.
2. Regularly scheduled multidisciplinary team review of appropriateness of youth for current level of care and consideration of movement to a different program within the same, or a different, level of care.
3. Processes for initiating consideration of movement between programs and levels of care.
4. Process for decision-making, including resolving differences of opinion between transferring and receiving units/teams.
5. Relationship between clinical and administrative decisions and quality improvement process regarding concurrence.
6. Communication of pertinent information between transferring and receiving units/teams.
7. Program improvement process to refine decision-making.

Recommendations for movement to a more restrictive level of care will be reviewed by a centralized mental health team which makes a determination if the referral is consistent with

entrance criteria and if the placement is appropriate. All beds and movement will be centrally coordinated. Placements will be consistent with decisions made through this acceptance process. A Memorandum of Understanding between DJJ and DMH governs movement between these Departments.

## **Future Needs Assessment**

### Inpatient Services

The June 2002 Revised And Stipulated Order for Enforcement of Judgment (“Stipulated Order”) in *Morris v. Harper* (now *Wilber v. Warner*) requires DJJ to comply with state law requiring that inpatient mental health care be provided in licensed beds. In connection with the proceedings in the *Wilber* case, licensing and certification staff of the Department of Health Services had found that DJJ was providing inpatient care in unlicensed facilities. In October 2005, the plaintiff in the *Wilber* case agreed to postpone enforcement proceedings pending development of this Mental Health Remedial Plan.

The June 2002 Stipulated Order reflected DJJ's intention to complete and license Correctional Treatment Centers in three locations – one for male youth in northern, one for male youth in southern California, and one for female youth at Ventura – and to convert a facility into an ICF at SYCRCC. When it agreed to the Stipulated Order, DJJ believed that it would be necessary to complete and license these facilities in order to meet youths’ needs for inpatient mental health care. Since then, DJJ has built or renovated two facilities intended to become licensed CTCs: one at Ventura facility and one at Heman G. Stark. DJJ secured a CTC license at Heman G. Stark where youth have been receiving inpatient mental health treatment since April 2006. It arranged for Metropolitan State Hospital, DMH to operate a licensed ICF at SYRCC. DJJ renovated the building at Ventura intended to be a CTC, but did not proceed with licensing when it decided instead to contract with community facilities for inpatient care for the few young women who require that level of care.

Since June 2002, DJJ’s population has been reduced by about one-half, to fewer than 3,000 youth. The female population has been reduced from more than 300 to about 125-150. DJJ believes that it is able to meet all needs for inpatient care in licensed beds with its current facilities and arrangements with community facilities and DMH.

Plaintiff’s counsel and counsel for the plaintiff in the *Wilber* case believe that there likely is a need for CTC or ICF beds in northern California and for young women. It is impossible to resolve this dispute at this time because DJJ is unable to produce some of the information that is critical to a bed needs analysis. Also, the mental health Consent Decree experts are not convinced that DJJ is able to reliably determine that youth who require inpatient care are always referred for such care. This is important since youth requiring, but not referred for, inpatient care would not be captured in utilization data. Finally, over the next four years, DJJ’s mental health programs will undergo substantial changes, including the training of all DJJ staff who interact with youth on the Integrated Behavioral Treatment model, the implementation of new mental health screening and assessment tools, the expansion of mental health and behavioral health services to all youth, and planning for renovation and building of facilities. These changes are likely to affect the need for inpatient care.

In collaboration with the mental health Consent Decree experts, and with assistance from the Department of Health Services *Licensing and Certification Division*, and the Department of

Mental Health, DJJ will evaluate the sufficiency of its number and type of inpatient beds, taking into account the treatment needs of the youth population by age, gender, home community, and assigned institutional placement. In collaboration with the mental health Consent Decree experts, DJJ will develop systems to track utilization of licensed beds and indicators suggestive of unmet need for inpatient care. DJJ will use these data and systems to refine and/or modify plans and implementation schedules to meet the needs of youth for inpatient care.

As new facilities are being built and as new mental health needs are identified, DJJ will work with DHS Licensing and Certification to explore licensing options. DJJ will also seek the assistance of the Licensing and Certification Division to ensure that it successfully distinguishes between youth who may be treated in nonlicensed DJJ mental health programs and youth who are required to be treated in licensed facilities. DJJ will develop screening and assessment policies and procedures that clarify the distinction.

#### Inpatient Services for Northern California Males

While the services available to serve Southern California males in DJJ facilities are reasonably comprehensive, the continuum of care is much more limited in Northern California. As noted above, the Stipulated Order in the *Wilber* case reflected an agreement between plaintiff's counsel in *Wilber* and DJJ that DJJ would expand the continuum of care in Northern California by building a licensed facility at the Stockton complex. DJJ did not proceed with that plan. Presently, DJJ provides inpatient care for males in northern California by contract with a community mental health facility in Sacramento, by having access to available beds at Napa State Hospital under the Memorandum of Understanding with DMH, and by sending northern California youth to southern California facilities for acute and intermediate inpatient care.<sup>12</sup> Additionally, if there is an emergency psychiatric situation, DJJ will send any youth to a local emergency room with appropriate mental health service capacity, regardless of whether DJJ has a contract with the hospital.

DJJ will work with the Consent Decree mental health experts to evaluate current practices, and if appropriate, propose alternative solutions. In particular, the experts will provide input on the adequacy of contract services (for youth under 18 and those 18 and older), treatment concerns related to transporting youth needing inpatient care, and the impact on family involvement and continuity of care for Northern California youth transported to Southern California.

In order to make an informed decision about the need for licensed inpatient beds at the Stockton complex, DJJ will work with the mental health Consent Decree experts to fill existing information gaps with respect to acute and subacute bed needs.

In consultation with the mental health Consent Decree experts, DJJ will reassess the adequacy of its current and planned combination of resources for Northern California, and make any necessary plans and adjustments, including plans with respect to licensed acute and/or subacute beds.

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<sup>12</sup> The Memorandum of Understanding with DMH is for ten acute or intermediate care beds that are in addition to the ICF beds at SYCRCC.

### Inpatient Services for Females

DJJ currently operates no inpatient beds for females; instead, DJJ has two contracts with local community mental health facilities for acute and intermediate care. DJJ also has the capacity to send girls, age 18 and older, to DMH state hospitals for intermediate care. Additionally, if there is an emergency psychiatric situation, DJJ will send any youth to a local emergency room with appropriate mental health service capacity, regardless of whether DJJ has a contract with the hospital. DJJ believes that it is meeting the needs of female youth for inpatient mental health care. In contrast, Plaintiff believes that inpatient care is being provided in the unlicensed DJJ mental health programs at Ventura.

In response to the *Wilber v. Warner* litigation, DJJ began the process of implementing a CTC at the Ventura facility by remodeling a building for that purpose. However, the facility has never been licensed. Now, given the much smaller number of females in the system than existed at the time the litigation was started, and given the possibility of moving females out of Ventura and closer to their home communities (see Safety and Welfare Remedial Plan), reconsideration of the need for a CTC at Ventura is warranted.

DJJ will work with the Consent Decree mental health experts to evaluate the adequacy of current contracting arrangements and, as needed and in accordance with the experts' recommendations, will develop alternative arrangements targeted for Northern and Southern California females, and females under the age of 18 and those 18 and older.

### Residential Mental Health Care

As the Integrated Behavioral Treatment Services becomes operational and is assessed, it may be found that additional levels of intensity (such as group home/reentry) and specialized programming (such as cognitive-behavioral therapy for the effects of previous trauma) are needed. It may also be found that the current structure of mental health programs requires refinement. Over the course of the next three years, DJJ will work with the Consent Decree mental health experts to make these determinations and, if changes are needed, DJJ will develop and implement a plan to modify the levels of care in its mental health programs. In collaboration with the Consent Decree mental health experts, DJJ's will devise program improvement processes which will include mechanisms for assessing and, as appropriate, adapting and adopting innovative programs for youth in DJJ custody.

In particular, the mental health experts consulted in the development of this Plan have recommended that DJJ consider whether there is utility in having two levels of residential mental health care – ITP and SCP – versus one, during the initial transition phase.

In consultation with the Consent Decree experts, DJJ will evaluate the ITPs and SCPs and determine whether/how to modify their roles and target populations. DJJ will provide its evaluation and determination in writing, with a summary of the Consent Decree experts' opinions and recommendations on the matter, to the Consent Decree experts, the Special Master and plaintiff's counsel.

## ACTION PLAN

1. All direct care staff will be trained on the Integrated Behavior Treatment Model in accordance with the implementation schedule for core program rehabilitation/treatment units described in the Safety and Welfare Remedial Plan and the implementation schedule for intensive treatment units as described below.
2. DJJ will develop a treatment hierarchy as described in this section as part of the Integrated Behavior Treatment Model on the timeframe described in the Safety and Welfare Remedial Plan.
3. DJJ will develop and implement a policy regarding forensic evaluations that is consistent with the principles discussed in this section by June 1, 2007.
4. In consultation with national experts, DJJ will develop a new Substance Abuse/Dependence Treatment Program, including admission and exit criteria, as part of the Integrated Behavior Treatment Model on the timeframe described in the Safety and Welfare Remedial Plan. The new Substance Abuse/Dependence Treatment Program will be implemented by July 1, 2009.
5. DJJ will appoint a mental health program administrator at each facility with one or more residential mental health program prior to the date the program is implemented (or an existing program is modified) as described in this section.
6. In consultation with the Consent Decree mental health experts, DJJ will adopt formal criteria for referring youth to each mental health level of care described in this section. These criteria will be fully implemented no later than January 31, 2007.
7. DJJ will establish a centralized Mental Health Review Team to review recommendations for placement or a youth in an inpatient or residential mental health program and recommendations for changes in levels of care. This review team will be responsible for determining if these recommendations are appropriate. The Mental Health Review Team will be in place prior to bringing the first modified, or new, residential mental health living unit on line.
8. In consultation with the Consent Decree mental health experts, DJJ will develop a policy and procedure for developing a treatment plan for each youth within three working days of admission to a residential mental health unit, for weekly treatment team meetings, and for monthly treatment team reviews to evaluate the need for continued stay in the program, refinement of the treatment plan, or recommendation for placement in an alternative treatment program. This policy and procedure will be implemented by June 30, 2007.
9. In consultation with Consent Decree mental health experts, DJJ will develop policies and procedures to guide and direct movement between mental health levels of care and programs. These policies and procedures will be fully implemented by July 31, 2007. DJJ will continue with its current process of central monitoring and oversight until policies and new procedures are in place.

10. DJJ will establish a protocol so that monthly treatment team reviews for any youth who has been in an IBTP or SCP for more than four months, or an ITP for more than two months, includes participation by at least one clinician not regularly involved in the treatment of the youth. This protocol will include the requirement for ongoing participation by a clinician not involved in the youth's treatment and central office review of treatment team meetings requiring the presence of an outside clinician consistent with this section. This protocol will be established and implemented by June 1, 2007.
11. No later than July 31, 2007, DJJ will have increased outpatient mental health staff consistent with the staffing standards included in this section.
12. By July 1, 2007, DJJ will implement five (5) Intensive Treatment Programs, seven (7) Specialized Counseling Programs, and one (1) Intensive Behavior Treatment Program, as described in this section.
13. In fiscal year 2007/2008, DJJ will establish one additional Intensive Treatment Program and one additional Intensive Behavior Treatment Program.

The intent of Actions Plan items 12 and 13 is to create sufficient capacity at each level of care to provide for the mental health needs of all youth in a timely way. Compliance will be measured by providing sufficient capacity, with minimal waiting time for youth, not simply by adding the units listed above. Consequently, plans for mental health treatment units may be modified based on the analysis of populations and needs for various levels of care, as described in this section.

14. No later than June 30, 2007, DJJ will reduce the maximum size of its ITP and SCP living units to 30, and its IBTP living units to 20 (exclusive of mentors).
15. No later than June 30, 2008, DJJ will reduce the maximum size of its ITP and SCP living units to 24, and its IBTP living units to no more than 16 (exclusive of mentors).
16. By June 30, 2010, DJJ will reduce the maximum number of youth in its residential mental health programs to the size determined in conjunction with the Consent Decree mental health and safety and welfare experts.
17. DJJ will determine the appropriate size of mental health living units in new facilities planned and implemented on the master planning schedule provided for in the Safety and Welfare Remedial Plan.
18. DJJ will develop a Program Service Day Schedule for each intensive treatment unit prior to bringing it on line. These schedules will be developed to ensure constructive program hours and out-of-room time consistent with the standards articulated in this section.
19. By no later than December 31, 2006, DJJ will develop written policies and procedures on transfer to DMH, or return to the committing court, of youth requiring long-term inpatient care in a licensed facility.

20. By November 30, 2006, DJJ will collaborate with DMH to strengthen communication, expedite transfers to DMH of youth who are appropriately referred for inpatient mental health services, and facilitate transition of youth no longer in need of such care back to DJJ facilities.
21. In the Standards and Criteria section, DJJ will identify an expert approved by the Consent Decree mental health experts and plaintiff's counsel to conduct an assessment and projection of the numbers and types of beds needed for each level of care and to develop an ongoing system to track the need for and use of those beds. The systems will be in place, and reports generated on a monthly basis by a date to be determined in the Standards and Criteria section.
22. By a date set in the Standards and Criteria section, and in consultation with the Consent Decree mental health experts and the expert identified pursuant to the preceding paragraph, DJJ will determine if modification to the current array of residential mental health programs, especially ITPs and SCPs, is appropriate and needed. DJJ will provide its evaluation and determination in writing, with a summary of the experts' opinions and recommendations, to the Consent Decree experts, the Special Master and plaintiff's counsel. Any recommendations to modify the ITPs and SCPs will be implemented by a date to be set in the Standards and Criteria section.
23. DJJ will work with the Consent Decree mental health experts to evaluate current practices, and if appropriate, propose alternative solutions for contract mental health beds. In particular, the experts will provide input on the adequacy of contract services and, based on objective evidence, treatment concerns relating to transporting youth needing acute inpatient care, and the impact on family involvement and continuity of care for Northern California youth transported to Southern California for acute or subacute care. This evaluation will address contract services for males and females and youth under 18 and those 18 and older. This evaluation will be completed no later than January 31, 2007.
24. Based on the analysis of the tracking data and evaluation of use of contract beds noted above, DJJ will reassess the adequacy of current inpatient resources for females and for Northern California males, and make any necessary plans to ensure timely and appropriate care for youth in need of inpatient services, including plans with respect to licensed acute and/or subacute beds, no later than four (4) months following completion of the analysis and evaluation. DJJ will begin implementing these plans the following fiscal year.
25. As new facilities are being built and new mental health needs are identified, DJJ will work with DHS Licensing and Certification to explore licensing options in a timely manner. DJJ will also seek the assistance of the Licensing and Certification Division to ensure that it successfully distinguishes between youth who may be treated in nonlicensed DJJ mental health programs and youth who are required to be treated in licensed facilities. DJJ will develop screening and assessment policies and procedures that clarify the distinction by June 30, 2007.
26. Over the course of the next three years, DJJ will develop an implementation plan to incorporate additional interventions into the IBTM. The priority and type of interventions will be determined in conjunction with the Consent Decree mental health experts.

27. By November 20, 2006, DJJ will develop a system to track and objectively prioritize youth placed on waiting lists for residential mental health programs.

## **Section 6**

# **EVIDENCE BASED TREATMENT**

### **THE ISSUE**

The efficacy of treatment, as well as the wise use of public resources, requires that rehabilitative treatment be based on the best evidence based practices available.

### **DISCUSSION**

#### **Evidence Based Psychosocial Treatments**

There are several important principles to keep in mind regarding the topic of evidence based psychosocial and psychopharmacological treatments within the juvenile justice population:

1. Although there are numerous studies of effective evidence based psychosocial treatments within the general population, few of these treatments have been studied and validated within the juvenile justice population. Thus there is a gap between psychotherapy research and its application with incarcerated youth. The data base regarding psychopharmacological interventions is even more restricted (Soller, et al., 2006).
2. Many of the evidence based treatments target individuals with single psychiatric diagnoses. Given the high comorbidity of youth within the DJJ system, it will often be necessary to prioritize and select either a principle psychiatric diagnosis or target behavior when selecting specific treatment interventions.
3. Many of the evidence based treatment approaches incorporate treatment of family members. In those situations in which it is impossible to involve families, it will be necessary to select treatments that do not require intensive family involvement, or modify treatments to work within the correctional setting. In situations in which families are engaged in the treatment regimen, treatments that include a family component will be used as appropriate.

#### Training in Evidence Based Psychosocial Treatment

Training in evidence based psychosocial treatment will take place in three phases. During the first phase, training in the Integrated Behavior Treatment Model will be disseminated to all categories of staff who have direct contact with youth. This training will be based on the schedule described in the Safety and Welfare Remedial Plan. This model will become the basis on which decisions regarding management of maladaptive behavior will be made. Also during the first phase of training, selected individuals will receive instruction on highly specialized evidence based treatment interventions that target specific diagnostic entities or target behaviors. Examples of such treatments are provided in Table 6.1.

**Table 6.1 Mental Disorders (DSM IV-TR) and Potential Treatment Interventions  
In Juvenile Justice Populations**

<b>Mental Disorder</b>	<b>Treatment Model</b>
Depression	Treatment of Adolescent Depression (The Treatment of Adolescents with Depression Study Team, 2003) Interpersonal Therapy (Mufson et al., 1993) Psychopharmacological agents.
Suicide	Dialectical Behavior Therapy (Linehan, 1993)
Anxiety Disorder	CBT (Compton et al., 2004) Psychopharmacological agents.
Posttraumatic Stress Disorder	CBT (Cohen et al., 2004) Psychopharmacological agents.
Bipolar Disorder	Mood stabilizing agents.
Personality Disorders	Dialectical Behavior Therapy (Linehan, 1993) for borderline personality disorder Low dose antipsychotics
Conduct Disorder	Potential role for use of atypical antipsychotics and mood stabilizing agents (Soller et al., 2006)
ADHD	Psychostimulant and related compounds
Substance abuse/dependence	Potential role of psychopharmacological agents.
Psychosis	Antipsychotic agents.
Autistic Spectrum Disorder	Antipsychotic agents Behavior modification programs.

The second phase of evidence based treatment integration will be the widespread dissemination of these specialized treatment interventions to mental health clinicians throughout DJJ’s facilities. The third phase will involve assessment of the efficacy of the treatment and modification of treatments in line with the needs of the DJJ population. This three phase training plan is discussed in more detail in Section 7, “Staff Qualifications and Training.”

[Maintaining Currency in Evidence Based Treatments](#)

Because there is a rapidly expanding body of knowledge about evidence based treatments for juvenile offenders, it is important for mental health leaders in DJJ to follow developments in the field. DJJ will establish a budget for developing and maintaining a central library of professional publications for mental health clinicians and for ongoing training and attendance at important national and regional conferences by key staff. DJJ’s Chief Psychiatrist and Chief Psychologists will be responsible for overseeing these efforts and for remaining current in their respective areas of expertise.

[Characteristics of the DJJ Population](#)

While the DJJ population is much smaller now, and the characteristics of the juvenile population may have changed in the interim, the work of Steiner et al. (2001) provides a potential model to conceptualize how evidence based treatment may be provided to the DJJ population. That model is based on a statistical analysis conducted as part of the 2001 study to subtype the DJJ population with mental disorders into four major clusters as summarized in Table 6.2.

**Table 6.2 Diagnostic Clusters and Prevalence Rates in the DJJ Population (2001)<sup>13</sup>**

Cluster	Diagnoses	DJJ Frequency (2001)	
		Males	Females
I	Mood Anxiety Borderline Personality Oppositional Defiant	46%	73%
II	Psychosis Attention Deficit Hyperactivity Schizoid Schizotypal	14%	24%
III	Eating Somatoform Adjustment	4%	15%
IV	Alcohol and Substance Abuse (sole disorder)	22%	10%
V	Alcohol and Substance Dependence (sole diagnosis)	30%	14%

Cluster I consists of mood disorders, anxiety disorders including posttraumatic stress disorder, borderline personality disorder (BPD), and oppositional defiant disorder (ODD). This cluster is primarily be treated with antidepressants, including selective serotonin reuptake inhibitors (SSRIs), anti-anxiety agents, and mood stabilizers. In the 2001 study, fifty percent of youths (male plus female) were present in this cluster.

If prevalence rates in 2006 are similar to those shown in Table 6.2, there are about 1,300 males and 100 females in Cluster I in the current DJJ population.

Cluster II is comprised of psychosis, attention deficit-hyperactivity disorder (ADHD), and schizoid and schizotypal personality disorders. Overall (boys plus girls), fifteen percent of the youths were present in this cluster. While there is some commonality of treatment across these diagnoses (e.g., anti-psychotics, especially new atypical antipsychotic agents for the treatment of psychotic symptoms), ADHD would be treated with stimulants and behavior modification. These diagnoses can be thought of as a package because, in contrast to Cluster I, where there is predominant disturbance of mood and affect, individuals in Cluster II have predominant disturbance of cognition, thought and attention.

If prevalence rates in 2006 are similar to those shown in Table 6.2, there are about 400 males and 30 to 40 females in Cluster II in the current DJJ population.

Cluster III consists of disorders rarely seen in DJJ youth: eating disorders, somatoform disorders, and adjustment disorders. In contrast to Clusters I and II, disorders in this cluster are most likely coincidental, meaning that, unlike the first two clusters, they probably do not reflect a special association to delinquent behavior. Of the youths interviewed only one percent meet the criteria

<sup>13</sup> Adapted from Figure 5b, Steiner, et. al. 2001

for eating disorder, two percent for a somatoform disorder, and three percent for an adjustment disorder. While a higher percentage of girls were present in this cluster, overall, only five percent of the youths in 2001 were in Cluster III. In addition to their rarity, these disorders also share a common method of intervention: their progress should be tracked during incarceration (e.g., weight tracking), expecting improvement over time without any specific further intervention. A particularly useful tracking mechanism would be the visits to nurse or general physician.

If prevalence rates in 2006 are similar to those shown in Table 6.2, there are about 100 males and 20 to 25 females in Cluster III in the current DJJ population.

Cluster IV-V, is comprised of alcohol and substance abuse and dependence. Only youths who were not included in Cluster I-III were included in this cluster. That is, if a youth met the criteria for depression and cannabis dependence, he/she would receive a score of “yes” for Cluster I, but a score of “no” for Cluster IV-V. Because rates of substance abuse and dependence were so high (85 percent), the overlapping comorbidity with other mental health problems needed to be separated. Steiner et al. (2001) propose that juveniles who suffer from combinations of other disorders and substance abuse problems would respond to intervention targeting their other comorbidity (e.g., depression). While mood problems can also arise from substance use, at this point we cannot confidently distinguish the order of events in this study. Overall, thirty-seven percent received a diagnosis relevant to substance use without a diagnosis present in one of the three other clusters. More specifically, 20 percent of the sample have problems with abuse and 27 percent have dependence, the latter requiring long-term therapy along with relapse prevention efforts.

If prevalence rates in 2006 are similar to those shown in Table 6.2, there are about 600 males and 15 females in the current DJJ population whose *sole diagnosis* is alcohol and substance dependence. Another 860 males and 20 females have a *sole diagnosis* of alcohol and substance abuse.

### **Soliciting and Facilitating Family Involvement**

Family involvement is a key principle of this plan. There are various points in the course of confinement which provide opportunities to involve families. They are at the local county level (prior to placement in DJJ), reception center, through facility site visits and phone calls, and during and after transition to the community. Family members may serve as an important resource at any or all of these times in the youth’s confinement. Involvement of family is particularly important to successful treatment for those receiving medical/psychiatric care who are under age 18.

It is recognized that in some instances a youth’s parents or caregivers may be unavailable due to impairment, other family priorities, and/or parental “burnout”. However, the majority of families are likely to be receptive to participating in some aspect of their youth’s rehabilitation. In interaction with families, staff will be encouraged to highlight small increments of improvement by the youth.

Involvement of families will be supported by DJJ by measures including, to the extent possible, placement of youth as close to their home community as possible, regularly scheduled family meetings, and regular telephone contact. To the extent possible, DJJ will provide assistance in arranging or facilitating transportation for family members. This may involve collaboration with

community and/or advocacy groups, assistance with forming car pools, or direct assistance if funding is available. DJJ will also pursue the use of video-conferencing in situations where family members are not able to travel to DJJ facilities.

Parents or legal guardians of youth under age 18 will be notified within 24 hours of all suicide attempts, hospitalizations, serious injuries, or serious offenses committed against the youth unless the youth requests that his/her parents or legal guardians not be notified and the Chief Deputy Secretary of DJJ determines that it would be in the youth's best interest to not notify the parents or legal guardians. (See California Welfare and Institutions Code section 223.) Parents or legal guardians of youth under age 18 will also be notified of changes in levels of care, unless the treating clinician determines that such notification is contraindicated. Parents or legal guardians of youth age 18 and over will be notified within 24 hours of all suicide attempts, hospitalizations, serious injuries, serious offenses committed against the youth, and changes in levels of care if the youth has consented to the notification. (See California Welfare and Institutions Code section 223.) DJJ's intent is to provide prompt and accurate information to parents and guardians in order to involve them with youths' treatment, but in a manner that is clinically appropriate and consistent with youths' rights to withhold consent.

It should be noted that the definition of "family" varies considerably in different communities and that it often extends beyond the nuclear family. In this Plan, relevant family members may include grandparents, aunts, uncles, neighbors, religious officials, and other community people. Engaging and involving individuals using this broad definition of family is not only desirable, but may be necessary for a youth whose nuclear family is either unavailable or non-receptive to participation in the youth's rehabilitation. This broad definition of family does not supersede the definitions set forth in state and federal law and does not extend to issues of legal consent or confidential patient information protected by law.

#### Intake and Assessment

DJJ will attempt to contact family members, generally parents or legal guardians, within two business days of the arrival of the youth in the reception center. For youth with a prior history of mental illness, or when intake screening suggests the presence of a mental illness, initial telephone contact will be followed by a face-to-face or telephone interview conducted by a clinician or case manager to obtain relevant past family and psychiatric history to assist in the initial mental health assessment. Staff will use standardized assessment measures to assess family background, strengths, and functioning. Where necessary and available, verbal consent for treatment for youths under the age of 18 will be requested within two business days of arrival and written consent obtained within seven days. Contact information and clinical information from this assessment will be documented in the youth's medical record.

Telephone contact between the youth and his/her family will be facilitated within 24 hours of arrival at the reception center to assist the youth in the early adjustment to his/her confinement. Ongoing telephone contact between the youth and family will be facilitated on a regular basis during the entire period of the youth's confinement.

Many youth with mental illness have received mental health treatment in county detention facilities. Communication with county treatment staff will enhance the intake and assessment process at DJJ.

### Engagement of Families

Strong efforts will be made to maintain contact with and engage the youth's family after placement in the appropriate DJJ facility. One evidence based model for family engagement that may be appropriate for the DJJ population is the Family Engagement Model developed by McKay et al (McKay & Bannon, 2005). This engagement program involves a manualized protocol that can be taught to intake teams to support strategies for engaging families in services. This model incorporates techniques from motivational interviewing.

For youth placed in intensive mental health treatment programs, when family members are available and appropriate participants, family engagement will include a minimum of weekly contact either in person or by telephone by a member of the youth's treatment team. The goals of these sessions are to: (1) update the family about the youth's clinical progress, (2) obtain information about any changes in the youth's family circumstances, (3) maintain regular contact between the youth and his/her family, (4) discuss plans for transition of the youth back to the community after confinement, (5) educate the family about the ongoing treatment needs of their child, and (6) solicit their support for his/her treatment. Details of these contacts will be documented in the youth's record. Details of mental health and substance abuse/dependence treatment will be protected under the guidelines of the state and federal statutes that govern confidentiality and privilege of such information. Before any family sessions are initiated, staff will obtain appropriate consents and waivers of confidentiality. For youth 18 years old and older, the assigned staff person will first get permission from the youth to contact family, and will leave it to the youth's discretion which family members will be contacted. In order to protect the confidentiality of the youth, before a staff person speaks with a family member who is not legally a parent or guardian for youth under 18, the staff person will obtain all legally-required waivers of confidentiality. Likewise, before a staff person speaks with anyone (including parents) about youth 18 and older, the staff person will obtain all legally-required waivers of confidentiality from the youth.

In cases where family members are not available or are not willing to be contacted by the treatment team, efforts to solicit their involvement will be documented in the youth's record.

Pursuant to California Family Code, Sections 6924(d), mental health treatment or counseling shall not involve the minor's parent or guardian if, in the opinion of the mental health clinician, the involvement would be inappropriate (i.e. deemed to be potentially harmful to the youth). Additionally, youth age 18 and over may prohibit staff from contacting parents and guardians.

The Reform Implementation Team will explore the possibility of establishing a program of "parent partners" for possible implementation by local mental health and program staff at facilities with Residential Mental Health Programs. This program, if found to be feasible, will involve establishing a network of parents of youth who have successfully participated in their child's treatment who will subsequently facilitate involvement of other parents. This model has been used extensively in mental health clinics and schools in many states, and has been found to provide "peer to peer" support for families and to improve engagement, access, and satisfaction with mental health services (Bickman & Heflinger, 1996; Hoagwood, 2005; McKay & Bannon, 2005). Duties of "parent partners" might include accompanying parents to family visits, conferencing with facility staff, case management relevant to re-entry planning, and general support. This may be very pertinent to ensuring mental health follow-up in local communities. In

addition, DJJ will explore the feasibility of organizing quarterly “Family Visiting Days” to encourage further participation of families in the child’s treatment.

### Transition to the Community

While receiving such services in a facility is important to improving adaptive functioning, youths may face difficulties in maintaining these gains when they are released. As they return to their communities they may face a variety of risks that challenge their skills to maintain sobriety and avoid illegal behavior, including troubled family environments, exposure to friends or family members who use substances or engage in illegal behaviors, unstructured time, problems with school or occupational performance, and lack of reinforcement for improved behavior. Research supports the importance of providing support during this critical transition period (Trupin, et al; 2004).

One model for assisting mentally ill youth with this transition is the Family Integrated Transitions (FIT) program. FIT provides integrated individual and family services to juvenile offenders with mental health and chemical dependency disorders during the period of transition of the youth from incarceration back to the community. The goals of the FIT program include lowering the risk for recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health status of the youth, and increasing prosocial behavior. Engagement and retention of families in treatment by enhancing their motivation to change is a cornerstone of the FIT intervention. FIT relies heavily on the engagement techniques of Motivational Enhancement Therapy, an approach developed by Miller and Rollnick (1991) to engage clients in treatment with the objective of increasing their commitment to change. It is a focused and goal-directed approach with the overarching objective of helping clients to explore and resolve ambivalence about change.

An evaluation of the effectiveness of the FIT program by the Washington State Institute for Public Policy found that it reduced 18 month recidivism for the target population from 40.6 percent to 27 percent. While an expensive program, this reduction in crime saved taxpayers in Washington State \$3.15 for every dollar invested in the program. Costs and savings in California may differ based on California recidivism rates and the cost of processing and sanctioning criminal offenses in California.

Another evidence based program for transition of youth to the community is the Family Justice (“La Bodega”) Model. This program is appropriate for youth in the core rehabilitation/treatment program. DJJ will implement the FIT Program for youth in mental health treatment programs, and the Family Justice Model Program for youth in core rehabilitation/treatment programs, on a pilot basis. Based on outcome evaluation of these pilot programs, DJJ will expand them as appropriate.

### **Monitoring Treatment Effectiveness**

The Health Care Services Remedial Plan includes provisions for monitoring service quality through performance indicators and a quality management process. Mental Health Services will participate in this process by, among other things, developing performance indicators to monitor the quality of services and measure patient outcomes. DJJ will review the existing mental health monitoring systems for youth to ensure that the proposed assessments in this program can be

feasibly incorporated into this process.<sup>14</sup> DJJ will review the options with respect to their compatibility with DJJ's assessment protocols so as to ensure continued enhancement and delivery of quality behavioral health treatments.

## **ACTION PLAN**

1. DJJ will develop and implement a system to document and track: (1) attempts to engage families in their child's treatment program, (2) family participation in their child's treatment, and (3) family notification of suicide attempts, hospitalizations, movement to different levels of care, serious injuries, and serious offenses committed against the youth consistent with DJJ policies. This system will be in use not later than February 29, 2008.
2. DJJ will investigate the feasibility of using the Family Engagement Model, or other evidence based models for family engagement it chooses to review, in its mental health programs. This feasibility review will be completed by no later than May 15, 2007.
3. If a Family Engagement Model, or other evidence based model for family engagement, is found to be feasible and appropriate for DJJ's population, an implementation plan will be developed and the model will be implemented no later than July 31, 2008.
4. DJJ will investigate the feasibility of implementing a program of parent partners. This feasibility review will be completed by no later than May 30, 2007.
5. If a program of parent partners is found feasible and appropriate for DJJ's population, an implementation plan will be developed and DJJ will begin implementation no later than August 10, 2008.
6. No later than May 30, 2007, DJJ will initiate a pilot using the Family Integrated Transition model for youth in its specialized mental health programs and the Family Justice ("La Bodega") model for youth in core treatment programs.
7. By February 2008, DJJ will complete a review of outcomes from the Family Integrated Transition model and the Family Justice model pilot programs.
8. If found feasible and appropriate for the DJJ population, DJJ will work with the Consent Decree experts to develop an implementation plan to continue the Family Integrated Treatment and Family Justice programs beyond the pilot phase no later than April 30, 2008.
9. No later than June 30, 2008, DJJ will provide a budget for acquisition of professional journals and publications at each facility. The Director of Mental Health Services/Chief Psychiatrist will oversee maintenance of the professional libraries.
10. Effective immediately, DJJ will provide funding for ongoing training and attendance at national and regional conferences for appropriate mental health staff.

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<sup>14</sup> Several mental health quality monitoring systems are currently available for youth with mental health problems. The purpose of these systems is to provide a comprehensive picture of youth treatment progress. Two examples are the University of Arkansas' Outcomes Monitoring Project and the Peabody Treatment Progress Battery (Bickman, 2005).

11. DJJ will conduct an analysis of treatment intervention efficacy and of the treatment needs of its population either through use of an existing mental health monitoring system or by developing its own by a date to be set in the Standards and Criteria section.
12. Based on the analysis treatment intervention efficacy and of the treatment needs of its population described in the previous action plan item, DJJ will modify its treatments and identify and implement new training as required by a date to be set in the Standards and Criteria section.

## **Section 7**

# **STAFF QUALIFICATIONS AND TRAINING**

### **THE ISSUE**

Because the Mental Health and Safety and Welfare Remedial Plans will not succeed in the absence of qualified mental health providers, DJJ must be able to attract and retain competent professionals. For existing staff and new hires, initial and ongoing training is needed to develop and maintain the skills required for implementation and maintenance of effective mental health programs.

### **DISCUSSION**

#### **Compensation**

Mental health care providers employed by the Division of Juvenile Justice will have pay parity with mental health care staff employed by Adult Operations and Adult Programs. Pay differentials may be used to aid in recruitment and retention to specific facilities or regions.

DJJ is committed to making all efforts to fully staff all mental health positions as expeditiously as possible to ensure its mental health programs comply with this Remedial Plan. This may include reviewing the levels of compensation, when appropriate, and developing recruitment and retention strategies consistent with state policy. DJJ Mental Health Services will work with the CDCR Office of Workforce Planning to arrange participation in mental health job fairs at DJJ facilities and recruitment events at professional schools and/or conferences. DJJ will also pursue additional strategies, such as improving working conditions to make employment with DJJ more attractive to qualified mental health providers and/or by developing new, or modify existing, job classifications.

#### [Department of Personnel Administration Salary Survey Findings](#)

In April 2006, the Department of Personnel Administration published preliminary findings from the state's first comprehensive survey of compensation in more than 20 years. This survey compared total compensation for state workers to that paid to private sector and other public sector employees who work in the same, or similar, job classifications. The survey of private sector employers is based on average total compensation in 2005. The survey of other public sector employers is based on average total compensation as of January 2006.

There were insufficient data from the survey of private sector employers for most mental health professions. However, the survey found that average total compensation for master's level social workers employed by the state is 76.4 percent of what the average social worker in the private sector earns.

Sufficient data were available to compare state employees with other public sector employees for psychiatrists, psychologists, and master's level social workers. The results of the survey are shown in Table 7.1.

Table 7.1: Total Compensation for State Employees  
 % of Median Total Compensation for Employees of Other Public Agencies

Job Classification	State Compensation as % of Other Public Agency Compensation	
	Starting	Maximum
Psychiatrists	78.7%	71.3%
Psychologists	87.3%	81.7%
Social Workers	73.7%	81.3%

Note that, for the one job classification where the comparison can be made, social workers in other public agencies earn about the same as their counterparts in the private sector.<sup>15</sup>

Plaintiff reserves her right to invoke the dispute resolution mechanisms under the Consent Decree at any time, but she may wait and see whether the problems of recruitment and retention of qualified mental health providers are resolved as part of the CDCR Adult Operations and Adult Programs federal lawsuit, *Coleman v. Schwarzenegger*.

### **Staff Qualifications and Licensure**

#### Psychiatrists

All psychiatrists hired by DJJ after the filing of this plan are to be licensed to practice medicine in the State of California and be board certified or board eligible, in accordance with the American Board of Medical Specialties, preferably in Child and Adolescent Psychiatry, Forensic Psychiatry, and/or General Psychiatry. Psychiatrists should have awareness and understanding of the operations of the juvenile correctional facility and the issues affecting it, including its interface with multiple systems (e.g. courts, probation, parole, social services, and child welfare agencies), the existing educational and health care systems within the facility, evidence based treatments, and expertise in using a wide array of psychopharmacologic interventions with this population.

#### Psychologists

All non-entry level psychologists hired by DJJ after the filing of this plan are to be licensed clinicians in the State of California. Entry level psychologists hired by DJJ after the filing of this plan must be license eligible and must receive their license within two years of employment with DJJ. Psychologists are expected to be well versed in cognitive behavioral treatment theory and practice either through prior education and experience or through additional training. They should be adept at teaching, coaching, and demonstrating cognitive behavioral treatment skills to non-clinical staff who will deliver most CBT services. Clinicians should have awareness and understanding of the operations of the juvenile correctional facility and the issues affecting it, including its interface with multiple systems (e.g. courts, probation, parole, social services, and child welfare agencies) and the existing educational and health care systems within the facility.

<sup>15</sup> Social workers employed by the state earn 76 percent of what social workers in the private sector make. Social workers employed by the state earn 76 to 81 percent of what social workers in other public agencies make. (A = .76B; A ≈ .76C; therefore B ≈ C)

### Interns

Psychology Interns must be pre-doctoral candidates from an accredited university. Master's level graduate students may also be used as field placement students or trainees.

### Treatment Team Leader

The role of the treatment team leader will be defined through the process of developing the Integrated Behavioral Treatment Model. For a general discussion of this function, refer to Section 3 of this plan.

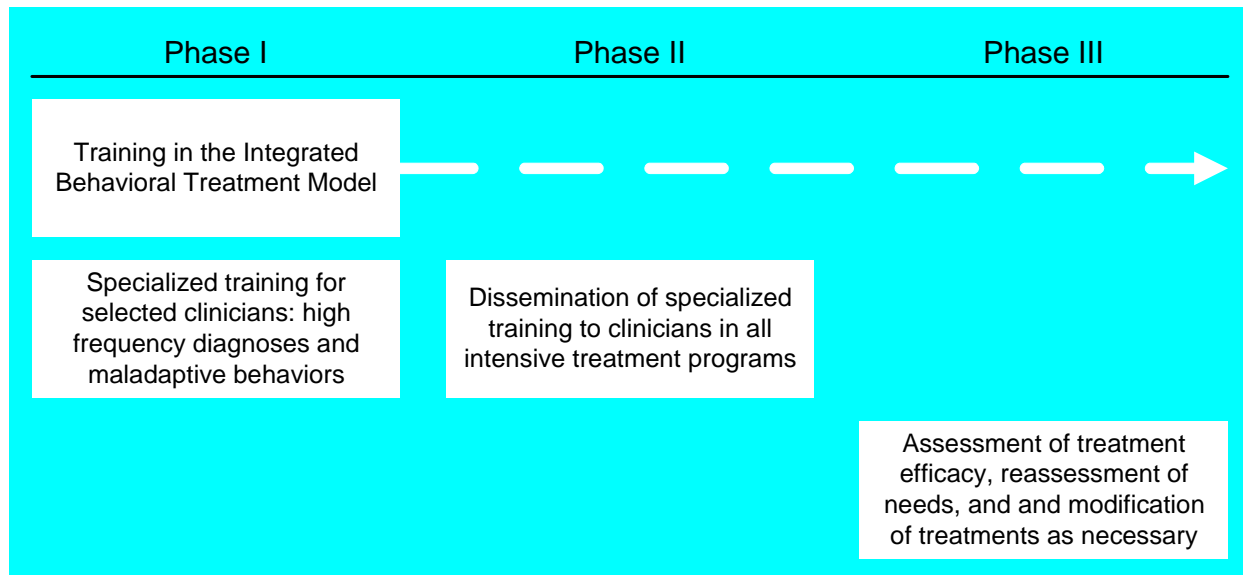
### Youth Correctional Counselor – IBTM

Under the Integrated Behavior Treatment Model, Youth Correctional Counselors will provide many of the skills training, shaping, contingency management, cognitive restructuring, coaching and role playing, etc. that constitute the interventions used in the treatment model. Therefore, at a minimum, as DJJ continues to hire Youth Correctional Counselors, in the future, preference will be given to applicants who have a Bachelor's Degree or higher and/or who have significant professional experience in casework, counseling, probation and parole, social services or a related field. To be eligible to work in a living unit operating under this treatment model, a Youth Correctional Counselor must successfully complete complete IBTM training as required by DJJ.

### **Training**

DJJ will develop training, write curriculum, provide training for trainers, and implement training of mental and behavioral health staff. DJJ will develop a training plan and schedule consistent with the sample training strategy described below and illustrated in Figure 7.1.

**Figure 7.1: Training in Evidence Based Treatment**



Psychologists who provide consulting and coaching to direct care staff in the Integrated Behavior Treatment Model receive in-depth training in the model. They will meet monthly on a regional basis, and quarterly on a state-wide basis, to share experiences and insights and to reinforce existing skills and receive training in new skills.

As described in the Safety and Welfare Remedial Plan, direct care staff receive training in all aspects of the Integrated Behavior Treatment Model, including in-depth instruction in the skill sets used. Managers and support staff also receive training as described in the Safety and Welfare Remedial Plan.

All training in standardized modules will be competency based.

### Phase I Training

The first training phase has three parts. First, selected staff, including clinical psychologists, will receive in-depth training in cognitive behavioral treatment theory and practice and in the elements and skill sets used in the DJJ Integrated Behavior Treatment Model. This training will be provided by consultants with documented expertise in the Integrated Behavior Treatment Model. These staff will become the primary trainers of non-clinical staff in the treatment model. Second, psychiatrists and psychologists will receive in-depth training in evidence based treatments for high frequency disorders found in the DJJ population. Third, in coordination with the implementation schedule for opening new living units and increasing staffing levels on existing units, all staff having contact with youth will receive training in the Integrated Behavior Treatment Model.

Residential unit direct care staff will receive training in:

- Cognitive-behavioral treatment overview
- Behavior modification components
- Interactive behavioral analysis
- Treatment hierarchy
- Treatment planning
- Motivational interviewing
- In-depth overview of skill set
- IBTM documentation

Managers will receive training in all of the areas listed. Training for managers will include components specifically directed toward administrative implementation of the treatment model.

Support staff will receive training to include to a brief cognitive-behavioral overview and information on treatment planning and IBTM documentation.

### Phase II Training

Phase II training will consist of wider dissemination of specialized evidence based treatment skills learned and practiced by clinical psychologists in the first phase of training. Phase II will also involve continued training of staff in the DJJ Integrated Behavior Treatment Model as additional facilities and living units are converted to the treatment model.

Psychiatrists and psychologists will receive additional training to acquire and practice new skills in evidence based treatments for additional disorders frequently found in the DJJ population.

### Phase III Training

Phase III training will expand specialized evidence based treatments throughout the entire DJJ system and complete the initial training of staff in the Integrated Behavior Treatment Model as the last living units are brought on line.

### On-unit Coaching

Clinical psychologists and other qualified mental health trainers will provide guidance to direct care staff through consulting, coaching, and demonstrating treatment approaches and techniques. Clinical psychologists will be in the living units working with direct care staff for a substantial part of every working day.

### Learning from Peers

Regular sharing of experiences, insights, and new knowledge among peers is an effective way to increase skills and promote fidelity to the treatment model. Selected treatment team members will meet together monthly with a consulting clinician or trainer from central office, another facility, an on-site expert, or an outside consultant for purposes of problem solving, sharing experiences with youth, and discussing IBTM issues and developments.

### Ongoing Training

Under the IBTM, all staff who interact with youth are “treatment providers.” As such, all staff must develop and maintain appropriate skills. In addition, as the IBTM is used, modifications and additions will be made to the model which will require additional training. To meet these needs, DJJ will develop a plan for ongoing training.

### Continuing Medical Education

Continuing medical education will be provided as described in the Health Care Services Remedial Plan.

## **ACTION PLAN**

1. Immediately on the filing of this plan, DJJ will ensure that mental health care providers employed by the Division of Juvenile Justice have pay parity with comparable staff employed by CDCR adult operations. DJJ will also ensure that pay differentials are used as appropriate to aid in recruitment and retention of mental health staff for specific facilities or regions.
2. Immediately on the filing of this plan, DJJ Mental Health Services will work with the CDCR Office of Workforce Planning to arrange participation in mental health job fairs at DJJ facilities and recruitment events at professional schools and/or conferences.
3. Immediately on the filing of this plan, DJJ will begin to participate in mental health job fairs and recruitment events.
4. DJJ will implement training in the Integrated Behavior Treatment Model as described in the Safety and Welfare Remedial Plan.
5. By a date to be specified in the Standards and Criteria section, DJJ will establish a schedule for training staff based on the timeframes by which various components of the Integrated

Behavioral Treatment Model are developed, including evidence based treatment for identified high frequency diagnoses and maladaptive behaviors.

6. As applicable to each clinician, DJJ will provide instruction in the evidence based interventions for high frequency diagnoses and maladaptive behaviors identified above to all mental health clinicians in intensive treatment programs by July 15, 2009.

## **Section 8**

# **POLICIES AND PROCEDURES**

### **THE ISSUE**

In all aspects of system reform, DJJ is moving toward being a policy driven organization. Policies and procedures not only define operations and systems of accountability, they also promote standardization. As a rehabilitative organization dedicated to improved outcomes through use of evidence based practices, policies and procedures help shape and standardize practices in furtherance of that objective.

### **DISCUSSION**

#### **General Mental Health Policies and Procedures**

DJJ will provide mental health care services at its facilities according to standard policies and procedures which will be used statewide to provide an appropriate level of care and treatment by appropriately credentialed health care professionals.

The previously filed Health Care Services Remedial Plan provides for the development and implementation of health care policies, procedures and protocols. The provisions of the Health Care Services Remedial Plan concerning the requirements for policies, procedures and protocols pertain equally to mental health. The Mental Health Services Director/Chief Psychiatrist will ensure that the requirements for policies, procedures and protocols are met with respect to mental health care.

DJJ's policies and procedures will be standardized and focused on the integration of mental health services and will clearly define the roles and responsibilities of professionals who implement them. As stated in the Health Care Service Remedial Plan, policies drive the identification of required resources and the evaluation of outcomes. They also play an essential role in the success of Quality Management and/or Peer Review programs.

DJJ will develop a complete set of essential policies and procedures both to form the basis of the delivery of services and to address the deficiencies identified in the expert's report. As with health care services, all policies related to mental health services will be referenced to standards contained in the current edition of *Standards for Health Services in Juvenile Detention and Confinement Facilities*, the current edition of *Correctional Mental Health Care Standards & Guidelines for Delivering Services*, current recommendations regarding mental disorders from the US Preventive Services Task Force (USPSTF), Practice Parameters published by the American Academy of Child and Adolescent Psychiatry, and Practice Guidelines published by the American Psychiatric Association.

DJJ will work closely with mental health subject matter experts to develop policies and procedures. Policies and procedures will be based on the guiding principles and key concepts identified in this plan.

DJJ will develop policies and procedures that cover the following mental health care issues:

1. Integrated screening and assessments.
2. Process for identification of mental health issues in youth.

3. Initial risk assessments.
4. Psychiatric and psychological evaluations.
5. Integrated and evidence based mental health treatment services (such as Cognitive Behavioral Therapy, Motivational Interviewing and Enhancement Skills, Dialectical Behavior Therapy, etc.).
6. Individualized treatment planning.
7. Mental health referral process.
8. Mental health level of care system.
9. Mental health program guides.
10. Standards for family involvement in assessment, treatment and transition.
11. Standards for family notification of suicide attempts, hospitalizations, movement to different levels of care, serious injuries, and serious offenses committed against the youth, including documentation requirements.
12. Standards for protecting and granting access to confidential information.
13. Suicide Prevention Assessment and Response Policy.
14. Seclusion and Clinically-indicated Restraint Policy.
15. Discharge, aftercare and transition planning.
16. Guidelines for documentation, report writing, etc.
17. Guidelines for movement between levels of care.
18. Mental health concerns in use of force, Disciplinary Decision Making System (DDMS), grievances, etc.
19. Abnormal Involuntary Movement Scale.
20. Psychopharmacological treatment.
21. Informed Consent for Psychotropic Medications.
22. Psychiatric Referrals and Crisis Response.

Mental health policies and procedures may be revised on the same terms as other health care policies under the Health Care Services Remedial Plan.

### **Pharmacy Services / Medication Administration Policies and Procedures**

The previously filed Health Care Services Remedial Plan provides for policy and procedure with regard to pharmacy services and medication administration. The requirements specified therein will also apply to mental health services.

Psychopharmacological treatment is one of the core mental health interventions for a wide range of diagnoses in psychiatry. Effective treatment for this highly morbid population must include expertise and familiarity with up-to-date principles of medication management that align with community standards of care. It is also important that DJJ physicians have an informed knowledge about the appropriate uses of such medications so that they are not used indiscriminately or without sound clinical indications. All medication treatment will include standard procedures with respect to the need to obtain informed consent.

DJJ will develop Policies, Procedures, and Guidelines regarding the use of psychotropic medications. DJJ policy on medication administration will incorporate the following principles:

1. Establish guidelines for specific and appropriate target symptoms that are amenable to treatment with psychotropic medications.

2. Use suitable standardized assessment techniques which are conducted at baseline prior to treatment and at standardized follow up intervals.
3. Assign a principal diagnosis wherever possible that most accurately represents the disorder that is causing the problematic target symptom.
4. Obtain appropriate baseline and follow up laboratory tests including blood tests and EKGs prior to and after starting psychotropic medication treatment.
5. Start with single agent treatment wherever possible with medications that target specific symptoms so as to limit potential side effects and allow appropriate monitoring and interpretation of treatment response.
6. Titrate medications to the adequate and optimal dose, using laboratory tests where medically indicated for monitoring and allow sufficient time (often weeks to months) to assess treatment response prior to initiating further changes in the medication regimen.
7. Consider combination and augmentation treatment only after reasonable certainty that the primary agent is ineffective and after having re-considered the principal diagnosis.
8. Polypharmacy will be avoided whenever clinically appropriate.
9. Monitor treatment response and side effects using appropriate measures of target symptoms and assessments of global functioning, such as the Clinical Global Impression (CGI).
10. Provide guidance on appropriate protocols to discontinue medications to minimize the risk of withdrawal symptoms or re-emergence of symptoms.
11. Review prior treatment history and records especially in regard to efficacy.
12. Review documented history of abuse of both illicit and prescribed medications.

### **Modification of General DJJ Policy for Mentally Ill Youth**

In addition to specific policies for mental health services, general DJJ policies that relate to all youth will require modification or additions in their application to mentally ill youth.

Modifications will be needed in DJJ policy on the use of force, use of restraints, and the disciplinary process.

### Use of Force

Policies and procedures relating to the use of force will include sections on mentally ill youth. Policy will recognize that:

1. Because of potential medical complications, in any controlled use of force, oleoresin capsicum spray (OC - also known as pepper spray or mace) is not to be used on youth who are on psychotropic agents.<sup>16</sup> In addition, some individuals who are very aggressive, agitated, intoxicated, or suffer from a severe mental illness may have altered perceptions and responses to pain and therefore may not respond as desired and may become more agitated by exposure.
2. If 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 preceded by a cooling down period to allow the youth to voluntarily comply with staff instructions.
3. The Institutional Force Review Committee is to include a representative from mental health when a use of force incident on a mentally ill youth is reviewed.

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<sup>16</sup> See Safety and Welfare Plan for definition of “Controlled Use of Force.”

Policy regarding accommodations in the use of force for mentally ill youth will be developed in consultation with the Chief Psychiatrist and outside experts. The Medical Director and/or Chief Psychiatrist for DJJ will develop a policy/procedure outlining a process of communication and documentation to ensure that healthcare and/or mental health professionals indicate if any use of force is not appropriate for a specific youth. This information will be provided to the unit staff and Duty Lieutenant who will be responsible for obtaining this information prior to a controlled use of force.

#### Use of Clinically Indicated Restraints

Clinically-indicated restraints will only be used in a licensed facility (or transportation to a licensed facility).

DJJ will develop policies and procedures to ensure that:

1. Clinically indicated restraints are only applied when all less restrictive interventions have been exhausted.
2. Health-trained personnel or medical service staff examine the youth every 15 minutes to determine any loss of integrity of skin, nerves, and circulation. This must also be appropriately documented.
3. All precautions are taken to insure that restraints do not jeopardize the health of the youth and all ongoing medically necessary treatment is administered.
4. Restraints are applied, if at all possible, when the youth is in a supine position.
5. Hog-tying is forbidden.

Division policy will address the following issues with regard to the use of clinically indicated restraints on mentally ill youth:

1. The types of restraints that may be used.
2. When mechanical restraints may be used, including the conditions necessitating their use and the requirements for the approval for their use.
3. The specific location where they may be employed.
4. Who may apply restraints and for how long restraints may be used.
5. Required documentation on standardized forms and using a format that is consistent with quality assurance standards.
6. A requirement to report any use of therapeutic restraint of a youth as a serious incident. The policy will specify that all documentation of the use of therapeutic restraint be subject to audit annually and be subject to inclusion in medical quality assurance reviews.
7. Documentation of the initial and ongoing training in the use and policies governing restraints.

Administration of medication that is medically indicated for certain mental disorders or severe agitation may diminish the need for restraints. DJJ will develop guidelines for medically appropriate use of psychopharmacological agents in youth who pose an imminent danger to self or others.

### Disciplinary Process and Mentally Ill Youth

As discussed in Section 5, policies and procedures relating to the disciplinary process will include sections on mentally ill youth that recognize that there are mental disorders and some side effects from psychotropic agents which include symptoms or behaviors that, on the surface, may constitute violations of the code of conduct. Special attention must be given to these because a disciplinary measure may not be warranted and may, in fact, be harmful in such instances. Policy will require that all unit staff, especially those responsible for imposing disciplinary measures, be trained in mental health and the side effects of psychotropic agents.

The disciplinary hearing committee considering allegations of misconduct involving a youth on a mental health caseload must include someone from mental health as described in Section 5, subsection, "Forensic Services."

### **ACTION PLAN**

1. In consultation with Consent Decree mental health experts, DJJ will develop a comprehensive set of essential policies and procedures for the delivery mental health services as described in this section. DJJ will provide plaintiff's counsel and the Special Master with copies of proposed policies and procedures for their review and comment prior to adoption. Updated mental health polices and procedures will be completed by a date to be specified in the Standards and Criteria section. Policy and procedure pertaining to psychopharmacological services will be coordinated with policy development consistent with the Health Care Services Remedial Plan.
2. In consultation with Consent Decree mental health experts, DJJ will develop policies regarding mentally ill youth and the use of force, use of restraints, and the disciplinary process. These policies will be consistent with the descriptions in this section. DJJ will provide plaintiff's counsel and the Special Master with copies of proposed modifications to these policies and procedures for their review and comment prior to adoption. These modifications will be completed by December 31, 2006.

## **Section 9**

# **MENTAL HEALTH RECORDS**

### **THE ISSUE**

Through the Health Care Services Remedial Plan, DJJ will use a Unified Health Record. Mental health records must be compatible with, or incorporated within, the Unified Health Record. Treatment records must be accessible to the appropriate staff in a timely matter.

### **DISCUSSION**

As described in the Health Care Services Remedial Plan, DJJ will have a Unified Health Record that contains all past and current documentation regarding the youth's medical and mental health treatment. This document will be immediately available to all health care staff who provide clinical care to the individual. There will be clear guidelines regarding the format and nature of documentation that is required for specific clinical services with appropriate audits to monitor compliance. There will be a mechanism to ensure that the record follows the youth as he/she is transferred to different facilities within DJJ, for example, from the Reception Center to the treatment facility. There will also be a mechanism to ensure that the medical and mental health records of youth who are admitted directly to a treatment facility (e.g. parole violators) are available at the treatment facility in a timely manner.

As also described in the Health Care Services Remedial Plan, DJJ will ultimately have a computerized medical record base that provides system-wide access to the medical record so that important clinical data is available at any facility in which a youth is placed for treatment. This record will have the capacity to allow restricted access to confidential sections of the medical record to staff who are authorized for such access. This record may be based on the current WIN system, or may be based on a separate system with greater capacity for functions such as scanning of medical and legal documents. DJJ will also explore the use of transcription services so that details of all clinical contacts can be transcribed directly into the medical record.

DJJ will review its current records systems in which multiple medical and treatment records exist at different locations. Problems related to redundancy and lack of access to clinical/treatment information based on the physical locations of the different records will be addressed. DJJ will identify or develop the appropriate computerized record system to address these problems and meet its needs.

Laws regarding confidentiality and protection of confidential and protected information will be followed in all matters related to the medical record. This is particularly important with regard to sensitive mental health information and history. Protocols will be put in place to restrict access to health care records within the facility. When privileged information is disclosed to non-healthcare staff, disclosure must be in compliance with state and federal law. Policies regarding the release of information to outside facilities and policies regarding the need to obtain informed consent from a youth or his/her parents or legal guardians will be periodically reviewed and revised when appropriate.

## **ACTION PLAN**

1. By a date to be set in the Standards and Criteria section, DJJ will review the current records systems to address problems related to redundancy and lack of access to clinical/treatment information.
2. By a date to be set in the Standards and Criteria section, DJJ will identify or develop an appropriate computerized record system to address problems of redundancy and lack of access identified in the previous action plan item.
3. Other actions pertaining to mental health records will be taken in conjunction with the Health Care Services Remedial Plan and be governed by that plan.

## **Section 10**

# **QUALITY MANAGEMENT AND PEER REVIEW**

### **THE ISSUE**

Systems to ensure the quality and integrity of mental health care are essential to the success of this Remedial Plan.

### **DISCUSSION**

#### **Quality Management Committees and Process**

The Health Care Services Remedial Plan identifies the components of quality management and peer review programs for DJJ. The purpose of these programs is to ensure that all health care delivery, including mental health, is consistent with national standards and DJJ Health Care policies and procedures. Overall responsibility for the quality management programs lies with the Medical Director.

Each facility is to have a Quality Management Committee (QMC) consisting of, at a minimum, the facility Chief Medical Officer, Psychiatrist, Psychologist, Administrator, Supervising Nurse, Dentist, Pharmacist, and any ad hoc members as deemed necessary. Custody Staff and/or other designees of the superintendent may, by invitation, participate in meetings of the Quality Management Committee with appropriate safeguards in place to protect confidential information. The purpose of these meetings is to coordinate care, discuss administrative and clinical issues, and to take necessary corrective action. Recommendations for correction action are to be based on clinical outcomes measured by data collected from clinical indicators. The process for identifying clinical indicators is outlined in the Health Care Services Remedial Plan.

Each Quality Management Committee has various subcommittees, including a Mental Health Subcommittee. This committee is chaired by a psychiatrist or senior psychologist. It meets bi-monthly to review:

1. All Special Incident Reports involving youth on the mental health caseload.
2. Use of clinical restraints.
3. Emergency Use of psychotropic medications.
4. Data gathered through the quality management program local audits.

The primary assignment of this subcommittee is to identify quality of care problem areas and makes recommendations to the Medical Director regarding change in practices that will lead to improvement of patient outcomes.

An external quality management process is conducted by a Quality Management Team from central office.

The Health Care Services Remedial Plan also includes requirements and processes for physician peer review and for protecting the confidentiality of certain quality management system information. Peer review is to include psychologists.

### **Internal Audits and Corrective Action Plans<sup>17</sup>**

DJJ will develop internal audit instruments for its quality management program to be completed by Health Care Services administration and the Chief Medical Officer of each facility. On a quarterly basis, mental health (and related medical) audit instruments will be completed according to identified priority.

The mental health experts consulted during the development of this Plan suggested the following list of areas for auditing of operations and care. DJJ will develop its own audit system consistent with the intent expressed by this list.

1. Documentation: medical records review
2. Medicine administration record review
3. Outpatient living unit care
4. Reception center assessment
5. Continuity of care for youth transferred between facilities
6. Restraints
7. Mental health treatment of seriously mentally ill youth
8. Seriously mentally ill youth in segregation
9. Discharged seriously mentally ill youth
10. Transfer of seriously mentally ill youth
11. Use of psychotropic drugs (specific audits for identified medication)
12. Serious incident reports of mentally ill youth
13. Training summary
14. Child abuse reporting and investigations
15. Treatment plan development
16. Mental health assessment protocols
17. Suicide and self injurious behavior statistics
18. Family involvement
19. Community transition plans
20. Compliance with acceptance and rejection criteria

The results of the audits will be presented for corrective action to each facility Quality Management Committee and, when applicable, to the appropriate subcommittee as identified in the Health Care Services Remedial Plan.

The facility Quality Management Team will develop Corrective Action Plans for each area that did not reach the target threshold level. Development of corrective action plans will involve any facility staff that the committee feels may be necessary to create a viable plan. The plan will include an implementation section so that a review can assess how the corrective action plan will be applied. A repeat audit will be conducted of the area in the next quarter or, in cases where the plan may take longer to implement, six months later. The appropriate Quality Management Committee will again analyze the results of the audit and, if necessary, devise another corrective action plan. These reports of corrective action plans will be filed in a Quality Management file at the facility and sent to Health Care Services for review and retention in the facility's Quality

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<sup>17</sup> The phrase "Internal Audits" is used to distinguish ongoing quality management by DJJ from audits conducted for compliance purposes as part of this Remedial Plan.

Management file. The Health Care Services may provide additional expertise to local facilities as needed to enhance corrective action plans.

## **ACTION PLAN**

1. DJJ will develop an internal audit system for mental health services consistent with the Health Care Services quality management and peer review program and with the recommendations of the experts consulted in the development of this Remedial Plan. This audit system will be in place by a date to be specified in the Standards and Criteria section.
2. All other actions relative to implementation of a quality management and peer review system will be taken in conjunction with the Health Care Services Remedial Plan and be governed by that plan.

## **Section 11**

# **FACILITIES**

### **THE ISSUE**

The Safety and Welfare Remedial Plan noted that none of DJJ's existing facilities meets the long-term programmatic needs set forth in the Safety and Welfare Plan and that, with the exception of Chaderjian, all of DJJ's facilities have long exceeded their useful life. Because of their size, insufficient space for treatment programs and mental health staff, and generally non-therapeutic environments, DJJ's facilities also do not meet the programmatic needs set forth in this Mental Health Remedial Plan.

### **DISCUSSION**

Because of the time it takes to plan and construct new facilities, DJJ will continue to use existing facilities for a number of years. Consequently, this Remedial Plan needs to take into account short-term plans for existing facilities as well as long-term plans for replacement facilities.

#### **Existing Facilities and Short Term Plans**

##### Adequate Space for Mental Health Programs and Staff

Based on its November 30, 2005 draft Safety and Welfare and Mental Health Plans, DJJ requested and received funding from the legislature to begin renovations to existing buildings and add modulars to meet the interim needs described in those plans. DJJ's request was based on an evaluation of current resources and an estimate of the number of staff needing offices and the number of treatment spaces required for each type of unit.

Based on existing building and site considerations, additional office and/or program space will be added by converting vacated rooms or by adding modular buildings adjacent to, or near, the living units as needed. The intention is to provide sufficient treatment rooms and offices so that small groups and private one-on-one counseling can take place consistent with the requirement set forth in this plan to maximize out of room time and to ensure structured activity based on evidence based principles for 40 to 70 percent of waking hours. However, while the addition of modular space will improve conditions for youth and staff, the experts consulted in drafting this plan believe that new facilities are required to meet the programmatic requirements identified in this plan.

As an interim measure, DJJ will consolidate most mental health programs for Northern California at the N. A. Chaderjian Youth Correctional Center. Each mental health living unit will have the population capacity and staffing as described in Section 5 of this Plan.

#### **Long-Term Needs and Plans**

##### Juvenile Justice Operational Master Plan

The long-term needs of mentally ill youth in DJJ facilities may also be affected by the Juvenile Justice Operational Master Plan described in the Safety and Welfare Remedial Plan. Among other things, this plan may lead to alternative strategies for dealing with some of the youth historically committed to DJJ. Since the prevalence of mental illness is so high in the committed population, any alternative strategy must also address mental health issues.

### Facilities Master Plan

The Safety and Welfare Remedial Plan also calls for a Facilities Master Plan. The Facilities Master Plan will, among other things, result in a systematic description and quantification of future facility needs based on a projection of future demand, demographics, projected program needs, and the geographical distribution of commitments. The Safety and Welfare Remedial Plan notes that living units for special populations will be smaller than the core rehabilitation/treatment living units and that living unit size will be guided by national standards for juvenile correctional facilities and, if standards are not available, by the recommendations of national experts.

### Replacement Facilities

While specific requirements for residential mental health programs will be developed through the normal capital development process, there are certain basic requirements that will affect the design of new buildings. For example, each facility must provide a safe and secure environment to house youth. In addition, to facilitate the implementation of effective mental health treatment, facilities must provide a secure and private setting for treatment and an adequate number of mental health treatment rooms for individual, family and group psychotherapy.

### Information Technology

To facilitate the implementation of mental health services, facilities should provide computer and communication systems initially equipped with state-of-the-art equipment which is adequately maintained. These systems should include a dedicated phone line with speakerphone, personal computer, internet access, and personal e-mail account for each mental health professional. Each treatment unit should have a dedicated facsimile line and equipment and capacity to print documents. Each facility should have appropriate information technology support for staff. Treatment units should also provide equipment for educational purposes, including rooms with videotape/CD/DVD and television monitors, and projection screens.

## **ACTION PLAN**

1. DJJ will develop an implementation plan for creating offices and mental health treatment rooms using renovations and modular buildings as described in this section. This implementation plan will identify locations and schedules for addressing deficiencies in this area. Deficiencies will be remedied in as expeditious a manner as possible. This implementation plan will be completed no later than January 31, 2007. Remodels and installation of modular facilities will follow the schedules developed in the implementation plan.
2. DJJ will ensure that mental health issues are taken into account in the Juvenile Justice Operational Master Plan and Facilities Master Plan on the schedule set forth in the Safety and Welfare Remedial Plan.
3. DJJ will ensure that planning for new mental health facilities is done in conformance with the principles outlined in this section. These plans will be implemented in accordance with the schedule developed as part of the Facilities Master Plan.

4. DJJ will develop a plan for providing appropriate technology for residential mental health programs and staff as described in this section. This plan will be completed no later than January 15, 2008. DJJ will request funding as necessary and begin implementation at the beginning of the fiscal year for which funds are appropriated.

All other actions described in this section, including maintaining physical plant conditions, developing and implementing acceptance/rejection criteria, and juvenile justice and facilities master planning, will be implemented as described in the Safety and Welfare Remedial Plan.

## **Section 12**

# **IMPLEMENTATION OF THE MENTAL HEALTH PLAN**

### **THE ISSUE**

This Remedial Plan requires many changes and additions to mental health services, systems, procedures and protocols in DJJ facilities. In order to implement this Plan, DJJ must create the capacity to change its mental health system. In order to ensure compliance with this Plan, standards and criteria, audit instruments, and performance schedules must be developed.

### **DISCUSSION**

#### **Create the Capacity for Change**

As emphasized in the Safety and Welfare Plan, implementation of reform requires that DJJ develop the capacity to change through enhanced staffing and improved organizational structure both at central office and at its facilities. This is no less true for the Mental Health Remedial Plan than it is for the Safety and Welfare Plan.

The Mental Health Remedial Plan introduces and/or modifies a significant number of new mental health policies, procedures, programming activities, screening and assessment protocols, training, automation systems, staffing levels, etc. Implementation of the Mental Health Remedial Plan will require staff resources over and above those needed for day-to-day management of the reformed mental health system. These staff are needed for at least three years for development of policies and procedures, development of training curriculum, working with IT staff, helping with implementation of new assessment protocols, and taking other action steps related to implementation of this Plan. To this end, DJJ will establish a multidisciplinary reform implementation team which will include at least four positions with clinical and/or administrative expertise in the area of mental health services. The mental health experts on this team will be senior clinicians and/or senior administrators who will be supported, along with other members of the reform implementation team, by a group of analysts and support staff as described in the Safety and Welfare Remedial Plan.

Implementation of the Mental Health Remedial Plan will also include assistance by outside consultants and development of a dedicated mental health training team consisting of at least three licensed clinicians plus an instructional designer and office technician.

Overall coordination and oversight of implementation of the Mental Health Remedial Plan will be provided by a high level administrator hired or appointed for this purpose.

#### **Standards and Criteria**

DJJ and the Consent Decree mental health experts will develop standards and criteria with thresholds of compliance for all action items listed in this Remedial Plan. The instruments used to measure and evaluate compliance may include indicators from sources cited in Section 8, "Policies and Procedures," that the experts judge to be critical to establishing an adequate mental health care system. The evaluation instruments will include components requiring professional judgment and components that can be objectively evaluated by non-experts. Thresholds for achieving compliance may vary for selected indicators, however the facility must obtain an overall score of 85 percent or greater for the facility to achieve substantial compliance as defined in paragraph 23 of the Consent Decree.

In addition to the standards and criteria that will be developed to track implementation of this plan, DJJ will prepare an integrated project schedule showing dates by which all action items are to be started and/or completed. This schedule is to include, but not be limited to, when new staff are to be hired and trained, when existing residential mental health programs will be modified in accordance with this Plan, when new residential mental health living units will open, and when new assessment tools and procedures will be in place.

## **ACTION PLAN**

1. DJJ will add or appoint a senior administrator with experience in implementing mental health programs to oversee and direct implementation of this Remedial Plan and its coordination with other Remedial Plans. This person will be hired or appointed no later than February 29, 2007.
2. DJJ will add or appoint four senior clinicians and/or senior administrators with expertise in mental health services to represent mental health issues and facilitate implementation of this plan. These staff will be part of the divisions' reform implementation team. They will be added or appointed no later than October 31, 2006.
3. DJJ will develop a dedicated mental health training team consisting of at least three licensed clinicians plus an instructional designer and office technician by no later than January 31, 2007.

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