I. INTRODUCTION

The Special Master submits for filing the Thirty-Third Report of the Special Master. This report reviews the *Farrell* Mental Health Expert Dr. Bruce Gage's third Mental Health comprehensive report for his 2015 round of audits (site visits June and July 2015) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plans. The Mental Health comprehensive report is attached to this report as Appendix A. The Special Masterôs report, consistent with an agreement by the parties, limits the summarization of the expert's report and instead identifies the major areas of improvement as well as areas of concern.

The report begins with an analysis of progress in implementing the Mental Health Program. An update on the implementation of the Integrated Behavioral Treatment Model (IBTM) is provided next, followed by information that describes progress in the few remaining safety and welfare items including the reforms of the Behavioral Treatment Program (BTP) and facility physical plant improvements. The Special Master recommends the transfer of monitoring of the *Safety and Welfare Remedial Plan* to Defendant. The report concludes with a discussion of progress in changes in the process of the Parole Board.

II. MENTAL HEALTH

The Mental Health Expert, Dr. Bruce Gage, conducted a round of site audits in June and July 2015. The site visits included N. A. Chaderjian Youth Correctional Facility (NACYCF), Ventura Youth Correctional Facility (VYCF), O. H. Close Youth Correctional Facility (OHCYCF) and the Central Office (CO). Dr. Gage completed a draft of his comprehensive report and the Special Master submitted it to the parties for comments on October 9, 2015. After

receiving feedback from the parties, the amended and final report was provided to the parties on October 23, 2015. Dr. Gage describes the mental health program as ñmaking steady progress in the delivery of mental health servicesò[1] and notes that with the exception of a few areas, many issues have been ñresolved or on a solid trajectory.ò[2]

Consistent with the rating system of other *Farrell* remedial plans, Dr. Gage assigned ratings of substantial compliance, partial compliance, and non-compliance for each of the audited items. Some of the items were not rated because they were either not applicable or there were insufficient information to assign a rating. The following table provides a summary of the ratings at each of the facilities and at the CO.

Table 1
Summary of Compliance Rating Percentages[3]

	NACYCF	OHCYCF	VYCF	CO	Cumulative
Substantial Compliance	63%	52%	76%	83%	67%
Partial Compliance	28%	20%	11%	14%	19%
Non-compliant	7%	2%	2%	3%	3%
Not Rated	2%	26%	11%	0%	11%

A comparison of ratings suggests there is only modest improvement in the number of items in substantial and partial compliance and a decrease in non-compliant items since the last audit round. The Special Master believes Defendant has made far more significant progress in the implementation of the mental health program than what is reflected in the ratings, particularly at VYCF and at the CO.

VYCFôs overall percentage of items in substantial compliance is skewed by the 11% of items that were not rated because there were no cases available for review during the audit period. For example, Audit Item 7c calls for review of documents to ensure involuntary

[1] P. 1, MH Audit Comprehensive Summary Final 10-23-15.
[2] *Id.*, p. 2.
[3] Compiled by OSM based on the Mental Health Expertôs final reports.

antipsychotic drugs were administered as ordered. This item was rated in substantial compliance during the last audit round but was not rated this round because none was prescribed during this audit period. The overall rate likely would have been above 85% had all items been rated.

Similarly, at OHCYCF, which does not have a mental health residential unit (MHRU) and was audited for the first time, the overall percentage of items in substantial compliance is also skewed by the number of not-rated audit items (26%). Most of these items are MHRU-related. Excluding these not-rated items, OHCYCFôs overall percentage of items in substantial compliance would increase from 52% to 70%. Of the 14 audit items found to be in partial compliance (13) and non-compliant (one), three are related to having youth being seen by psychiatry on a more timely basis and more thorough and complete documentation by psychiatry. Another two audit items are related to the content and thoroughness of the Initial Psychological Assessments, which is understandable as OHCYCF just began to conduct intake assessments because of a backlog of intakes at NACYCF.

Table 2
Comparison of Ratings
Inclusion and Exclusion of Not-Rated Items - OHCYCF

	Substantial Compliance	Partial Compliance	Non-Compliant	Not Rated
Include Not Rated Items	52% (33/64)	20% (13/64)	2% (1/64)	26% (17/64)
Exclude Not Rated Items	70% (33/47)	28% (13/47)	2% (1/47)	

NACYCF appears to be the facility that is most in need of attention as it received less than substantial compliance ratings on 23 of the 63 audited items. However, a review of those 23 audit items (18 were in partial compliance and five were non-compliant) suggests a majority of the items could be readily addressed through more concerted efforts. For example, eight of the 23 items are related to having youth being seen by psychiatry on a timely basis and more

thorough and complete documentation by psychiatry. Another four audit items are related to the content and thoroughness of the Initial Psychological Assessments.

There are four audit items with which all three facilities were found to be in partial compliance. Defendant should consider exploring means to address these issues on a broader basis. The four audit items are:

- Item 1. Facility staff can articulate (paraphrase) the DJJ mission and vision statement.
- Item 2a. The facility Executive Management includes representatives from clinical services and programs.
- Item 3d. Suicide monitoring logs are incomplete or missing.
- Item 12d. For youth in residential Mental Health (MH) units, there is an updated case plan done at least every 45 days.[4]

At the CO, the overall percentage of audited items in substantial compliance increased from 70% to 83% from the last audit round (30 of 36 audit items). Of the remaining six items, (five were in partial compliance and one was non-compliant), four are related to Defendantôs inability to timely place youth into licensed mental health facilities on an inpatient basis. Excluding these four items related to licensed inpatient care, the COôs overall rate of items in substantial compliance is 94% (30 of 32 audited items).

As noted in the Mental Health Expertôs comprehensive report, timely placement of youth into a licensed mental health facility is a statewide issue and requires outside cooperation that is beyond Defendantôs ability to control.[5] Defendant has been stymied in attempting to rectify this issue because outside licensed care facilities are reluctant to accept its referrals on a timely basis and sometimes do not accept them at all. Thus, each referral is treated on a case-by-case basis. Although this approach is far from satisfactory, there have been few, if any, viable alternatives available at Defendantôs disposal.

[4] For NACYCF and VYCF only as OHCYCF does not have MHRU.
[5] P. 5-6, MH Audit Comprehensive Summary Final 10-23-15.

Defendant has continued to pursue a solution and is finding alternatives. Final negotiations are underway with Good Samaritan to provide licensed care for minors. This will provide services for those minor youth at VYCF.[6] Failing to find a solution with an outside vendor in the northern part of the state, Defendant is in discussions with health care services for adult inmates that already have a Correctional Treatment Center (CTC). Discussions are underway regarding what modifications could be made to the CTC so it could accommodate youth.

Table 3
Comparison of Percentage of Items in Substantial Compliance
Rating Percentages

	Round 1[7]	Round 2[8]	Round 3	Increase
NACYCF	42%	58%	63%	5%
OHCYCF[9]			52%	
VYCF	50%	72%	76%	4%
Central Office	52%	70%	83%	13%
Cumulative	47%	64%	67%	3%

A. Current Progress

Of the eight steps in the Mental Health Implementation Plan, five are completed and the remaining three have made significant progress toward completion. The completed steps are:

- The Mental Health Youth Definition
- Defined levels of care
- Entrance and Exit Criteria
- Policies and Procedures
- Program Guide

Plan elements that are nearing completion include:

- Intake Procedures
- An Evidence-based Treatment Program

[6] If no options are found for placement in the northern part of the state, this may be an option for all youth.
[7] *See* OSM 31, p. 26.
[8] *Ibid.*
[9] The Mental Health Expert audited OHCYCF, which does not have a MHRU, for the first time.

- Quality Assurance (QA) Procedures

Policies and Procedures

Defendant has completed all policies and procedures by finalizing the one remaining policy regarding involuntary administration of psychiatric medication in October 2015. The Mental Health Expert has reviewed and commented on all of the policy changes. In chronological order, the policies and procedures are listed by completion date.[10]

- July 21, 2014: Mental Health Services Policy. This policy incorporated nine formerly separate policies. It includes:
    - Acceptance and Rejection Criteria,
    - Mental Health Levels of Care which include Licensed Facilities,
    - Forensic Evaluations,
    - Community Re-entry of Youth with Mental Health Treatment Needs, Communication with Counties,
    - Mental Health Referrals,
    - Principles of Mental Health Assessment, and
    - Treatment, Mental Health Documentation, and Mental Health Evaluations.
- December 26, 2014: Treatment Confidentiality Policy[11]
- January 6, 2015: Mental Health Services Guide[12]
- February 19, 2015: Informed Consent Policy[13]
- June 30, 2015: Suicide Prevention Assessment and Response Policy (SPAR)[14]
- July 2, 2015: Psychopharmacological Treatment Policy[15]
- October 14, 2015 Involuntary Administration of Psychiatric Medication[16]

[10] Completion date is different from implementation date. Implementation is the date all staff are trained on the policy.
[11] *See* Policy 6259,Treatment Confidentiality Policy and Forms
[12] *See* Policy 6250.1, Mental Health Services Guide, Appendices A, B and C.
[13] *See* Policy 6252, Informed Consent for Mental Health Treatment Policy and Procedure
[14] *See* Policy 6263, Suicide Prevention, Assessment, Response Policy and Procedure
[15] *See* Policy 6276.6, Psychopharmacological Treatment Policy and Procedure
[16] *See* Policy 6280, 6280.1 Involuntary Administration of Psychiatric Medication

Intake Procedures

Defendant is again timely in completion of the initial intake and has begun to use the semi-structured interview, though it is inconsistently documented. While most of the steps in the assessment process are being completed, the intake process continues to need refinement.

The California Youth Assessment Screening Instrument (CA-YASI) is not being included in the initial psychological assessment process. This assessment provides important risk and needs information that complements the data collected by the Psychologists. Timely completion of the assessment must be ensured. The Case Conceptualization Guide provides the needed guidance regarding how to integrate the different information sources of the intake process but actual case formulations are still the exception at NACYCF. Evidence of case formulations is stronger at VYCF and continued improvement in the quality of the formulations is evidenced at this reporting period.[17] The Mental Health Expert noted there is no evidence that the psychological assessments are being used to inform case planning.[18]

Defendant is working on revising the Initial Case Review (ICR) process. The Mental Health Expert opines that Defendant should use the ICR process to present the findings of the intake process to the youth, get feedback from the youth about the findings and to begin to formulate the treatment direction. To do this requires a complete and finished assessment that includes a case formulation, treatment targets and barriers.[19]

Developing a Treatment Program

Defendant continues to refine the use of the Trauma Focused Cognitive Behavioral Treatment Program (TF-CBT) and to add other rehabilitative services. Consultation with Dr.

[17] *See*, p. 6, MH Audit Comprehensive Summary Final 10-23-15.
[18] *Ibid.*
[19] *Ibid.*

Griffin, the expert in TF-CBT,[20] has continued. The first presentation of a case for review by Dr. Griffin was held and the next one is scheduled.[21] Dr. Griffin is under contract for another year to assist Defendant in ensuring proper implementation of the program. Psychologists are also beginning Relapse Groups where they meet with youth to discuss the challenges of relapse and coping methods. Re-entry parole agents are working with the youth who are transitioning back to the community.[22]

In addition to the medication education group that has been implemented at NACYCF[23], VYCF has now also implemented this group. Licensed psychiatric technicians (LPT) facilitate the groups and the Chief Psychiatrist, Dr. Saxton, supervises them.

Dr. Bowlds and Dr. Parks[24] trained the unit staff of both facilities in the content and application of two additional rehabilitative groups.[25] The two curricula, *Mood Matters* and *Express Yourself,* will be implemented within several weeks. The curricula include explanations of structured activities and how to use them.[26] While the Special Master is familiar with the curricula from the SBTP, the Mental Health Expert needs to review them.

Defendant has also created an excellent training that has been delivered to all Registered Nurses to ensure nurses are able to assess mental health conditions. Dr. Gage, the Mental Health Expert, reviewed the training and indicated it is of high quality. The training helps to ensure that

---

[20] Dr. Griffin is the Assistant Professor of Psychiatry and Pediatrics Principal Investigator, Child Trauma Training Center, University of Massachusetts Medical School.

[21] Dr. Heather Bowlds informed the Special Master of the case presentations by Clinicians on an October 15th phone call. The first presentation was held October 1, 2015 and the next is scheduled for October 22, 2015.. Psychologists who have gone through the initial training and participate in all of the case presentations are eligible for certification in TF-CBT.

[22] The Special Master has met with several youth while visiting the mental health units who have told her about their meetings with the re-entry staff.

[23] Yvette Marc-Aurele, Mental Health Team Leader, provided this program update to the Special Master while on site at NACYCF on September 30, 2015. Defendantôs Response to the MH Comprehensive Summary confirms information.

[24] Dr. Parks is a Senior Psychologist Supervisor in the Sexual Behavioral Treatment Program (SBTP).

[25] Staff trained included Youth Correctional Counselors (YCCs), Senior Youth Correctional Counselors (SYCCs) and Case Work Specialists (CWSs). Unit staff, not Psychologists will facilitate these groups.

[26] *See* Mental Health Rehabilitative Groups.pptx.

when no mental health staff is on site and a nurse is asked to make a mental health assessment that s/he understands the proper assessment process.[27]

Progress in ensuring fidelity to the TF-CBT continues, as does the implementation of the additional rehabilitative services that will create a robust and well-rounded mental health program.

Quality Assurance Procedures

A continued strength that Defendant demonstrates in all programs is the development of several types of QA processes. The mental health program is building on some of the IBTM QA processes and has developed processes that are consistent with the best practice in mental health. Two plans for clinical supervision have been developed and once one is selected, it will be finalized and implemented.

As with the other IBTM Cognitive Behavioral Treatment (CBT) groups, group observation forms have been developed and are soon to be implemented. Forms for the new groups, *Mood Matters* and *Express Yourself,* are completed and similar forms are being developed for TF-CBT.[28] The actual process for implementation and a schedule has yet to be determined. The process of observing groups and providing feedback is something that all unit staff members are familiar with.

In addition, Dr. Bowlds has implemented some good standard supervisory practices and some QA measures that are typically used in the delivery of mental health services. Dr. Bowlds receives a Senior Psychologist Monthly Report. This report is completed by each Senior Psychologist and reviewed with Dr. Bowlds. It addresses the following areas:

- Residential Treatment Plan Compliance (Mental Health Unit)

[27] *See* OJT RN MSE Training 10-14.pdf and Mental Health Status Examination.pptx.
[28] *See* Express Yourself Group Observation Form (GOF) Session and Mood Matters GOF Session IV for examples.

- Outpatient Treatment Plan Compliance (Core)
- SBTP Treatment Plan Compliance
- Scheduled Intervention Groups (if applicable)
- Case Conference (CC)
- Individual Education Plan (IEP) documentation: (applies only to youth with a MH designation and an IEP)
- New Intakes
- Requested Level of Care Changes
- IBTM Training completed
- Peer Review conducted

Dr. Bowlds has also established a QA Committee at the CO. This committee is in the process of creating a quarterly diagnostic review. The review process should help with identifying both the accuracy of diagnoses and whether or not the proper case formulation and other steps in the diagnostic process are being accurately completed and shared.

Finally, as noted above, Dr. Bowlds has implemented case presentations by Psychologists to ensure their full understanding of TF-CBT. Case reviews that use peer and expert feedback are typical QA methods used in mental health. It is in such reviews that feedback can be given regarding existing weaknesses such as a failure to identify clear treatment targets and to document progress in achieving the targets.[29]

Transfer of Monitoring

The Mental Health Expert has indicated that many of the headquarters and facility MH audit items have achieved two rounds of substantial compliance. The expert recommended that most of these items be returned to Defendant for monitoring.[30] The parties reviewed a list of proposed items for transfer and reached agreement that 83% (30/36) of the CO audit items and 54% (34/64) of the facility audit items can be transferred back to Defendant. In addition, VYCF

[29] Dr. Gage identified that Psychologists need to do a better job with not just case formulation but stating treatment targets and documenting progress on p. 4 of the MH Audit Comprehensive Summary Final 10-23-15.
[30] Items marked in red in the Mental Health Audit facility tables recommended changes 8-15 and MENTAL HEALTH HQ AUDIT TABLE change recommendations 8-15 are those scheduled for transfer.

achieved two rounds of substantial compliance in several items that the northern facilities did not.[31] As such, the Mental Health Expert suggested and the parties agreed to transfer of an additional eight items. VYCF is to be congratulated for the continued demonstration of efforts to implement a robust mental health program. As in the past, while the expert will no longer monitor these items, should he or the Special Master observe problems with any of the items, they will work with Defendant to remedy the situation or resume monitoring them. Defendant is to be congratulated for this accomplishment.

By agreement of the parties, Dr. Gage clarified audit tool language on several items so that Defendant and the Office of Audits and Court Compliance (OACC) have a clear understanding of how to assess some of the more clinical items. OACC has been asked to conduct a pre-audit of NACYCF and the results of the OACC audit will be compared to Dr. Gageôs results to assess OACCôs understanding of the clinical items. The next round of mental health audits is scheduled for November 2015.

III. INTEGRATED BEHAVIORAL TREATMENT MODEL

Progress in implementation of the IBTM is steady and consistent. Perhaps one of the most encouraging indicators is the number of long-term initiatives that demonstrate commitment to the model well past transfer of monitoring back to Defendant. The Special Master and the Mental Health Expert, who oversee the IBTM implementation, have been in close contact with Defendant and worked with them on several issues throughout this reporting period.

In her last report, the Special Master opined that she was concerned about what appeared to be insufficient time spent in the facility living unit and program areas by senior and mid-level facility managers. It appears this issue has been remedied.

[31] Eight additional items, 11c, 11d, 11i, 11j, 12c, 12e, & 14b (2 sections), have been removed from VYCF's audit table

Perhaps the most notable and useful change has been the schedule change for Program Administrators who are now required to work late one night per week and the later hours are to be spent in the living units. This has allowed for greater observation, participation and feedback by mid-managers to first-line supervisors and the line staff. The difference in the units visited by the Special Master was palpable.[32] There were no signs of deviation from the IBTM (including the Reinforcement System [RS] and the late night program) and progress was evidenced in the relaxed atmosphere, the increased engagement of staff with youth, the level of safety and comfort expressed by the youth and the managers working with the unit staff to increase understanding of the elements of the IBTM.

Executive management continues to demonstrate commitment to maintaining the CO IBTM Team. While there has been some staffing turnover, the team has quickly replaced the vacancies with highly skilled permanent employees. The two new full-time Treatment Team Supervisors (TTS) are very knowledgeable, skilled and have excellent interpersonal skills. The CO IBTM Team leaders are now working on replacing the two VYCF team member vacancies.

In addition, a new decision by Executive Management to combine all training under the CO IBTM Team has been implemented. The Special Master has opined in the past that there were gaps between the knowledge and understanding of those delivering block training and those on the CO IBTM Team that confused the staff and at times resulted in misinformation.[33] Having both units work together should make for more consistency in messages. Plans are being made to implement curricula review and QA measures.[34]

[32] In addition to regularly scheduled audits through the reporting period, the Special Master visited OHCYCF and NACYCF on September 29-30, 2015. During the visit the Special Master observed groups, spent time in the living units talking to youth and staff and spent time with facility administrators.
[33] OSM 28, pp. 34-37.
[34] *See* email OSM Info from Christienne Sanders, IBTM Program Administrator.

A clear sign of the understanding and importance of long-term monitoring and evaluation of the IBTM is the re-establishment of a research unit by Defendant.[35] Defendant has hired a Research Program Specialist III and has plans to add a Program Specialist II to the unit. The unit includes two Research Analysts and a Staff Services Manager. The unit has begun to take on some of the responsibilities of the CO IBTM Team, freeing that team to focus more on coaching, mentoring and training.

The Assessment Process

Defendant was finally able to conclude the contracting process with the CA-YASI vendor and has crafted a thoughtful process for improving the CA-YASI. The California version of the YASI includes more variables and is more complex than the version of the tool used in most jurisdictions. Defendant is working with the vendor to identify what, if any, data points can be eliminated, thereby streamlining the current tool. The projected schedule for the first draft of the revised tool is November 2015. Many steps in the process, including data transfer, are quite complex, so full implementation of the revised tool is likely to be spring or summer of 2016.[36]

The other outstanding issues in the assessment process have been discussed in the Mental Health Section of this report. They largely revolve around ensuring that both CA-YASI and psychological data are used to formulate an initial case conceptualization, the findings of which are presented to a youth in the ICR as a starting point to work with the youth to develop his or her case plan. A simplified YASI should help with this process but work remains to be done to develop case formulations and to revise the ICR.[37]

[35] *See* DJJ Data_Charter_VA1ASP.pdf
[36] The Special Master reviewed the vendor contract and discussed timeframes with Dr. Bowlds.
[37] It is the opinion of the Special Master that the number of people present at the ICR could be reduced and this might help to move what is currently a hearing to a presentation and discussion with the youth.

Case Management Process

The contracted vendor for the CA-YASI is also working on revisions to the case management training and coaching modules and materials. Once revised, the contractor will provide a booster training for staff and specifically those who will provide training in case management. The bottom line to developing case plans that have clearly articulated behavioral goals and document progress is practice, practice, practice and that is what Defendant is doing.

The Special Master and the Mental Health Expert have been observing and attending the weekly IBTM meetings of the facilities in person and via conference calls. The meetings are all structured to discuss general issues regarding case management and they include specific reviews of cases. Each facility has developed a slightly different process for this purpose but all are consistently discussing what constitutes a good case plan.[38] The meetings all have a teaching and learning component designed for staff to learn how to understand assessment data, write clear behavioral goals and to document youth progress.

As noted many times by the Mental Health Expert, case plans remain too generic and do not demonstrate a clear understanding of either the criminogenic or developmental issues that youth need to address. That said, the Mental Health Expert has also opined that the level of understanding and skill required to develop accurate and thorough case plans is often the last skill set developed when implementing a model such as the IBTM.[39] He has also noted improvement, if not in the case planning documentation, in the understanding by youth regarding what their case plan is and what their behavioral goals are. This demonstrates the deeper

[38] The Special Master observed the OHCYCF and the NACYCF IBTM team meetings on September 30, 2015. The Mental Health Expert called into the NACYCF meeting as he has on other occasions. Clear efforts are being made to more clearly identify the stage of change of a youth, what his risk and needs are and what the specific behavioral change goals s/he is addressing. Administrators at OHCYCF meet with YCCs on their late night to review progress notes in an effort to help YCCs understand how to document progress.

[39] The Mental Health Expertôs most recent comment on this issue can be found in MH Audit Comprehensive Summary Final 10-23-15, p. 4.

engagement between staff and youth in the treatment process, which will also help drive the need to develop more individualized and refined case plans.

Finally, the foundation to effective case planning is effective listening and communicating. Defendant has a cadre of staff trained in a technique called Motivational Interviewing (MI) that is a strategy to facilitate and engage intrinsic motivation. Many staff members were provided the first stage of MI training several years ago. The training, while excellent, was provided at the time the division was experiencing the closure of many facilities. The level of concern and uncertainty at the time made it difficult for staff to understand the important role of this strategy in successfully implementing the IBTM. There is now an eight-hour module of MI training in the current block training.

Defendant has also contracted with a vendor to provide advanced training to two of the MI trainers who in turn will share this training with the other MI trainers. In March of 2016, the vendor is also scheduled to provide on-site training to approximately 30 additional staff members so they can be approved to train MI.[40]

Cognitive-based Behavioral Treatment (CBT) Group Delivery

As part of one of the vendor contracts, Defendant has the author of several of the CBT curricula scheduled to provide training for trainers. While it is unclear exactly which curricula Defendant will begin with, the Cognitive Behavioral Primer and Counterpoint are two curricula targeted for this support. The process of keeping staff skills current and training new trainers is ongoing. The practice of having regularly scheduled refresher training is an excellent practice to address staff turnover and the need to keep enhancing staff skills.

Defendant has created outstanding tracking systems to ensure that CBT groups are taking place. The task of tracking this data has been transferred to the CO Research Unit. Reports track

[40] Stephen Malcom Berg-Smith is an MI trainer and is certified to provide training of trainers.

consistency of group delivery, when groups are not held, and whether or not they are made up timely.[41]

The reports for June, July and August of 2015 clearly demonstrate which units are consistent in their group delivery and which are having problems. For example, the intake unit had delivery percentage above 95% for each month of the three-month period. OHCYCF apparently had difficulties delivering groups in June 2015 with delivery percentages of 65%, 83%, and 74% for core, BTP and SBTP units, respectively. The problem at OHCYCF apparently has been rectified as the delivery percentage exceeded 90% for all units during July and August 2015. The VYCF BTP (100% delivery) never missed group delivery for the three-month period, whereas at NACYCF BTP, the delivery percentage declined from 97% in June to 89% in July and 50% in August 2015. All core units had problems with group delivery in June 2015 with the completion percentages of 65%, 77%, and 80% for OHCYCF, NACYCF, and VYCF, respectively. Recognizing there can be valid reasons for fluctuation, this data provide a useful management tool for all levels of staff.

The research unit is also analyzing attendance sheets to ensure that youth are consistently attending groups. If a youth misses too many groups in a particular program, they need to retake the class. The research unit is now going to be able to provide this feedback to unit staff.

The one area that needs to be tracked is the quantity of substitution that is taking place by facilitators. Both the Special Master and the Mental Health Expert have observed the failure to have consistent group attendance by a facilitator for many groups. This has resulted in less than solid adherence to the curriculum and considerably diminishes the potential impact.

[41] *See* Facilities Week Grp Int ï June 2015, Facilities Week Grp Int ï July 2015 and Facilities Week Grp Int ï August 2015.

Behavioral Management and Level System

On September 23, 2015 the new level system was officially launched. Prior to the launch, each unit was provided with a daylong training.[42] The training provided unit staff an excellent opportunity to understand both the theoretical underpinnings of the level system and to explore pragmatic implementation concerns. Superintendents, Assistant Superintendents, Program Administrators and Treatment Team Supervisors also received eight hours of training so they could serve as the resource for SYCCs and the line staff.

Advance planning for the roll out included the time needed to work with the technology staff to ensure that the Ward Information Network (WIN) was able to perform the new tasks associated with the level system. Not surprisingly, the antiquated WIN system was not able to perform calculations correctly so there was a bit of concern by the youth when, on the first day, they found themselves all demoted to the lowest level of the system. Fast response and good humor by the staff saved the day. This is yet again another example of the need of the CDCR to bring Defendant into the 21st century with a contemporary technology platform.

A week after the implementation, the Special Master visited with youth in facilities and they had a basic understanding of the new system and remained a bit perplexed by the initial confusion that resulted when the WIN system failed to classify the youth's current level achievement accurately. Large posters displayed the new system and an excellent Frequently Asked Questions sheet had been distributed to youth.[43] The changes needed for WIN to properly calculate a youthôs level is expected to be completed by the end of October 2015.

Despite some small challenges, the type of preparation for this system change was thoughtful and comprehensive. The IBTM CO Team and the committee that has worked so hard

[42] The Special Master attended a unit training on July 21, 2015.
[43] *See* LS-Youth Handout 9-18-15.pdf.

on crafting a new level system are to be congratulated. This is the last significant element of the IBTM model that needed to be implemented. The order of the day will now be on refinement of understanding and the ability to implement it with fidelity.

Another exciting development is the hiring of two Recreational Therapists. One therapist is being hired for VYCF and the other one will be shared by OHCYCF and NACYCF.[44] These positions are being hired to help staff develop and engage in activities with youth. Depending on the level of a youth, staff engage in structured activities (staff led) or unstructured (where youth can function independently). To create a robust behavioral health system, staff members need to understand how to use daily living and recreational activities as learning opportunities. Many staff members understand this well. After an activity, they will take the time to point out how a youth has improved in a particular skill or to explore alternative ways of interacting. These therapists will work with the staff to help provide yet more support for behavioral shaping and learning.

Quality Assurance

The Program Administrators, TTSs, SYCCs, CWSs, PAs and Senior Case Work Specialists (SCWSs) have completed the Skill of the Week (SOTW) proficiency process. To ensure fidelity in the observation process, it is essential that the staff performing the observations have enough proficiency to provide valid and accurate observations.

The process consisted of observing the delivery of the SOTW, providing feedback and where needed, remediation. The same process will now begin with all YCCs. The concept of being observed and receiving feedback, while difficult for some staff, is becoming almost routine. Feedback forms have been created for all curricula and schedules developed for

[44] *See* DJJ Response to MH Comprehensive Summary.pdf

observations. The next proficiency review will be with the Substance Abuse curriculum. This process is a critical step in increasing fidelity to the interventions.

IV. OUTSTANDING SAFETY AND WELFARE AUDIT ITEMS

When the parties stipulated to revert monitoring of the *Safety and Welfare Remedial Plan* to Defendant, they agreed that two audit items remained outstanding and required further monitoring by the Special Master. The two items are the BTP and facilities improvement.[45] The Special Master is pleased to report that Defendant has made substantial progress on both items and recommends transfer of monitoring of the BTP to Defendant. The status of each of the two outstanding items is discussed below.

A. Behavioral Treatment Program

Defendant has implemented an effective BTP model consistent with the purpose and intent of the *Safety and Welfare Remedial Plan*. When implemented properly, the model has the net effect of eliminating the use of isolation by Defendant. The number of youth housed in the facilitiesô BTPs remained low throughout the calendar year. The BTP average length of stay (LOS) appears to be reasonable at all facilities and most youth have been able to transition out of BTP within the 60-day target.[46] With the exception of a few youth who refuse to come out of their rooms, youth spend the bulk of their days out of their rooms attending school, participating in resource groups, performing work assignments, and engaging in activities with the staff.

Defendant has completed a work plan for implementing the newly released BTP program guide, which has been updated periodically to reflect the implementation progress. The latest updated version of the work plan shows that most of the tasks/deliverables have been completed. In addition, Defendant has implemented a self-audit process through the use of a quality control

[45] *See* OSM 30, p. 51.
[46] According to the BTP monthly reports, 13 of 15 youth transitioned out of BTP in August and 15 of 17 youth transitioned out of BTP in September had LOS of 60 days or less.

checklist to ensure compliance with the key components of the program guide. The first round of self-audits has been completed, results of which show that all three facilities in general are adhering to the program guide requirements. Defendant indicates the self-audits will be conducted on a monthly basis until the program guide is fully implemented. Upon full implementation, the self-audits will be conducted on a quarterly basis.

BTP Population and LOS

The BTP youth population remained low throughout the calendar year except for a temporary spike during August 2015 when youth returned to their schools.[47] From a historical low of 25 in May 2015, the number grew to 51[48] as of August 17, 2015. This volatility is inherent for BTP units as the youth population can fluctuate significantly because of events such as group disturbances and destabilization of group dynamics caused by changes in the youth population total and mix. The total rapidly declined to 39 as of August 31, 2015 and further reduced to 34 as of September 30, 2015. This rapid transition suggests the BTPs are effective in accomplishing the purpose and intent of the program by promptly addressing the violent and aggressive behavior that resulted in the BTP referral and transferring the youth back to their core living units quickly.[49] In the past, most such youth would tend to remain in the BTP for lengthy stays.

The total number of youth with LOS in excess of 60 days remained constant ï eight on May 31, 11 on August 31, 2015, and eight on September 30, 2015. VYCF has two particularly

[47] Despite creative efforts at all facilities, the spike in violence upon return to school is common in juvenile institutions. This problem speaks directly to facility design issues. Having facilities with smaller number of youth who are consistently interacting with each other is the best way to avoid this phenomenon. In larger settings where youth are separated, the separation often results in violence upon contact after the summer break. Absence does not make the heart grow fonder in the juvenile mind but provides an opportunity to create stories about others that result in a buildup of anger.

[48] From memorandum of October 1, 2015 from Program Administrator Alicia Ginn to Deputy Special Master John Chen.

[49] According to the BTP monthly reports, 13 of 15 youth transitioned out of BTP in August and 15 of 17 youth transitioned out of BTP in September had LOS of 60 days or less.

recalcitrant youth who have not shown any willingness to integrate with other youth ï one with LOS of 449 days while the other with 353 days. Although one of the two youth is being transferred to the adult prison in the near future, the VYCF BTP staff continues to work with both youth and progress has been made as both youth have been able to program with most of the other youth in the unit.[50] At NACYCF, two of the three youth with an LOS in excess of 60 days are scheduled to be transferred to adult institutions and show little inclination to respond to staff intervention efforts.[51] At OHCYCF, no youth has a LOS of more than 60 days which is consistent with its historical pattern of very few youth with lengthy LOS. The following tables provide the facilitiesô BTP youth population and their LOS as of May 31, 2015, August 31, 2015, and September 2015.

Table 4
BTP Youth Population
As of May 31, 2015[52]

	Under 60 Days	Over 60 Days	Total
OHCYCF	10	1	11
NACYCF	2	3	5
VYCF	3	4	7
Total	15	8	23

Table 5
BTP Youth Population
As of August 31, 2015[53]

	Under 60 Days	Over 60 Days	Total
OHCYCF	9	0	9
NACYCF	8	2	10
VYCF	11	9	20
Total	28	11	39

[50] Based on conversation between Deputy Special Master and SYCC Mark Carrillos on October 7, 2015.
[51] Based on conversation between Deputy Special Master and TTS David Rossi on September 29, 2015.
[52] *See* OSM 31, p. 12.
[53] From BTP monthly report of August 2015.

Table 6
BTP Youth Population[54]
As of September 30, 2015

	Under 60 Days	Over 60 Days	Total
OHCYCF	7	0	7
NACYCF	8	3	11
VYCF	10	6	16
Total	15	8	34

The average LOS was low at OHCYCF and NACYCF. As of September 30, 2015, the average LOS for OHCYCF, NACYCF, and VYCF were 34, 39, and 88 days, respectively. The number declined significantly at NACYCF but increased slightly at VYCF between May and September 2015. With fewer youth in the unit, there likely will be more volatility in the average calculation as one or two youth with lengthy LOS could easily significantly inflate the average. This was the case at VYCF with the two aforementioned youth having lengthy LOS. With these two youth excluded from the average calculation, VYCFôs average LOS was 43 days for September 2015 and in line with the low average LOS at OHCYCF and NACYCF. The following table provides a comparison of the average LOS between February, May, and September 2015.

Table 7
Comparison of Average LOS[55]
February 2015, May, and September 2015

	February 2015[56]		May 2015[57]		September 2015[58]	
	Average LOS	Youth	Average LOS	Youth	Average LOS	Youth
OHCYCF	47	17	30	15	34	7
NACYCF	79	18	111	6	39	11
VYCF	209	15	74	11	88	16

[54] From BTP monthly report of September 2015.
[55] *See* the BTP monthly report for September 2015 and *see* OSM 32, p. 29 for February and May 2015 monthly BTP reports.
[56] *See* OSM 32, p. 29 for the February 2015 BTP monthly report.
[57] *See* OSM 32, p. 29 for the May 2015 BTP monthly report.
[58] From BTP monthly report of September 2015.

Review of Program Service Day (PSD) Data

Defendantôs PSD schedule calls for youth to be out of their rooms at least 44 hours per week (or at least 40% of their waking hours) while engaging in a structured activity based on evidence-based principles. A review of Defendantôs PSD data over a two-week sample period shows youth at both OHCYCF and VYCFôs BTPs were out of their rooms well in excess of the minimum requirement. This was not the case at NACYCF. The following tables provide the average number of out-of-room hours and the activities engaged by the youth at the three BTPs during each of the two-week period.

Table 8[59]
Average Weekly PSD Service Hours
Week of September 14, 2015 – September 20, 2015

	OHCYCF	NACYCF	VYCF
Average Weekly Head Count	10.7	11.2	16.5
Average Service Hours Per Youth			
Clinical	.46	.59	.48
Counseling	7.8	9.05	8.97
Education	17.45	6.65	14.22
Organized Recreation	12.90	18.60	25.43
Other Structured	34.29	3.84	10.85
Average Weekly Hours Per Youth[60]	72.89	38.73	59.94
Average % of Waking Hours Out-of Room	65.1%	34.6%	53.5%

[59] Compiled by OSM using Defendantôs ñProgram Service Day Trend Analysis of Overall Weekly Hoursò for each of the facilities.

[60] For youth placed in BTP for partial week, their weekly hours are extrapolated based on the number of days while they were assigned to the BTP. For example, if a youth is assigned to BTP for one day during the week and has one hour of counseling time for that one day, the system would automatically extrapolate seven hours of counseling time in calculating the weekly average.

Table 9[61]
Average Weekly PSD Service Hours
Week of September 21, 2015 – September 27, 2015

	OHCYCF	NACYCF	VYCF
Average Weekly Head Count	11.8	10.2	15.5
Average Service Hours Per Youth			
Clinical	.61	1.59	.76
Counseling	8.19	9.96	8.22
Education	17.63	9.27	16.15
Organized Recreation	15.70	17.58	26.87
Other Structured	34.59	.43	10.59
Average Weekly Hours Per Youth[62]	76.71	38.83	62.59
Average % of Waking Hours Out-of Room	68.5%	34.7%	55.9%

A review of the hours of youth assigned to NACYCFôs BTP for the entire week shows significant disparity between the youthôs out-of-room hours. For the week of September 14, 2015 through September 20, 2015, the out-of-room time ranged 23.84 hours to 63.58 hours (average of 40 hours) and for the week of September 21, 2015 through September 27, 2015 the range was 11.69 hours to 63.08 hours (average of 44 hours). The BTP staff suggest "youth refusal to come out of their rooms" was the reason for some youth not having at least 44 hours of out-of-room time. This apparently was confirmed by youth interviews during the self-audit conducted by the facilityôs Quality Assurance Coordinator (QAC) through the use of a BTP review checklist.[63] The self-audit process is discussed in a latter section of this report.

[61] Compiled by OSM using Defendantôs ñProgram Service Day Trend Analysis of Overall Weekly Hoursò for each of the facilities.

[62] For youth placed in BTP for partial week, their weekly hours are extrapolated based on the number of days while they were assigned to the BTP. For example, if a youth is assigned to BTP for one day during the week and has one hour of counseling time for that one day, the system would automatically extrapolate seven hours of counseling time in calculating the weekly average.

[63] *See* results of NACYCFôs BTP self-audit conducted by QAC Marty Giannini.

BTP Site Visits

The Special Master and the Deputy Special Master made site visits to all BTPs to observe the unitsô activities and to interview youth about their experiences at the BTP.[64] They observed vast improvements in the interaction between youth and staff in the units. In her previous reports, the Special Master repeatedly identified the issue of staff congregating near the YCC station while youth were confined to their rooms or in the dayroom either alone or in a group with little or no staff interaction or intervention.[65] Based on recent site visit observations, staff clearly are much more proactive in engaging with youth in activities.

During her recent visit to the NACYCF BTP, the Special Master observed two staff members engaging with youth in a board game in the dayroom while other youth were in school. Youth are only confined to their rooms when they refuse to come out. At VYCF, the Deputy Special Master observed one youth on a work assignment cleaning up the hallway and another youth in the dayroom talking to a staff member about his upcoming General Educational Development (GED test while other youth were in school. At OHCYCF, all youth were in school at the time of the Deputy Special Masterôs visit.

Youth interviewed overwhelmingly believe staff really care about them and are doing their best to help them succeed in transitioning out of BTP. For example, the aforementioned youth in the VYCFôs dayroom told the Deputy Special Master that staff members in the unit consistently emphasized to him the importance of completing his GED before his pending transfer to an adult institution. He was taking the last GED test in that afternoon and said he received much encouragements from staff throughout the unit. Another youth announced to the

[64] The Special Master and the Deputy Special Master visited Kern Hall at NACYCF on September 29, 2015, the Deputy Special Master visited Inyo Hall at OHCYCF on October 5, 2015 and the Deputy Special Master visited Monte Vista Hall at VYCF on October 7, 2015.
[65] *See* example in OSM 32, p. 31.

unit staff that he just completed his last course for his high school diploma, and he was heartily congratulated by staff and other youth in the unit. The VYCF BTPôs school truancy rate recently declined to as low as 1.6%, which is unprecedented and the positive youth and staff interaction undoubtedly contributed to this significant development.[66]

Except for those who refused to do so, all youth spend most of their waking hours out of their rooms attending school, resource groups, or other activities. Even those who refused stated that staff constantly checked on them and encouraged them to come out more. For example, one particularly entrenched youth at NACYCF, who is scheduled to go to an adult institution and ñposted upò[67] in his room for an extended period, spoke highly of two YCCs. He said one YCC spends time talking to him and wants him out of his room participating in program and another YCC constantly reminds him she does not want to see him refusing program as ñshe is always on my door getting me to come out more.ò [68]

Each BTP is required to formally conduct at least two structured activities each day.[69] Examples of structured activities include discussion of current events, board games, book club, and Decisional Balance Spelling B. Most of the activities are identified in the weekly calendar and a ñBTP Structured Activity Recordò is to be completed for each session and maintained in a binder for audit purposes.[70] Youth in the BTP units acknowledge that the activities take place routinely and that they generally enjoy such activities.[71]

---

[66] In the past, VYCFôs BTP school truancy rate was as high as 70%. A review of weekly school truancy data for the Fall 2015 semester shows the weekly unexcused absence rate ranging from a low of 1.6% during the week of August 24, 2014 and August 31, 2015 to a high of 24.2% during the week of October 26, 2015. Over a 13-week period, only one week had an unexcused absence rate in excess of 20% and two weeks had rates in excess of 10% (10.6% during the week of September 28, 2015 and 13.7% during the week of November 2, 2015).
[67] Youth refused to leave his room; often threatened to assault staff if staff came into the room.
[68] Statement of a youth to TTS Marty Giannini in October 2015 during self-audit of NACYCF.
[69] Directed by Deputy Director Anthony Lucero during the Superintendent's meeting on July 21, 2015.
[70] *See* email of October 16, 2015 from Program Administrator Alicia Ginn to Deputy Special Master forwarding a sample of the record.
[71] Based on informal discussions between the Deputy Special Master and youth in the units.

Implementation of the BTP Program Guide

While noting positive developments, the Special Master in her thirty-second report indicated the key remaining concern is Defendantôs ability to demonstrate sustainability by successful implementation of the newly released BTP program guide. She identified the need for a work plan to implement the program guide by identifying tasks, measuring progress, and targeting areas that need further refinement. The work plan is an essential tool for assessing Defendantôs progress in implementing the program guide and readiness to assume monitoring for this audit item.

Defendant completed a work plan in August 2015 after review and comment by the Special Master. The Special Master found the work plan to be an excellent document as it is clear and easy to track the tasks/deliverables.[72] The work plan has been updated several times and the latest updated version, dated October 15, 2015,[73] shows that all, except three of the deliverables identified in the work plan, have been completed. One of the deliverables pertains to providing training to staff members not assigned to BTP or high core units (low core units, mental health units, education staff, etc.).[74] The work plan originally called for such training to be completed by September 2015. VYCF completed the training on October 14, 2015, but the two facilities in the Stockton Complex will not be able to complete all training until the end of October 2015. The remaining two deliverables are mentoring and coaching activities ï one to prepare a list of mentors and coaches and the other to develop a protocol. While efforts are fully underway, the two deliverables have not yet been completed. Defendant anticipates these two deliverable will be completed in November 2015. The Special Master finds the work plan consistent with her assessment of the status and progress of program guide implementation.

[72] *See* email of August 18, 2015 from the Special Master to Program Administer Alicia Ginn.
[73] Updated BTP Work Plan, October 15, 2015.
[74] Staff members assigned to BTP and high core units have been trained in May and June 2015.

Staff members of the BTP units overwhelmingly expressed support for the program guide.[75] Besides providing clarity on program functions and requirements, they believe the program guide clarifies misconceptions by some staff members from other living units about the purpose, intent, and functions of the BTP program. The BTP staff are particularly enthused about the provision that eliminated the Juvenile Justice Administrative Committee (JJAC) hearing, which streamlined the process for entering into and exiting from BTP. They also appreciate the requirements of continuous involvement and interaction by staff from the sending unit throughout the youthôs stay at the BTP. The staff at VYCF also reported that youth are responding positively to the new BTP level system[76] because they understand the system and believe it is fair and provides a clear path for exiting from the BTP.

QA ï Self-audits

In addition to the work plan, Defendant adopted a self-audit process to assess progress and ensure compliance with certain key components of the program guide. The self-audit process consists of having the facilitiesô Quality Assurance Coordinator (QAC) complete a checklist that contains a series of questions designed to assess the BTP progress in meeting the BTP program requirement from the youthôs initial placement, case planning and execution, and ultimate transition from BTP to the sending unit. The evaluator is to respond to the questions based on documentation review, physical observations, and youth/staff interviews. The checklist was finalized after review and comment by the Special Master. As with the work plan, the Special Master found the checklist to be excellent and, if applied accurately, will assist the BTPs to accomplish their mission.[77]

[75] Based on discussions between the Deputy Special Master and BTP unit staff at all facilities.
[76] Based on discussions between the Deputy Special Master, SYCC Mark Carrillos, and PA Marisol Vigil.
[77] *See* email of September 1, 2015 from the Special Master to Program Administrator Alicia Ginn.

Defendant completed the first round of self-audit of BTP in October 2015.[78] In general, other than certain questions that were not ratable because the program guide was not placed into effect on September 1, 2015 and where there was insufficient data, the self-audits disclosed the facilities are making remarkable progress in their program guide implementation efforts. The Special Master, based on program outcome and her observations during site visits, agrees with the assessments in the reports and found the reports' comments to be relevant, useful, and constructive. The results of the self-audits are shared with BTP supervisor and managers and the executive staff at the facilities. A copy of the report is submitted to the Deputy Director for review and possible follow-up.

B. Facilities Improvement

This audit item pertains to improving the appearance and functionality of the living units to provide for a less prison-like setting and an environment conducive to treatment. In her previous reports, the Special Master suggested Defendant renovate a unit at each facility and use it as the model for the renovation of other living units.

As noted in her thirty-second report, Defendant has completed the renovation of the Glenn Hall at OHCYCF in June 2015. The Special Master found the outcome to be quite impressive, and the renovation dramatically improved the look and feel of the living unit to be more consistent with the IBTM. She opined that, once fully completed, Glenn Hall is an appropriate model for other living units at OHCYCF to emulate.[79]

In accordance with the Special Masterôs suggestion, Defendant developed a schedule that calls for renovation of one living unit each month at VYCF and at the Stockton Complex in line with the general design of the prototype and consistent with the therapeutic goals of the IBTM.

[78] The self-audits of OHCYCF and NACYCF were conducted by TTS Marty Giannini (QAC) and the self-audit of VYCF was conducted by Program Administrator Alicia Ginn due to illness of VYCFôs QAC.
[79] *See* OSM 32, p. 35.

Based on the schedule, VYCF is to complete renovation of all of its living units by March 2016 and those at the Stockton Complex by July 2016. It should be noted that the units will vary in the level and type of facility improvements to ensure consistency with the behavioral health model. To make progression through the level system more desirable, a low core unit will have more amenities than a high core or a BTP unit.[80]

Defendant reported that it is ahead of schedule at the Stockton Complex by completing two instead of one living unit per month at that location.[81] The living units completed are Glenn, Humboldt, and El Dorado at OHCYCF and Merced, Feather, and Mojave at NACYCF. Defendant reports that it anticipates completion of two additional units, Butte and McLoud, in October 2015.[82] If this trend continues, OHCYCF should complete renovation of all living units by December 2015 and NACYCF by March 2016.

During her site visit to the Stockton Complex on September 29, 2015, the Special Master visited each of the six renovated living units and found renovation to be substantially completed although most units still were missing certain items such as rugs, curtains, and gaming systems. Defendant indicated that all are on order and will be delivered in October 2015. The Special Master will revisit the living units in conjunction with her mental health audits of NACYCF and OHCYCF in November 2015.

The renovating efforts at VYCF apparently are on schedule and the facility is in the process of renovating three living units.[83] VYCF has encountered some difficulties with furniture delivery and the three units are in different stages of completion. Defendant anticipates completion of all three units by the end of October 2015 and all remaining units by March 2016.

[80] A description of the facility differences between units can be found in the Facilities Plan.
[81] *See* email of October 13, 2015 from Tammy McGuire to Deputy Special Master.
[82] *Ibid.*
[83] *See* email of October 13, 2015 from Tammy McGuire to the Deputy Special Master, forwarding an email of Assistant Superintendent Maria Harper.

The Special Master intends to visit each unit in conjunction with her upcoming visit with the Court on October 30, 2015.

Defendant has also developed a protocol for monthly inspection of each living unit to identify items in need of repair and replacement due to wear and tear, which occur frequently in group living settings. An inspection check sheet has been developed and funds have been set aside to ensure repairs and replacements occur rapidly.

C. Next Steps

The Special Master believes Defendantôs BTP program is in substantial compliance with the purpose and intent of the *Safety and Welfare Remedial Plan.* Desired outcomes have been achieved over an extended period and monitoring responsibility for this audit item should be returned to Defendant. Although facility improvements have not been fully completed, Defendant has demonstrated that significant progress has been made and there is a clear and reasonable expectation that the desired outcome will be achieved in the very near future. The Special Master believes monitoring of this item should also be returned to Defendant.

As all outstanding *Safety and Welfare Remedial Plan* items have been completed, the Special Master believes full monitoring of the *Safety and Welfare Remedial* Plan should be returned to Defendant.

V. PAROLE BOARD

The Juvenile Parole Board Commissioner has continued to work with Defendant to develop a parole decision-making process that relies heavily on current research and practice that assesses a youthôs risk to reoffend. The Commissioner has developed criteria for release decision-making that gubernatorial appointees as well as civil service appointees have discussed,

reviewed and are now applying.[84] These criteria are based in large part on those variables that research shows are predictive of risk to reoffend.

Currently Board members are working to develop materials for youth that describe both how to prepare for a board hearing and what factors are considered in release decision making. The Commissioner hopes that this document, if shared with youth, can eliminate some of the information that mischaracterizes the hearing process. Similarly, board members are planning a training for YCCs that will be delivered in unit team meetings to ensure that the line staff and managers who work directly with youth each day are clear regarding what the release decision-making factors are.

The willingness of Parole Board members to meet with unit teams and individual staff members speaks to not just the level of commitment the members have to ensuring consistency in the decision-making process but the level of involvement and integration the members have in the facility operations. In recent months, the Board has worked with Defendantôs CO IBTM Team and other staff to ensure alignment between the tools and factors that are used to assess risk to re-offend by living unit staff with those youth being considered for release.

The high level of engagement by Parole Board members with the facility staff creates open and trustworthy communication between them. The proactive engagement of the Parole Board Commissioner, in his efforts to reshape the parole decision-making process, will no doubt help to hasten and cement the process into practice. The next steps in the process include the development of hearing protocol and question guidelines for Parole Board members and to

[84] While the Special Master has not seen the final criteria, she did review early drafts. The criteria were in development for approximately four months and have been in use for approximately six months. It is her opinion that the elements of the decision-making criteria are consistent with the factors believed to be the best predictors of risk to reoffend.

review Parole Board regulations and to submit any needed modifications for review by regulatory authorities.

The Special Master opines again that Defendant needs to substantially revise the JJAC process that will be needed to align that process with the Parole Board Hearing process. The purpose of JJAC needs to be reviewed. With the much smaller population, it is highly questionable if this process, which consumes a great deal of time for a variety of unit staff members and currently has senior facility staff leading it, produces a result that merits the cost of the function.

VI. CONCLUSION

Defendant has made consistent progress in all areas under review by the Special Master and the Mental Health Expert in this reporting period. Of most interest is the level of activity that demonstrates sustainability of the reforms that have been made.

Defendant has virtually eliminated the use of isolation. The days of youth being locked in their rooms for 23 hours a day are gone. While there will always be challenges with the occasional staff member who will try and do something like this, the policies and procedures that Defendant has in place, the on-going nature of the training and the quality assurance measures make it highly unlikely this will easily become a practice once again.

The BTPs that once were ñlock downò units, in which large numbers of youth with a wide array of behavioral problems resided for months and sometimes years, now are treatment units reserved only for those youth engaged in aggression and the length of stay is typically less than 60 days and in many cases only a few weeks. The BTP youth are engaged in treatment, school, and activities with staff. The level and type of privileges are reduced from those of core units to incent youth to go back to core units. There is consistency in philosophy and basic

operations across the units in the three facilities. The unit audit process is a tool to ensure adherence to the BTP model as evidenced by the clear BTP Program Guide and to help unit staff develop their skills and programs. Monitoring of this program should be returned to Defendant.

With respect to facilities improvement, Defendant has demonstrated that significant progress has been made and there is a clear and reasonable expectation that the desired outcome will be achieved in the very near future. Defendant has a plan in place to conduct regular inspections of the living units to identify items in need of repair and replacement and funds have been set aside to maintain the units in acceptable standards. Monitoring of this item should be returned to Defendant.

There is evidence in many areas of Defendantôs work that speaks to the sustainability of the reforms made. The contracting with vendors for services over the next few years to ensure refinement and advancement of core IBTM elements such as the assessment tool, the case management process and the delivery of core curricula are just a few examples. Contracting with outside experts such as the TF-CBT expert and a Motivational Interviewing expert to assist staff in developing their skills are other examples of Defendantôs commitment to not just implementing core elements of the IBTM but to deepening understanding and fidelity to the programs. The reestablishment of a research unit to provide support for quality assurance measures and to study and evaluate the effectiveness of programs demonstrates commitment to the principles of evidence-based practice.

With the near resolution of the access to licensed care for minors and solutions for challenges with the delivery of psychiatric services at NACYCF in mental health and the implementation of the level system in the IBTM, the Special Master expects she will soon be recommending a return of monitoring of all items of the *Mental Health Remedial Plan* to

Defendant. The Mental Health Expert is auditing both the Mental Health Program and the IBTM by the close of the year. The Special Master encourages Defendant to finalize the last elements needed in each of these programs and to demonstrate this capacity in the upcoming audits by the Mental Health Expert.

Finally the Special Master believes that with the exception of the IBTM that has been and continues to be monitored by the Mental Health Expert, transfer of monitoring of the *Safety and Welfare Plan* should return to Defendant.

The Special Master respectfully submits this report.

Dated: November 16, 2015

_____

Nancy M. Campbell
Special Master

Mental Health Audit Comprehensive Summary

Summer 2015 Audits

October 23, 2015

INTRODUCTION

The Farrell lawsuit remedial plan specifies a number of requirements for the delivery of mental health services within the Division of Juvenile Justice (DJJ). This Comprehensive Summary reviews the salient findings of the mental health audits of NACYCF, OHCYCF, VYCF and Headquarters conducted in June and July of 2015.

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

DJJ has made steady progress in the delivery of mental health services. Some of the most salient markers of progress are stability in the mental health leadership and staffing, low levels of use of force with mental health youth, more consistent delivery of evidence-based treatment, improved documentation, better organization of mental health services in general, and (most importantly) a strong relationship between mental health clinicians and unit staff. The latter is largely attributable to the growth of the IBTM model and the associated collaboration between all DJJ staff in its implementation. Mental health clinicians specifically have clearly and strongly invested in the IBTM and are important partners in its implementation and penetrance.

The DJJ census has continued to remain fairly stable which has allowed continued strengthening of teams and development of programming. This has had many palpable but difficult to quantify benefits which can loosely be captured as improvements in the milieu of the residential mental health settings.

Though targeted mental health programming is developing slowly, the improved teamwork and settling and structuring of the milieus on the residential mental health units is itself a great benefit to the welfare and clinical improvement of the mental health youth on these units. With the addition of some focused and structured treatment components, there is little more needed to bring the residential units to a sound position.

Another observation that is a clear indicator of improvement is that the youth themselves, in most instances, are able to readily articulate what they are working on and are even able to distinguish what they are working on in their Treatment Plan and their Case Plan to an even greater extent than previously. Clearly, treatment is understood by the youth to be a prominent aspect (if not "the" prominent aspect) of their stay at DJJ.

The area most needing attention in terms of mental health services rendered, as DJJ well understands, is the psychological assessment and its use and integration into the Case Plans. Bringing more substance and focus with an emphasis on intelligible and succinct formulations will provide all staff with a clear sense of what each youth faces, providing the "why" behind the domains of risk identified by the CA-YASI. Such formulations are also important in guiding

formal mental health treatment. In both instances, the "why" can help staff work with youth to identify targets for treatment and provide a context for building understanding of and compassion towards the youth.

The limited availability of licensed level care remains a substantial problem, especially for youth under 18. Again, this is a general problem in the state; DJJ is challenged to solve this on its own.

ORGANIZATIONAL FUNCTIONS

The issues here have largely been addressed and resolved.

Relationship Between Mental Health and Other Staff

Simply put, this is no longer a problem. Though pockets of difficulty remain, these are the ordinary challenges of different world views rather than an institutionalized division. Continued attention will always be required to maintain an appropriate balance between the needs of treatment and safety and security. But that there is a balance is the essential point to be made here; there is no stronger marker of the general progress DJJ has made.

The structure of mental health services has continued to improve. The distinction between those who are in treatment and those who are getting services in support of the Case Plan and the IBTM is much clearer. It will be important to assure that the balance does not tip too far towards delivering just supportive services in the core units, but (to reiterate a point made many times previously) the success of the IBTM should diminish the need for treatment of core youth – and this seems to be reflected in the data.

The order brought through cleaning up the referral process, re-structuring of the approach to mental health crises, and emphasis on targeted treatment have continued to reap benefits in terms of reducing the once desultory and crisis-driven approach to mental health. And unit staff have become more comfortable and proficient in addressing crises, seeking mental health assistance when necessary.

The organizational structure is also much clearer though the formal relationship between programs and clinical services is still not entirely clear in the facility organizational charts. It is important to be cognizant of the difference between formal administrative chains of command and the relationships between the different chains of command and the addition of some "dotted line" relationships has helped clarify this. Still, how mental health program development and IBTM program development are coordinated at the facility level is not easily understood from the organization charts. But that mental health, IBTM, and security (and other services) are all well and appropriately represented in Executive Management is well demonstrated by Executive Management minutes. Further, a number of observations demonstrate that coordination is in fact occurring, such as the way that the CBT groups intrinsic to the IBTM have been modified (appropriately) for the residential mental health units.

With regard to case planning, mental health involvement at NACYCF, even on residential mental health units, remains somewhat spotty. This could, and should, be quickly remedied.

There has been slow improvement in the specific recognition within Case Plans of mental health problems and their impact on risk domains and treatment responsivity. It is expected that this would lag behind other elements as this degree of sophistication only comes with substantial experience with the integration of treatment concepts.

Policies

The mental health policies are essentially complete. DJJ has done a tremendous amount of work here. Compliance with policies also seems quite strong, despite the reworking of so many of them.

The role of mental health in forensic functions such as DDMS, JJAC, and parole board hearings has been well clarified and compliance with these policies is also much stronger, with notable improvement at NACYCF.

Staffing

Mental health staffing is much improved, especially for psychology. However, there has been further slippage in the quality and completeness of psychiatric work at the Northern Complex. The staffing plan calls for 0.5 psychiatrist at each residential setting and 1.0 for each 100 outpatients. This is achieved at VYCF but the Northern Complex is slightly short of this. There are also inadequate provisions for psychiatric coverage when psychiatrists are away. LPT coverage at VYCF has also been a problem, despite this being a post position.

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

Ancillary Services

Ancillary services remain adequate. And as before, the limitations of the formulary have not been a problem because non-formulary requests are regularly honored.

RESIDENTIAL MENTAL HEALTH SERVICES

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

As noted above, the structure and quality of the milieu of the residential mental health units has improved. DJJ continues to develop the Trauma Focused CBT, including reaching out for expert consultation to look at developing an individual therapy approach for youth not yet ready for a group. Groups and individual treatment are being run consistently and are generally well documented. Other evidence-based modalities such as CBT and Rational Emotive Behavior Therapy are also being employed (in core units as well).

It should be noted that DJJ recently moved the female population to a new setting with two dayrooms, allowing some separation of the mentally ill from the rest of the population. This will likely result in stabilization of the unit but time will tell.

Medication education has been implemented at NACYCF and is being run by the LPTs. This is a small but important step towards the development of rehabilitative services. This can pave the way for other specialized services such as mental illness awareness, relapse prevention, social skills (which may need to be different than or augmentation of those provided in IBTM modules), and specialized community transition services including accessing community services and family engagement. The latter is currently undertaken by psychologists and, in most instances, the records demonstrate an effort to reach out to families, though this could be better structured. While work with families is logistically challenging and some families are less than supportive, it is nonetheless important to reach out for a number of reasons: to gain a better understanding of the youth, to try to improve family conditions, and to determine how best to engage family in the youth's rehabilitation and treatment – including after release.

While yet to be determined, the new level system is structured in such a way that it is at least reasonably likely that it will be effective for the residential mental health units. But it still may be necessary to augment it with approaches that serve to promote medication adherence and treatment engagement.

A unified Treatment Plan for the residential mental health units that is shared by all clinical staff is being developed and has been implemented to some degree at VYCF. This needs to be completed. The treatment planning conferences are a sound forum with good discussion and youth participation and should provide a ready basis for establishing a unified treatment plan.

One common and important weakness of Treatment Plans and documentation regarding treatment is the failure to specifically comment on and address progress or lack of progress. Clearly, this is an essential aspect of treatment that implicates the formulation, associated long-term goals, and the short term goals that should be the measurable steps of progress. All require greater specificity in treatment interventions/modalities and a clearer sense of what progress would look like for a particular youth. But as with Case Planning, this degree of sophistication is expected to lag behind other development. DJJ is now at the point where sufficient structure and treatment components are in place to turn attention to this important area. But it also needs to be said that Treatment Plans are close to being sufficient now; focus on this aspect is the kind of organizing principle that can help elevate them to the next level.

As noted above, Case Plans are slowly improving but they continue to be fairly generic in most instances. There has been some limited improvement in the degree to which Case Plans address mental health issues such as youth limitations or specific behaviors and risks related to symptoms, but most still do not. But as before, few Case Plans are frankly inconsistent with the mental health needs of the youth or with the Treatment Plan.

Case Plans on the residential units were frequently not completed timely. As the standard for frequency of Case Planning is different for core and residential units, there may be some uncertainty about when Case Plans are due following transfer. In general, a transfer to a

different type of program should result in a new Case Plan (and Treatment Plan for that matter) within a short period of time, generally within two weeks but certainly within 30 days. Whether there is any substantial benefit to updating Case Plans every 45 days is debatable. Though it would be unwise to move to every 120 days, given the instability and changeability of this population, every 60 days would be reasonable.

Psychotropic prescribing remains sound, though as noted above there has been a decline in the timeliness of visits and the completeness of documentation at NACYCF.

Transfers into and out of the residential units are being done consistently within policy and there was no evidence of inappropriate placements. DJJ has done a good job of correcting this process.

OUTPATIENT MENTAL HEALTH SERVICES

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

Most Mental Health Youth in outpatient settings continue to be primarily youth stepped down from residential settings. These youth are followed closely in most instances but in a couple of cases at NACYCF, youth had not been seen since stepping down. And in some cases, treatment plans are vague, such as the youth will be "seen as needed or on a weekly basis". This does not really belong in a Treatment Plan. Either a youth is receiving structured treatment or is not, including a clear and specific plan to treat or monitor a youth stepping down from residential settings. Services rendered in support of the Case Plan and crisis response and routine referrals do not need a Treatment Plan to support them. And documentation of supportive services do not necessarily need to be placed in the UHR but do need to be in the Case File/WIN and accessible to other unit staff (though could be placed in the UHR as well as in the Case File).

At NACYCF, psychologist staffing on the core units has improved. There has been a concomitant increase in the number of youth receiving services. However, there were a number of instances where the Treatment Plan was not being followed, primarily in that sessions were absent or inconsistent. It is essential that Treatment Plans be implemented as planned. For treatment to be effective, it must be targeted and consistently delivered.

Psychotherapy services at VYCF are sound though there appears to be a drop off in the number of youth receiving treatment services, with more receiving supportive services. As noted above, this is probably fine, and likely a good thing, but it will be important to make sure that the pendulum does not swing too far towards supportive services.

There remains minimal or no group therapy in most core settings, but as noted before, this may be reasonable if the need for formal treatment declines in these settings owing to the effectiveness of the IBTM. But groups can provide a more efficient means of providing treatment for some disorders.

OTHER MENTAL HEALTH SERVICES AND FUNCTIONS

Licensed Mental Health Care

The lack of availability of licensed mental health care is a significant problem for DJJ that has become progressively more concerning. It is important to state again that DJJ has been making reasonable efforts to secure contracts and agreements in order to be able to provide services to the seriously ill. DJJ continues to have no provision for minor youth needing more than acute level services and even acute level services have been challenging to obtain. DJJ has entertained the possibility of developing its own CTC. While laudable, and perhaps the only viable solution in the short run, this is not a good solution. Not only are there problems with economy of scale, it is not clinically advisable as the census would likely be so low that it would be difficult to develop an effective treatment milieu.

Screening

Both pre-admission screening and post-admission screening continue to be adequate and reliably done. Youth with evident mental health needs are placed directly onto residential mental health units.

Initial Psychological Assessment

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

There has been clear improvement in the timeliness of the assessments, largely by virtue of dedicating additional resource to the intake unit.

The assessments still generally result in no formulation or summary of the results that can be used to guide either treatment or case planning, though those done at VYCF (both for the female population and some males) continue to show improvement in this regard. But there is still no evidence that the results of the psychological assessment are being used to help formulate Case Plans even in these cases.

It is understood that DJJ is looking at the whole intake process, which is welcome and necessary. As mentioned previously, the ICR is often run more like a hearing than a preparation for entry into a treatment program. It is important to have a meeting with the youth at the end of the assessment process to present findings, get feedback from the youth, and begin to develop directions for treatment. In order to do this, it is necessary to coordinate the elements of the intake process to produce a finished assessment, including a formulation, targets for treatment, and barriers to treatment. Such a complete assessment is essential for DJJ to take the next steps towards improving Case Planning and Treatment Planning. The assessment process also needs to be more formally and explicitly tied to recommendations for clinical services, including referral for psychotropic medications. There needs to be more formalization of the referral process for mental health treatment in general following the intake assessment.

Psychologists' IBTM Functions

For the sake of brevity, it only need be said that there has been a complete turnaround here. Praise is due to the whole mental health team for their efforts here.

Use of Force
Use of force in general remains down, including with mental health youth. No problems were identified here.

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

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

By way of brief conclusion, it is important to emphasize how far DJJ mental health has come. Restructuring the initial assessment process, adding some formal rehabilitation programs in residential settings, assuring psychiatric coverage, and providing for licensed level services are the primary remaining issues. Most all the rest is either resolved or on a solid trajectory.

Respectfully submitted,

Bruce C. Gage, M.D.
10/9/15