I. INTRODUCTION

The Special Master submits for filing the Thirty-Fourth Report of the Special Master. This report reviews the *Farrell* Mental Health Expert Dr. Bruce Gage's fourth Mental Health round of audits (site visits November 2015) as well as his fourth Integrated Behavioral Treatment Model (IBTM) comprehensive report for his fourth round of audits (December 2015) and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justice's (DJJ) compliance with the *Farrell* remedial plans. The Mental Health audit reports and the IBTM comprehensive report are attached to this report as Appendices A and B respectively. The Special Master's report, consistent with an agreement by the parties, limits the summarization of the expert's report and instead identifies the major areas of improvement as well as areas of concern.

The report begins with an analysis of progress in implementing the Mental Health Program followed by an analysis on the implementation of the IBTM. Finally, 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 is provided. The Special Master recommends the transfer of monitoring of all remaining remedial plans to Defendant.

II. MENTAL HEALTH

The Mental Health Expert, Dr. Bruce Gage, conducted another round of site audits in November 2015[1]. The site visits included N. A. Chaderjian Youth Correctional Facility (NACYCF), Ventura Youth Correctional Facility (VYCF), O. H. Close Youth Correctional

[1] This is the second round of audits in 2015. The first round was in June and July of 2015 and was discussed in OSM 33.

Facility (OHCYCF). Dr. Gage reviewed only those audit items not transferred to Defendant by agreement between the parties and provided a summary report for each facility but not a comprehensive report.[2] Dr. Gage did not find it necessary to complete an audit of the Central Office (CO) as four of the six remaining audit items pertain to timely placement of youth into licensed mental health facilities. Defendant and Dr. Gage have continued to explore alternatives regarding this issue and a proposed solution is discussed below. The Special Master provided the facilities' audit results to the parties for review on December 24, 2015. The audit results were finalized on February 3, 2016 after receiving and considering the parties' feedback.

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 was insufficient information to assign a rating. The following table provides a summary of the ratings at each of the facilities.

Table 1
Summary of Compliance Rating Percentages[3]

	NACYCF	OHCYCF	VYCF	Cumulative
Substantial Compliance	84%	86%	92%	87%
Partial Compliance	5%	6%	6%	6%
Non-compliant	6%	3%	0%	3%
Not-Rated	5%	5%	2%	4%

[2] The parties agreed in November 2015 that 83% (30/36) of the CO audit items and 54% (34/64) of the facility audit items for OHCYCF and NACYCF and 66% 42/64 for VYCF be transferred back to Defendant for monitoring.
[3] Compiled by OSM based on the Mental Health Expert's final reports.

The percentages of audit items in substantial compliance would be slightly higher if the not-rated items are excluded from calculation. For NACYCF, OHCYCF, and VYCF, the percentage would be 89%, 90%, and 94%, respectively.

Table 2
Summary of Compliance Rating Percentages (Excluding Not-Rated Items)[4]

	NACYCF	OHCYCF	VYCF	Cumulative
Substantial Compliance	87%	90%	94%	90%
Partial Compliance	7%	7%	6%	7%
Non-compliant	6%	3%	0%	3%

Defendant should be commended for making remarkable improvement in each facility's compliance ratings since the last audit round. Between July 2015 when the Mental Health Expert concluded his previous site visits and the current round in November 2015, Defendant improved its compliance ratings at the facilities by 16% at VYCF to 34% at OHCYCF, with a cumulative increase of 20% for all three facilities. This is directly attributable to the leadership of Dr. Heather Bowlds and the diligent efforts of the mental health clinicians at the three facilities.

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

	Round 1[5]	Round 2[6]	Round 3	Round 4	Increase
NACYCF	42%	58%	63%	84%	21%
OHCYCF[7]			52%	86%	34%
VYCF	50%	72%	76%	92%	16%
Cumulative	47%	64%	67%	87%	20%

[4] Compiled by OSM based on the Mental Health Expert's final reports.
[5] *See* OSM 31, p. 26.
[6] *Ibid.*
[7] The Mental Health Expert audited OHCYCF, which does not have a Mental Health Residential Unit (MHRU), for the first time.

When the not-rated items are excluded, the total numbers of audit items found to be less than substantially compliant at the facilities are eight, six, and four for NACYCF, OHCYCF, and VYCF, respectively. A review of these outstanding items disclosed few systemic issues among the facilities.

Although this audit item was rated in partial compliance at all three facilities, staff members at the facilities are improving in their ability to articulate the DJJ mission and vision. After the mental health audit, Defendant created laminated cards with the vision and mission for staff to carry.[8] This strategy may be in part responsible for the substantial compliance rating on this item in the IBTM audit. A similar audit item exists in the IBTM audit where staff members were asked to articulate the general principles of the IBTM. Defendant has achieved a substantial compliance rating at all three facilities during the last two IBTM audit rounds, which suggests staff are well versed in the foundational principals underlying Defendant's mission and vision even while some struggle to articulate the vision and mission itself.

Staff members at OHCYCF and VYCF continue to struggle when responding to the question of who has the authority to initiate controlled use-of-force incident. This is likely caused by the rarity of controlled use-of-force incidents and a lack of clarity as to what constitutes controlled use of force. This issue has no immediate impact on the facilities' operations and should self-correct as time progresses.[9]

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[8] *See* IBTM Mission Card #2

[9] The Special Master has shared her opinion with Defendant that the concept of controlled versus immediate use of force may no longer be useful. This concept, like the former use-of-force process, is taken from the adult use-of-force review model that Defendant has improved upon. The protocol for controlled use of force is designed to reduce the use of force by staff by slowing the process and creating a high standard of accountability. The reduction in use of force that has resulted from Defendant's current force review process has so dramatically increased de-escalation intervention efforts and reduced use of force to potentially make this process no longer necessary. The Division of Adult Institutions would be wise to learn from DJJ what an effective use-of-force review process is and how it can reduce use of force.

Both NACYCF and OHCYCF were found to be non-compliant on the audit item pertaining to case plans not identifying medical, mental health, and dental needs. This issue should be addressed by the planned changes to the intake and case planning processes as DJJ collects the necessary information but is not explicitly addressing it in the case plans.

VYCF has two other outstanding items, which are being addressed and should be resolved shortly. One of the items is having the Psychologists attend case plan meetings more regularly, and Defendant has assigned a higher priority for the Psychologists to attend such meetings. The other one is holding case conferences on a more-timely basis. Defendant has suggested that the previously prescribed timeframe of 30 days for youth assigned to mental health units is unrealistic and proposes to hold such conferences on a 45-day schedule. The Mental Health Expert agrees and this change should rectify the problem.

OHCYCF also has two outstanding items. One is youth not being seen within 10 days after a psychiatry referral has been made. This appears to be a workload issue and Defendant has contracted for Tele-Psychiatry care, which is discussed below. The other item is the need for a process for family therapeutic engagement for youth receiving mental health services. This condition is likely caused by the fact the OHCYCF has no mental health units and few, if any, identified as receiving outpatient mental health services. In his comment to Defendant's response on this issue, Dr. Gage suggested it is important to assure that this is well documented for mental health youth and that there is careful

consideration of the need for a structured or therapeutic approach to working with the family to assist them to understand and to support the youth.[10]

NACYCF has two other outstanding items that appear to be workload related. They are updating of case plans (every 45 days) and having the required staff attend case conferences. The issue apparently stems from a shortage of Psychologists, which has been an ongoing problem. In its response to the Mental Health Expert's draft report, Defendant stated that remedial action has begun and the Mental Health Expert has acknowledged that Defendant has been making a concerted effort in this regard.

Below is a table showing the audit items at each facility that have not achieved substantial compliance. Excluding the not-rated items, there is a total of 19 items that are not in substantial compliance status and, as noted above, efforts are already underway to address them.

Table 4
Items Not in Substantial Compliance

	Partial Compliance	**Non-Compliance**	**Not-Rated**	**Total**
NACYCF	4	4	4	12
OHCYCF	4	3	3	10
VYCF	4	0	1	5

Defendant believes a solution to licensed care placement has been found. Defendant has worked hard to find both state and contract options for placement of youth under and over 18 years of age who require acute and intermediate care for mental health

[10] It should be noted that 29 youth in the Sexual Behavior Treatment Program (SBTP) at OHCYCF receive family counseling so the facility staff know how to engage families with youth in therapy. Defendant simply needs to ensure that this program is provided to the few youth with a mental health designation.

issues.[11] As discussed in prior reports, Defendant explored developing a Correctional Treatment Center (CTC) at VYCF but given the small number of referrals and the licensure requirements, the cost for such a center is prohibitive. The Mental Health Expert agreed that such an option was not a wise use of resources as for months at a time, it would virtually sit empty while being fully staffed. Defendant has continued to maintain and to develop contracts with private hospitals throughout the state. While contracts are in place, Defendant's referrals are often rejected because of the severity and nature of the crimes the referring youth have committed.

From July through January 2015, there were two referrals for a higher level of care. In both cases, Defendant was unable to find a timely placement.[12]

In light of this, Defendant has proposed using services from the Division of Adult Institutions (DAI). The parties, Mental Health Expert and the Special Master toured the Psychiatric Inpatient Program (PIP) at the California Institution for Women (CIW) on February 5th.[13] The facility is clean, secure, has a comprehensive mental health program and an excellent staff to patient ratio. There is an Adolescent Psychiatrist on staff. The program staff are highly committed to providing quality mental health services. The tone of the facility is one of care and concern for the patients. The program is licensed and accredited.

[11] Defendant currently has three contract options one of which will take adults and youth and the other only adults. The former has rejected all but one referral and the latter will only take youth for a few days. Defendant needs contractors who will accept referrals timely and for services ranging from stabilization to longer-term commitments.

[12] In one case the youth stabilized and in another, the youth was an adult commitment and was transferred to the DAI.

[13] *See* DAI and Division of Health Care Services (DHCS) Letter of Commitment to DJJ Wards with Mental Health Care Needs

There are many advantages to using a facility of this type. For one thing, the staff can communicate openly about the patient. In addition, the philosophy regarding medications is the same. Too often when youth are referred to contract facilities, Defendant has little or no information regarding what treatment is provided. Typically, there is an attempt at stabilization through medication and immediate release. The return of a highly medicated youth does not resolve the problems that resulted in the crisis. The PIP program staff welcomed Defendant to call and to discuss cases as early as they believe necessary so if immediate transfer is needed, the staff will be prepared to receive the referral. This type of collaboration could result in more effective case management.[14] The proposed option for male youth is the licensed Acute Care Hospital at California Men's Colony (CMC). This facility has a 50-bed mental health crisis unit. This program can provide shorter-term crisis stabilization.[15]

The Mental Health Expert agrees with Defendant that using these two facilities to assist with crisis situations is likely the best option for youth. Defendant has scheduled a tour of the CMC facility. Information from the tour will inform the parties if that facility is a safe and appropriate alternative for male youth. The parties are nearing an agreement on this issue.

A. Current Progress

Of the eight steps in the Mental Health Implementation Plan, six are completed and the remaining two are nearing completion. The completed steps are:

[14] Many thanks go to Dr. Toche for both her cooperation on this issue and for the proactive steps she has taken to pave the way for this collaboration. The staff of the PIP are welcoming, supportive and collaborative.
[15] While the PIP can provide longer care than the hospital at CMC, the reality is that right now the private contractors, if they accept youth, often take them for periods as short as 24 hours. The crisis facility typically can keep the youth for about 10 days. This is a significant improvement and clinically a more adequate time frame for stabilization.

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

Plan elements that are nearing completion include:

- Intake Procedures
- Quality Assurance (QA) Procedures

Intake Procedures

Defendant is well aware of the shortcoming in its intake process and has a plan in place to revamp the process by the end of May 2016.[16] In addition, as discussed below, improving the content and quality of the case plans will take time through continuous monitoring, mentoring and coaching efforts.

Elements of the intake process have improved.[17] The Initial Case Review (ICR) meeting has improved. Notably the room where the meetings between staff and youth take place has been freshly painted, is clean, the furnishings are in good condition and together make for a more inviting environment for youth to meet with staff. Staff are attempting to use a more youth centered approach. All disciplines continue to be represented and most members speak directly to the youth, not about the youth. Clarity of the meeting purpose is better but the actual role of the members remains somewhat unclear.[18] Notably the staff are typically no longer calling the meeting a hearing.

[16] *See* Intake Reform Project Plan.
[17] The Special Master observed several intakes on December 17, 2015.
[18] As discussed in OSM 33, p.7, the Mental Health Expert has indicated the purpose of this meeting is to present the findings of the intake process to the youth, get feedback regarding the findings and to begin to formulate a case plan.

Some of the challenges for this process is the fact that different staff attend the meeting. Members of the various disciplines who are currently attending the meetings are working together to clarify meeting purpose and the role of each member. The team is creating an outline for the meeting structure and role definitions for members. In addition, they are creating a worksheet for the youth to help prepare them for the meeting.

The quality of the initial assessment is improving. The summary of assessment information has improved and case formulations are more evident and beginning to show more specificity. Treatment targets and barriers are being discussed more. Challenges that remain with intake include the inclusion of the California Youth Assessment Screening Instrument (CA-YASI) data by Psychologists into their initial assessment, the failure to have case formulations for all youth, a lack of timeliness and the failure to share information between the various professionals assigned to gather information. The desired outcome is a coordinated intake process that produces a clearly articulated risk assessment (sufficiently addressed by the static risk and domains produced by the CA-YASI), formulation describing the youth's particular source(s) of risk, and identification of treatment targets and barriers that provides the foundation for the case plan.

Case Planning

Case planning is without question one of the most difficult skills to develop and to ensure consistent, accurate and timely implementation. Complicating this is the necessary boundaries that must be kept between the mental health practitioners and the unit staff. Timely assessment, integration of assessment information into the formulation of a case plan, ensuring youth lead the planning process, and accurate and timely recording of progress all require integration of multiple people and systems.

Training and coaching staff in a correctional mental health unit to work together to accomplish all of these steps takes time and is a never-ending process. The Mental Health Expert has consistently opined that the development of solid case plans would be the last issue that Defendant would accomplish in both the development of a mental health program and in the IBTM.[19] The reason for this includes the need to have a robust and timely intake process that provides accurate data for case planners. The ability to change the organizational culture regarding the role and primacy of case planning is difficult. For the mental health units, a central issue is how to integrate treatment and case planning without violating the confidentiality of youth and mental health practitioners. There have been many gains in the area of case planning and there is still work to be done.

What has been accomplished is significant. The future is embodied in the work seen at VYCF mental health programs. At this facility, the timeliness of case plans has improved and there is more evidence of the integration between treatment plans and case plans. There is no inconsistency between treatment plans and case plans and in a smaller number of cases, these issues are well integrated. Perhaps most important is that mental health issues are being considered in case planning. The quality of the case notes of some of the Youth Correctional Counselors (YCC) in the girls unit is simply excellent. Similarly, in the girls unit, the quality of the targets is very good and goals are measurable. The quality of both the boys and girls units' case management is solid.[20]

NACYCF is not quite as far along as VYCF. As has been discussed in prior reports, VYCF benefits from the consistent and excellent oversight of the Senior Psychologist, Mr.

[19] For example, *See* OSM 33, p.14.
[20] *See* the VYCF MH Facility 11-15 AUDIT Summary in Appendix A. Some of the observations are from conversations between the Office of Audits and Court Compliance (OACC), the Mental Health Expert and the Special Master team during the Mental Health Audit.

Gordon Rose. The institution has also benefitted from less turnover among the Psychologists and several of the Psychologists are highly skilled and dedicated. NACYCF has been challenged with more turnover among the mental health practitioners. While progress is definitely evident, the lack of consistent staff has slowed progress.[21]

Treatment plans at NACYCF are better and are beginning to show evidence of case formulations and while still not timely, case plans should be in the near future with the timeframe for case planning expanding from 30 to 45 days. The quality of the plans has improved and especially in showing clearer evidence of true treatment targets. The integration between treatment and case plans is improving and there is evidence of addressing skill building and understanding of the stages of change. Psychologists are still not present at case conferences and meetings.

A critical issue that resulted due to Psychologist vacancies that has been rectified at NACYCF is the youth with mental health issues in core units not being seen regularly by a Psychologist. A recently contracted Psychologist has been consistently meeting with all youth in the core units who have identified mental health issues.[22] The return of a Psychologist from maternity leave is also helping to address the vacancy rate for Psychologists as will a new hire that will be starting in March of 2016. There now remains only one Psychologist vacancy.[23]

Another important issue that has been rectified at OHCYCF and NACYCF is the timely meeting with youth when a psychiatry referral is made. The Medical Director has

[21] The turnover of Psychologists is not surprising and is difficult to combat. The quality of the recent hires is excellent but the challenge is that young Psychologists typically will only stay a few years in this setting. The hiring process is prolonged and difficult, making it hard to avoid vacancies.
[22] *See* FW Weekly Youth List and FW Youth List for lists of youth in the core units at NACYCF that a Psychologist has met with.
[23] *See* DJJ Response to MH Audits, pp. 2-3.

implemented a Tele-Psychiatry Program. The program consists of the youth being interviewed via videoconferencing. The program was implemented in November of 2015.[24] The Psychiatrist has met with youth weekdays and weekends on three separate days typically seeing eight to 10 youth per session. The Psychiatrist is scheduled to work one to two days per week based on need. This service provides relief and backup for the on-site Psychiatrists.

In both institutions' mental health units, the youth can now clearly distinguish between treatment and case planning. Of perhaps greatest importance, in both facilities the Psychologists and the unit staff are collaborating and working together. While there is still work to be done to refine the intake process and the case plans, there is notable progress and evidence that the coaching and training needed to further improve is ongoing.

Quality Assurance

Psychologists continue to have monthly case presentations with the Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) consultant, Dr. Griffin. The consultant is being scheduled to do on-site training for the newly hired Psychologists. There will also be follow-up training for those already trained.

The QA Committee at headquarters continues the diagnostic reviews and has begun tracking mental health referrals from each site to ensure time frames are met. The work of this committee will help the Psychologists learn to complete accurate case formulations. The practice of observing group delivery and providing feedback has continued with the implementation of the observation forms and process for the groups *Mood Matters* and

[24] *See* FW-Tele-Psychiatry

Express Yourself that have been implemented on the residential mental health units at NACYCF and VYCF.[25]

B. Transfer of Monitoring

Defendant has achieved one round of monitoring where substantial compliance has exceeded 85%. While there is no agreed upon marker for substantial compliance in the case of the *Mental Health Remedial Plan,* Defendant has demonstrated the ability to implement a mental health program that provides the services and treatment needed by those youth with a mental health diagnoses. [26] Defendant has created systems that limit the residential programs to only those with a true mental health diagnosis. No longer are youth with only behavioral challenges placed in mental health units. The result of this is a significantly reduced population that receives the level and type of attention needed.

The unit staff and the mental health practitioners (Psychiatrists, Psychologists and Licensed Psychiatric Technicians (LPTs) work collaboratively to meet the needs of youth. The changes in how all units respond to behavioral issues have resulted in Psychologists of mental health units and all units not devoting most of their time responding to emergencies. Psychologists are now engaged in individual and group treatment. The treatment model is defined, credible and is monitored with quality assurance systems. The behavioral management elements of the IBTM have been successfully integrated into the residential mental health units and the youth respond well to the reinforcement and level systems. Youth violence is the exception and the use of force is rare. Perhaps most

[25] Information provided in a conversation between the Special Master and Dr. Bowlds on February 5, 2016.
[26] One of the historically challenging issues in this case is what is the marker of substantial compliance. Defendant has often argued for a quantitative marker while Plaintiff has often opined that each situation is unique and qualitative markers must also be considered. The Special Master agrees that each situation is unique and that a combination of both approaches is necessary. A baseline often used has been an overall rating of 85% for substantial compliance. Exceptions to this baseline are based on a variety of issues.

rewarding is hearing the unit staff members speak of the youth with care, concern and affection and the youth indicate that they feel safe and that staff work with them.

The Mental Health Expert has provided guidance for ways in which the mental health programs can continue to develop and to be refined. With continued support from executive and senior management, the Special Master has confidence that the committed and skilled unit staff and the mental health professionals will do just that. The Special Master recommends transfer of monitoring of the *Mental Health Remedial Plan* to Defendant.

III. INTEGRATED BEHAVIORAL TREATMENT MODEL

The Mental Health Expert conducted his fourth round of site audits of the facilities during December 2015. During this audit round, Dr. Gage reviewed only those audit items not transferred to Defendant by agreement between the parties[27] and provided summary reports for each facility and a comprehensive report. Dr. Gage did not conduct a site audit of the CO but instead performed a document review of the audit items not transferred to Defendant. The Special Master provided the facilities' audit results to the parties for review on February 8, 2015. The audits were finalized on February 10, 2016 after the review and consideration of the parties' comments.

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

[27]The parties agreed on August 25, 2015 that 64% (7/11) of the CO audit items and 33% (8/24) of the facility audit items be transferred back to Defendant for monitoring.

Table 5
Summary of Compliance Rating Percentages[28]

	NACYCF	OHCYCF	VYCF	CO	Cumulative
Substantial Compliance	67%	71%	71%	82%	71%
Partial Compliance	16%	12%	16%	27%	17%
Non-compliant	4%	4%	0%	0%	2%
Not-Rated	13%	13%	13%	0%	11%

The overall percentage of audited items found to be in substantial compliance has steadily increased between each audit round at all facilities and at the CO.

Table 6
Comparison of Percentage of Items in Substantial Compliance Rating Percentages

	Round 1[29]	Round 2[30]	Round 3	Round 4	Increase
NACYCF	11%	32%	54%	67%	13%
OHCYCF[31]	34%	43%	59%	71%	12%
VYCF	22%	46%	63%	71%	8%
CO	13%	13%	46%	82%	36%

Although the percentages of audit items found to be in substantial compliance at the facilities and at the CO are below the 85% percent threshold typically used by the parties to target substantial compliance, the Special Master does not believe quantitative measures alone should be used to determine compliance. One reason is because there are so few items to be audited, (24 at each of the facilities and 11 at CO), a small deviation can affect the percentages significantly.[32] For example, at the CO, only two items were found

[28] Compiled by the OSM based on the Mental Health Expert's final reports.
[29] *See* OSM 31, p. 26.
[30] *Ibid.*
[31] The Mental Health Expert audited OHCYCF, which does not have a MHRU, for the first time.
[32] Other remedial plans had significantly higher numbers of audit items. For example, the *Safety and Welfare Remedial Plan* has a total of 352 audit items to be audited at the CO and at the three facilities, which is more than four times the total of 83 for the IBTM audits at the CO and at the three facilities. Each audit item at the IBTM audit obviously has more impact on the overall percentage than the *Safety and Welfare Remedial Plan* audit.

to be in partial compliance but that reduced the compliance rating to 82%. A review of these three items revealed that, although they are legitimate issues that needed to be addressed, none has raised immediate concerns from a program and operational standpoint. One pertains to evaluation of the newly installed Level System (LS). The Mental Health Expert noted that the LS is well conceived, consistent with the IBTM principles, but is premature for full evaluation at this time. The other item is related to refinement and documentation of Defendant's population management practices where no known problems exist because of its relatively low population and the flexibility of adding more living units when needed.[33]

Another issue that has been recurrent in assessing compliance in all *Farrell* remedial plans is that not all audit items can be weighted equally. In short, some audit items are more complex and will require more work to implement than others so actually attempting to weight audit items is a difficult and not very useful process.

The audit items that were identified to be in partial compliance, non-compliant, and not ratable are identified in table seven below.

Table 7
Items Not in Substantial Compliance

	Partial Compliance	**Non-Compliance**	**Not-Rated**	**Total**
NACYCF	4	1	3	8
OHCYCF	3	1	3	7
VYCF	4	0	3	7
CO	3	0	0	3

[33] Defendant has taken appropriate steps to resolve this by developing a research group and has also begun to produce more sophisticated population analyses than previously.

The audit items that were identified to be in partial compliance, non-compliant, and not ratable are nearly identical at all three facilities. They are:

- Three of the 24 items in the audit tool (Items 13, 14, and 15) pertain to outcome evaluation, which is largely tied to the newly installed LS. All three items were not rated at the three facilities, as outcome evaluation is deemed premature at this time. Defendant has placed a high priority on quality assurance and outcome evaluation and established a research unit. The research unit is ready to perform the outcome evaluations once sufficient LS data become available and all three items will be in substantial compliance. Just by completing this step, each of the three facilities' overall compliance rating will increase by 13%, to 80%, 84%, and 84% for NACYCF, OHCYCF, and VYCF, respectively.
- All three facilities were rated in partial compliance on developing case conference protocol (Item 8) and case plan protocol (Item 9) in accordance with the IBTM principles. The Mental Health Expert noted that the protocols have been developed but quality control measures are still needed to ensure consistency with the IBTM. These two items are very near to be in substantial compliance, which should increase each of the three facilities' overall compliance rating by another 8%.
- Two of the facilities (NACYCF and OHCYCF) were found to be non-compliant and one facility (VYCF) was found to be in partial compliance on incorporating the initial psychological assessment results into the initial case plans (Item 20.5). This item is being addressed as a part of Defendant's effort to revamp the intake process that is scheduled to be completed by the end of May 2016.

- Both NACYCF and OHCYCF were rated in partial compliance on the content and completeness on the initial assessment of youth (Item 20.1). Again, this is an issue that is being addressed as a part of the intake process.

Based on the above analyses, the Special Master concludes that most, if not all, of the remaining IBTM audit items are being addressed and nearing completion and do not pose any significant impediment to the full delivery of the IBTM programs and services to youth in the facilities.

A. Current Progress

If culture is the way of thinking or beliefs that exist in an organization, the measure of it is often found in listening to the language of the staff. Discerning if a culture such as the IBTM has embedded is measured in several ways one of which is the language and beliefs shared by staff. The Special Master now finds herself being lectured or perhaps more accurately having the various elements of the IBTM explained to her by staff who but a few years ago were at best suspicious of the need for a behavioral change approach to working with youthful offenders. Now during audits or casual encounters when inquiring about if something like the Reinforcement System (RS) works, the Special Master finds staff looking at her as if she is not very bright because of course it works. To be expected, the level of understanding about behavioral change strategies varies from person to person but the vast majority speak now about why interaction with youth and positive reinforcement are effective strategies to help youth develop into what is still most commonly described as "prosocial behavior."

Where the language used to be about control and Disciplinary Decision Management System (DDMS), it is now about keeping youth busy, Skill of the Week

(SOTW), groups and positive checks. The managers have repeatedly shared that the RS has resulted in staff focusing on the positive achievements of youth and that this has shifted the culture from staff thinking about "what have you done wrong?" to catching youth doing things right. There remain some staff members that opine that the good old days when we focused only on security need to come back but this group diminishes in size each year. Of particular note is the impact of the many new supervisors who are fully committed to the IBTM.

The quantitative measures that demonstrate that the IBTM is becoming the way we do business are many. Cognitive-based Behavioral Treatment (CBT) group reports, tracking of positive checks, monthly reports regarding the level of unit activities, individual and group observations and the use-of-force reviews are just a few of the many mechanisms that have also become part of the culture that provide feedback regarding progress.

Such data is reviewed by the appropriate levels of management and also incorporated into meetings. Case review presentations by staff where all staff and managers critique and review the case plan presented provide excellent learning opportunities and monitoring mechanisms. Learning strategies have been incorporated that initially and understandably felt a bit threatening but now are becoming understood to be not a "gottcha" but a way to grow. Whether a case presentation or being observed while delivering a group, the notion that both quantitative and qualitative strategies are used to improve is becoming normative.

The most important measure of change is reflected in the youth. Youth now speak about the domains they are working on, the groups they attend, how many positive checks they are getting and what level they are on. When asked by the Special Master's team and

the Mental Health Expert if they feel safe, youth now look at us like that is a bit of an odd question. The only unit where youth still worry very much about safety is the intake unit and that is because of the newness and often the stories they have been told in detention centers. This is not to say there are still not problems and challenges. It is to say that there are durable mechanisms to sustain the gains and to develop more.

The Assessment Process

The key issues that remain in the assessment process have been discussed in Section II of this report. The only addition is that the work required to streamline and to simplify the CA-YASI is underway with the contracted vendor. The contractor is working now to change the scoring system.

Case Management

The organization of the case files has improved dramatically. The deficits of the existing information systems remain and will continue to impede the development of a more user-friendly case management system until Defendant invests in a more contemporary information technology platform. Case conferences are timely and more and more show strategies to engage the youth in the planning.

The content of case plans has also improved. Case plans are more complete and less generic in content.[34] While there remains work to be done identifying the actual behavior targets for change and helping youth develop actionable steps to achieve them, the staff and youth are now very familiar and growing comfortable with the domains of the CA-YASI and this has turned the attention of the unit team staff to the areas of greatest concern. The on-going struggle for staff in this regard is their lack of understanding of the

[34] *See* VYCF 12-15 IBTM Audit Report p.2-3, NACYCF 12-15 IBTM Audit Report, p.2 and OHCYCF 12-15 IBTM Audit Report, p.2.

learning model and the stages of change. Where staff are beginning to understand the stages of change, there is some incorporation of this understanding in the behavior targets set for youth. This results in more realistic targets that youth can achieve which in turn results in the positive reinforcement needed to support further skill development.

The Mental Health Expert noted in his audit summaries for all facilities that progress statements are becoming the norm.[35] While still not documented in the case plan, evidence of this is showing up in the case notes. The case notes are where the supervising YCC or any staff member can note progress of a youth. These notes are beginning to focus on action steps and stages of change instead of the formerly generic statements often simply indicating the YCC has met with the youth. YCCs are demonstrating a greater understanding of how to interpret the case plans and to focus on the desired behavioral targets and stages of change.

The Mental Health Expert provided case management training for the VYCF staff on January 15, 2016. The focus of this training was to help staff understand issues such as the differences between barriers and targets for case plans, how to use the stages of change to assist in developing case targets and proper documentation strategies. Defendant has discussed doing this again and having the session video-taped for further use.

Once the CA–YASI changes are made, Defendant has contracted for additional case plan training with the vendor of the CA-YASI. This and the planned training for trainers by the Motivational Interviewing (MI) Expert will position Defendant to train all staff in MI. Both contracts and accomplishments of contract goals to date are clear evidence of Defendant's on-going commitment to improving the case planning function.

[35] *Ibid.*

Behavioral Management and Level System

The Mental Health Expert noted "fidelity to the RS is improving everywhere." While VYCF has always been the strongest in this regard, OHCYCF has made great strides to ensure the RS is being implemented properly. As the expert noted, the key to this appears to be both the oversight provided by managers staying late to observe the late night program to ensure it is held and that the youth who earned the privilege are receiving it and having security staff do the same as well as providing creative and engaging structured activities during late night.[36] The positive check system is working well and those staff at NACYCF who gave negative checks when youth asked for a positive check have been made aware that this behavior is not consistent with the RS. Youth seeking positive checks is exactly what the system attempts to promote!

Finally, the "goodie" locker system is working; the supplies are adequate and staff are doing a good job of getting supplies that youth want. The only problem is that sometimes overly enthusiastic staff are being too generous and giving group rewards that are outside of the system.

The technology challenges in implementing LS actually indicated that the embedding of the behavioral management model is fairly far along. The initial implementation resulted in all youth dropping to the entry level. In the past, many staff would have used this type of situation to denigrate the concept of the system. That was not the case in this instance. Staff understood the problem, explained it to youth and saw it for what it was -- a short-term barrier.

[36] Information provided during the audits by several staff members appears to indicate that while some of the NACYCF managers are using this thorough approach, many are not staying late enough on their late shift to actually observe the activity. Nor are they having security staff work with them in this regard. Both strategies are encouraged in light of the impact this approach has had at OHCYCF.

The staff interviewed by the Special Master team and the Mental Health Expert, while frustrated by the wasted time that resulted from the technology problem, did not express concerns with the level system itself. Concerns expressed were not about the system per se but was the structure going to work as well as it should. For instance, what appears to be appropriate concern about the length of time to promote from the entry level to the next level was shared. The concern was about not wanting to discourage the youth. These types of concerns have been catalogued by the IBTM CO Team and will be reviewed for modifications. The team has a thoughtful plan for making modifications based on the first six months of experience.

It appears that any attempt at this time to remove the RS would result in youth and staff push-back. While there is still not complete fidelity to the system, it is almost there. The fact that staff members who do not give positive checks are the outliers is a clear indicator that the RS is "just how we do business." It is critical that the funds for the incentives be a committed line item in the budget for the treatment program and not viewed as expendable. Incentives are an essential component to the learning and change process. They come in many forms but often start with a simple candy bar or bar of soap.

Quality Assurance

One of the many benefits of working with the University of Cincinnati Corrections Institute (UCCI) team was their appropriate emphasis on developing and implementing quality assurance strategies. The IBTM CO Team took this strategy to heart and has worked diligently to help staff see QA as not just how business is done but as a supportive coaching strategy to help them. All CBT curricula have observation forms and Defendant has a methodical plan for moving through each curriculum. SOTW is finished and the

substance abuse group monitoring has begun.[37] As discussed above, another quality assurance strategy is having the clinical presentations of cases done by Psychologists, Parole Agents (PA) and Case Work Specialists (CWS) to their respective teams. This process helps supervisors and managers assess the understanding of staff in treatment and case planning.

The many training efforts of Defendant are yet another strategy to ensure quality delivery of services. Ongoing training such as block training now under the supervision of the IBTM CO Team is coordinated more carefully with other IBTM training to ensure consistency of message. This annual training is an opportunity for staff to refresh their skills and to enhance their understanding of the elements of the IBTM. Specialized training continues including assessment, case planning, Motivational Interviewing and specific curricula.[38]

Another valuable strategy to ensure fidelity to the reform effort is the Office of Audits and Court Compliance unit. Members of this unit have worked with the *Farrell* experts to develop their understanding of how to audit each remedial plan. The unit has undertaken revision of some of the audit tools.[39] Farrell Experts who have trained the auditors have been universally pleased with the quality and integrity of the audits performed.

Finally, Defendant has two Quality Assurance Coordinators (QACs). The QACs are the "go to" people that are in the units on a regular basis completing a variety of audit

[37] *See* FW OSM 34 for an example of the observation schedule for mid-managers at VYCF on the substance abuse curriculum.
[38] For example, a contractor is scheduled to train at VYCF the Girls Moving On Curricula for staff in the girls unit and four staff members will be trained to be trainers. *See* Girls Moving On Update.
[39] *See* Notification of Farrell Audit Tool Revisions-1 and OACC Farrell Audit Tool Revision Schedule 11-21-14.

checklists and quality assurance measures. They work with the IBTM CO Team and Facility Administrators to ensure fidelity to the model. The Special Master is very familiar with the work of both of the current QACs (a third is soon to be hired so each facility has a QAC) and has nothing but high regard for their commitment to the principles of the IBTM and the quality of their work. They are dedicated and passionate staff members who are highly regarded by others and looked to by line staff and managers as a resource for learning and change. The dedication of resources for this function and the placement of such talented and skilled individuals in the positions is a clear indicator of the commitment by Defendant to fidelity to the IBTM.

B. Transfer of Monitoring

The Special Master reiterates her suggestion that full monitoring of the *Safety and Welfare Plan that includes the IBTM* should be returned to Defendant.

IV. OUTSTANDING SAFETY AND WELFARE AUDIT ITEMS

In her thirty-third report, the Special Master opined that full monitoring of the *Safety and Welfare Remedial* Plan should be returned to Defendant. Of the two outstanding audit items, the Special Master noted Defendant's BTP program is in substantial compliance with the purpose and intent of the *Safety and Welfare Remedial Plan.* The Special Master further noted Defendant has demonstrated that significant progress has been made in facilities improvement and there is a clear and reasonable expectation that the desired outcome will be achieved in the very near future.

A. Behavioral Treatment Program

In her thirty-third report, the Special Master suggested Defendant is ready to assume monitoring of this audit item based on the following considerations:

- The program has achieved the desired outcome as evidenced by the low number of youth housed in the unit and their length of stay (LOS). Except for those who refuse to come out, youth spend the bulk of their time out of their rooms engaging in various treatment, education/vocational and recreational activities.
- The program is sustainable with successful implementation of the very well designed BTP program guide, which was adopted under the guidance of the Mental Health Expert with extensive comments and suggestions from the Plaintiff and the Special Master. A work plan was developed, periodically updated, and shows major tasks and deliverables have been accomplished.
- Quality assurance has started to take place through the use of a quality control checklist to ensure compliance with key elements of the program guide. The facility's QAC is currently performing this function on a monthly basis.

A review of more recent data further suggests Defendant is ready to assume monitoring of this item. As of January 31, 2016, the total BTP youth population at the three facilities was 21 (six at NACYCF, six at OHCYCF, and nine at VYCF).[40] These numbers in general have been very consistent over the last year and have been at or near a historical low level for the BTP youth population.

The average LOS remains low and reasonable[41] at NACYCF and OHCYCF, which were 52 and 69 days, respectively, during January 2016.[42] VYCF's BTP unit apparently is dealing with a particularly challenging population at this time and the average LOS for January 2016 was 142 days,[43] which, while quite high, is significantly below the LOS of a

[40] *See* BTP Monthly Report for January 2016.
[41] With so few youth in the unit, one of two youth with lengthy stay could inflate the average considerably
[42] *See* BTP Monthly Report for January 2016.
[43] *Ibid.*

few years ago where the average constantly exceeded 300 days. Staff reported that some youth reached the transition level but failed to transition successfully back to the sending unit because of anger and aggression issues. Some youth engaged in violent behavior against other youth in the BTP that resulted in dropping their incentive level, which in turn lengthened their BTP stays. This is the purpose of the BTP to provide opportunities for youth to practice their skills in interacting with other youth without resorting to violence. While learning how to manage and control their anger and aggressive behavior, there will be successes and failures. Youth progress through the BTP program at very different rates. Such situations will arise in the BTP setting. VYCF has a strong leadership team and its BTP staff members are deeply committed to working with youth to facilitate a rapid transition out of the unit. The progress of these youth is being monitored and monthly reports are submitted to the CO on the status and intervention efforts for each youth.

With the exception of those youth who refuse, youth continue to spend the bulk of their days out of their rooms. Defendant's Program Service Day (PSD) data show youth averaged 60, 63, and 62 hours in out-of-room time at NACYCF, OHCYCF, and VYCF, respectively during the week of January 4, 2016 through January 10, 2016. During recent visits by the Special Master and the Deputy Special Master as a part of the IBTM audits and *Mental Health Remedial Plan* audits, both observed most youth in the BTP units were out of their rooms and engaged in activities with staff members and other youth (dialoging with staff, board games, ping-pong, etc.).

On December 17, 2015, plaintiff conducted a site visit to the Northern California Youth Complex and spent a considerable time visiting and interviewing youth at the BTP

units in NACYCF (Kern) and OHCYCF (Inyo). Plaintiff did not identify any specific concerns during the site visit.

The BTP Program Guide is nearly fully implemented. According to the most recent version of the BTP Work Plan, which identifies and tracks Defendant's progress in implementing the BTP Program Guide that was released in May 2015, all deliverables have been completed with the exception of two items. One of the items is to provide mentoring and coaching on structured activities and the second is to identify and provide data for quality assurance and quality improvement. Defendant has established a recreational therapist position and is actively recruiting for the position. One of the priorities for the position is to coach and mentor the BTP staff members to engage youth in structured activities. The deliverable for data gathering for quality assurance and quality improvement purposes is scheduled for completion at the end of March 2016.[44]

The quality assurance process continues to improve. The Defendant shared with Plaintiff the completed BTP quality assurance checklists for all three facilities for September, October, and November 2015 by the facilities' QAC. Plaintiff made comments and suggestions about the quality of the work completed. The Special Master believes the purpose, intent, content, and structure of the checklist to be very sound. She also noted that the quality of the work continues to improve as evidenced by the checklists completed for December 2015. The completed checklists for December 2015 have been shared with Plaintiff.

[44] *See* email of January 12, 2016 from Program Administrator Alicia Ginn to the Deputy Special Master.

B. Facilities Improvement

In accordance with the Special Master's suggestion, Defendant developed a schedule that calls for renovation of one living unit each month at VYCF and at the Northern California Youth Complex consistent with the general design of the prototype and with the therapeutic goals of the IBTM. Based on the original schedule, VYCF is to complete renovation of all of its living units by March 2016 and those at the Northern California Youth Complex by July 2016.

Defendant is well ahead of schedule at the Northern California Youth Complex. With the exception of delivery of some items, renovation has been completed for all living units in the complex. Defendant has prepared a "Facility Improvement Spreadsheet," which is an inventory of all work (i.e., painting) and purchases (computers, furniture, artwork, etc.) required to complete renovation for each type of living unit (high core, low core, intake, MHRU) within each facility. According to the most recent version of the spreadsheet, as of February 4, 2016, all work has been completed for all living units in the Northern California Youth Complex and the only missing items are some art work, rugs, curtains, and bedspreads that have been ordered but not yet delivered. In addition, work orders have been issued to install certain art work that have been received.[45]

Defendant is on target to complete renovations of all living units at VYCF as scheduled. According to the latest Facility Improvement Spreadsheet,[46] renovation has been completed at four of the eight livings units and near completion for one other unit

[45] *See* Facility Improvement Spreadsheet" for NACYCF and OHCYCF.
[46] *See* Facility Improvement Spreadsheet" for VYCF.

(bedspreads on order). Renovation progress varies at the three other living units but all should be completed before the end of March 2016.

During their site visits to the facilities in November and December 2015 to conduct audits of the *Mental Health Remedial Plan* and the IBTM, the Special Master and the Deputy Special Master visited every living unit at all three facilities. They observed vast improvement in the appearance, cleanliness, and conditions of the living units. While far from ideal because of the facilities' age as well as their basic design configurations, they are adequate to produce a therapeutic setting conducive to providing treatment and services consistent with the IBTM principles.

C. Next Steps

The Special Master reiterates her previous suggestion that full monitoring of the *Safety and Welfare Remedial Plan* should be returned to Defendant.

V. CONCLUSION

The Special Master believes that a durable and lasting solution to the many issues raised by the *Farrell* lawsuit has been achieved. That is not to say that all issues are resolved or that fidelity has been perfectly achieved. Neither is the case. Nor will it ever be the case. As the Mental Health Expert noted in his IBTM Comprehensive Report, the IBTM is not static.[47] There is always more work to do to refine and to improve the many elements of the IBTM. As research provides new information, the program should change. As population demographics and needs change, the program should change. As staff brings new talents and gifts to share, the program should change.

[47] Appendix B, IBTM Comprehensive Summary 2-16, p. 2.

Significant cultural change is difficult in any organization but even more so in large residential programs. The complexity of multiple shifts alone makes it more difficult to provide the support, coaching and experiences required to change belief systems. Such organizational change typically takes a minimum of five years to embed and that does not mean all staff are fully supportive of the changes. The Mental Health Expert has the difficult task of determining when both his guidance and his monitoring are sufficient to project that the gains made are stable and will continue.[48]

The question for this lawsuit is whether the changes made can and will be sustained. Is there sufficient evidence that the IBTM is deeply embedded enough in the attitudes and beliefs of staff (the culture) to not be eliminated and is there evidence that the systems and structures in place are sufficiently robust and rooted to continue to support development of the IBTM and not sliding back into the "moral accountability model?" The Special Master and the Mental Health Expert believe the answer is yes.

As discussed, some elements, if significantly undermined, would result in not just push back from youth but also staff. Good luck to the administrator who decides to defund the incentives! The reduction in youth violence attributed to the use of the RS and the increase in structured and unstructured activities has turned the belief system of most staff into seeing the system as favorable. Similarly, the early fear and resistance to groups has been overcome. The majority of staff now indicate that they like facilitating groups and see the groups as an integral part of the program.

The concern is less that the elements of the IBTM be eliminated but will they continue to be refined to the point that the fidelity is at the level is should be. The many

[48] The projection on the part of an expert, of course, cannot control the multitude of factors that can disrupt the change process. Legislative and fiscal changes can quickly undermine or derail gains.

quality assurance systems discussed above are indicators that Defendant understands and is committed to this effort. The fact that the IBTM CO Team not only continues but continues to attract some of the best talent in the Department is an indicator that Defendant is committed to quality improvement.

Finally, and of most importance to the Special Master is the values of the executive and senior leadership. On occasions too numerable to recount, the Special Master has heard the Director of the DJJ remind staff that the changes that are being made are not in response to the lawsuit but because they are the "right thing to do." The current Director has made it clear that without the law suit the Division would be doing the same thing. Senior leaders have reiterated that while the lawsuit was the catalyst for reform, the reform springs from the values and beliefs of the staff that want to help youth reduce the chance that they will recidivate. The impact of the modeling by many executive and senior managers is evidenced in the wave of hiring and promotion of the staff into supervisory and program positions who believe the IBTM is the right thing to do.

The Director has carefully and strategically nurtured and supported the development of the staff who has the values, beliefs and skills to support the next level of development of the IBTM. The management pipeline is weighted now in the direction of those who are excited about and support the reform efforts.

After six years of monitoring and working with the staff of the DJJ, The Special Master has every confidence that they will stay the course and continue to refine the IBTM. The Special Master looks forward to visiting them years from now to see their progress. They are by and large as committed a group of human service providers that the Special Master has ever worked with. They will continue to address the many challenges that come

with the difficult work of helping the youth that our society so often gives up on and throws away. Their efforts will not be perfect. But they know that as they are imperfect and deserve a chance to change, so do the young people they serve.

Should the parties agree on full transfer of monitoring, if appropriate, the Special Master requests an opportunity to catalog the learning from this case in one more report.

The Special Master respectfully submits this report.

Dated: February 22, 2016

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Nancy M. Campbell
Special Master

NACYCF Mental Health Audit Summary

November 2015 Audit

BACKGROUND

The *Farrell* law suit remedial plan addresses a number of clinical services, including mental health. For a more detailed summary, please see previous summaries. The remedial plan/consent decree addresses:

- Provision of mental health care
- Adequacy of policies and procedures
- Quality assurance and peer review procedures
- Staffing
- Sufficiency of ancillary staff
- Training, supervision, and discipline of clinicians
- Adequacy of mental health records
- Crisis management and suicide watch policies and procedures
- Use of mechanical restraints on mentally ill wards
- Adequacy of mental health care facilities
- Adequacy of mental health programs (including number of programming beds)
- Psychotropic medications
- Programs and services provided to wards in restricted housing units
- Initial screenings
- Substance abuse treatment

It is important to note that a number of audit items have been removed from the original audit owing to defendant's substantial compliance.

FACILITY AUDIT

As at the other facilities, staff continue to struggle to articulate the mission and guiding principles of DJJ but are better able to describe the principles of the IBTM. DJJ has provided laminated IBTM cards and continues to focus on developing a more robust understanding of the principles of the IBTM. Coordination and collaboration between mental health and program staff is also better. One clear change was that staff were readily able to explain the process for controlled use of force.

The cooperation and collaboration between mental health and other staff at NACYCF has improved substantially, including on the BTP and core units. This applies not only to mental health treatment but also to the IBTM itself.

Facility Management and Mental Health

These items were removed from the audit. There is nothing to suggest that there has been slippage in this area.

Access to Mental Health

Staffing was removed as an audit item. But at NACYCF, there is again a shortage of psychologists with none assigned to core units. Thus, there are essentially no psychological

treatment services being provided to youth on core units. They reportedly get some limited supportive services when transferring out of mental health residential, but this was not well demonstrated in the record. This reflects a significant problem with access to services and must be remedied.

It should be noted that DJJ did dedicate additional psychology resources to the intake process and also informed the intake psychologists that the initial psychological assessment is to be completed within 30 days rather than 45. These interventions should allow the timeline and thorough completion of the initial psychological assessment give current rates of admission.

Psychiatric services are improved in terms of timeliness and thoroughness, though still not back to where they previously were. The timeliness of response to referrals and of follow-up is often tardy but the quality of documentation is more consistently complete. However, psychiatric follow-up continues to not be timely in many instances. Telepsychiatric services are beginning at OHCYCF and should allow the on-site psychiatrist enough time to meet the needs at NACYCF.

LPTs continue to run a medication education group and provide important supportive functions for mental health generally and psychiatry specifically. Their role in providing support such as helping to conduct side effect and medication monitoring (e.g. gathering weights and doing tests for movement disorders) could be expanded.

Psychologists continue to be less frequently called upon to respond to crises and routine behavioral problems than previously. The IBTM and the structure of the crisis response system together have reduced crises.

Clinical Policy Implementation

The new Mental Health Program Guide has been completed. Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is being used in the residential mental health units, though there have been challenges in using the group format that DJJ has addressed by developing an individual approach through consultation with experts.

There were no instances of emergency medication usage and no indication that it is not being used when it should be.

Clinician documentation is in line with policy expectations and community standards.

Suicide Assessment and Monitoring

The suicide monitoring policy is being followed more closely and documentation is much more complete and thorough, including reasons for placement on monitoring and for reducing monitoring. Monitoring was readily available 24 hours per day. Further, monitoring logs were almost universally available and complete. The only area of difficulty was with youth on FS, some of whom were monitoring longer than required and a few were missing monitoring logs for this period. But as this status is, reasonably, being essentially discarded, this is not seen as an issue.

Use of Force

Part of this item was also removed. We saw no evidence of anything that would raise concern regarding use of force with mental health youth. As noted above, staff better understand how to implement controlled use of force.

Admission Mental Health Screening and Evaluation

DJJ has a sound mental health screening process so this was removed from the audit. It is completed reliably and timely.

However, as during the last audit, the initial more detailed Intake Assessment process that includes the specified testing done by psychologists continues to be problematic, though less so. Many youth are still not getting their initial assessment done timely. But they are more reliably completed. Psychologists are still not incorporating the CA-YASI into their assessments, still because the CA-YASI not being completed by the time they must complete their assessment. There is better summarization of assessment materials. Formulations, when present, show some improvement with a greater degree of individual specificity but they remain very mixed. Treatment targets and barriers to treatment are more often present and some are good but there seems to be difficulty understanding the difference between targets and barriers. For instance, learning disability is not a target of treatment but a barrier to treatment. But it is important to reiterate that there has been clear improvement in the quality.

There continues to be little evidence of exchange of information between those charged with collecting intake information.

Placement and Treatment on Residential Mental Health Units

The placement of mental health youth was removed from the audit; there was no evidence of any problems with placement.

Modified TF-CBT is being delivered in line with expert consultation. LPTs continue to conduct medication education groups. NACYCF had also implemented Mood Matters and Express Yourself, which are reasonable modules for the mental health residential population. There remains a plan to hire a recreation therapist who should be able to help staff develop other structured activities to offer these youth. Residential psychologists continue to do a good job with family engagement.

Treatment plans have improved and are better integrated. The plans more consistently include formulations, though they remain uneven in quality. Treatment targets are more often present but are also uneven in terms of quality. In general, though, the quality of treatment plans has improved.

Despite continued problems with the frequency of follow-up for medications in most cases, psychotropic treatment is consistently appropriate for the disorders being treated. But documentation is not as strong as it was previously. Notably, medication monitoring is less reliably present.

Case plans are still often not done timely. There is better integration between the case plan and the treatment plan. But case plans remain fairly generic in most instances though attention to stages of change and specific skill development are beginning to appear occasionally. There is evidence of greater attention to progress related to goals but this has not resulted in any substantial changes in plans as progress is almost always indicated, though not always clearly supported by documentation. The teams continue to function more effectively and to coordinate their efforts. But as at the last audit, psychologists were not present at case planning conferences on residential mental health units a substantial minority of the time. Despite these improvements, case plans continue to lack any formal recognition of behavioral problems and barriers to treatment represented by mental health conditions and health conditions generally.

Youth awareness of their treatment and case plan goals continues to be strong, even better than the last audit, and most have a clear sense of the difference between what they are working on in each.

Outpatient (Core Unit) Mental Health Treatment
As noted above, there is virtually no psychological treatment occurring on the core units.

Psychiatric services are being reasonably well rendered and are timely. The quality of the progress notes is also pretty much back to what it had been historically. Prescribing practices are very sound.

Substance abuse program
This was removed from the audit. No problems were detected with regard to the program.

CONCLUDING COMMENTS

The gains in the coordination between mental health and program staff in NACYCF have been sustained. However, this is rarely reflected in the case plans.

There has also been substantial development of structured services on the residential units. Treatment planning has also improved. Psychologists are also developing greater facility in creating formulations and developing more focused treatment plans.

The primary areas of concern are the assessment process and the lack of psychologists on the core units. The latter is a serious issue that must be addressed promptly. Psychiatric services need to be shored up but it is expected that the new telepsychiatry service focused on OHCYCF will remedy this problem.

All in all, mental health services continue to develop, albeit with some setbacks primarily related to loss of staff.

Respectfully submitted,

Bruce C. Gage, M.D.
12/23/15

OHCYCF Mental Health Audit Summary

November 2015 Audit

BACKGROUND

The *Farrell* law suit remedial plan addresses a number of clinical services, including mental health. For a more detailed summary, please see previous summaries. The remedial plan/consent decree addresses:

- Provision of mental health care
- Adequacy of policies and procedures
- Quality assurance and peer review procedures
- Staffing
- Sufficiency of ancillary staff
- Training, supervision, and discipline of clinicians
- Adequacy of mental health records
- Crisis management and suicide watch policies and procedures
- Use of mechanical restraints on mentally ill wards
- Adequacy of mental health care facilities
- Adequacy of mental health programs (including number of programming beds)
- Psychotropic medications
- Programs and services provided to wards in restricted housing units
- Initial screenings
- Substance abuse treatment

It is important to note that a number of audit items were removed from the mental health audit owing to substantial compliance by DJJ.

FACILITY AUDIT

OHCYCF does not have residential mental health settings but all other components of the mental health program were reviewed.

As before, facility staff struggle to articulate the Mission and Guiding Principles of DJJ. But there continue to be gains in understanding the IBTM and the role of mental health within it, especially when staff are given cues to guide their responses. DJJ has provided laminated IBTM cards and continues to focus on developing a more robust understanding of the principles of the IBTM.

The cooperation and collaboration between mental health and program staff is solid at this point and can be said to have become the norm.

Facility Management and Mental Health

These items were removed from the audit. There is nothing to suggest that there has been slippage in this area.

Access to Mental Health

Staffing was also removed as an item and psychologist staffing is sufficient. Their work has continued to focus more on supporting the IBTM more than providing psychotherapy. A before, it is important to recognize that this is at least in part a positive development in that youth feel less in need of such services (or respite from the units), indicating the services and environment available to them through the IBTM are effective. But it remains important to assure that there is not an over-correction and that psychologists continue to render formal treatment services.

Psychiatric services are improved in terms of timeliness and thoroughness, though still not back to where they previously were. The timeliness of response to referrals and of follow-up is often tardy but the quality of documentation is more consistently complete. Telepsychiatric services are beginning at OHCYCF and should remedy this problem.

The referral continues to work fairly smoothly. It is being used consistently to make formal referrals rather than being used as an informal communication mechanism. And crisis calls are not being done through this mechanism, and also continue to be much lower volume.

Clinical Policy Implementation

The new Mental Health Program Guide is in effect and Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice selected by DJJ, has been rolled out. There are essentially no youth receiving active treatment at OHCYCF (other than psychotropic medications). The one youth receiving services is essentially being tapered off them. Thus it is not possible to assess the adequacy and compliance of these items.

Documentation, in this instance limited to psychiatric documentation, is generally in line with policy expectations and community standards.

Suicide Assessment and Monitoring

The suicide monitoring policy is being followed more closely and documentation is much more complete and thorough, including reasons for placement on monitoring and for reducing monitoring. Monitoring was readily available 24 hours per day. Further, monitoring logs were more consistently available and complete, though some improvement is still needed. For youth on FS, some were on monitoring longer than required. But as this status is, reasonably, being essentially discarded, this is not seen as an issue.

Use of Force

This was removed from the audit. There was no evidence raising concern about the use of force with mental health youth.

Admission Mental Health Screening and Evaluation

As noted previously, DJJ has an adequate mental health screening process. It is done reliably and DJJ has a sound mental health screening process so this was removed from the audit. It is completed reliably and timely.

Intake assessments done by OHCYCF, though few, are somewhat improved and are now being done timely. There is no integration of the CA-YASI domains and formulations are more often

present, but most lack specificity. Treatment targets and barriers to treatment are rarely identified.

Placement and Treatment on Residential Mental Health Units

The great majority of mental health you are on a residential mental health unit, though not in OHCYCF. There were only two Mental Health Youth at OHCYCF and both had been appropriately stepped down from residential units.

Outpatient (Core Unit) Mental Health Treatment

As noted above, there is currently limited formal mental health treatment occurring on the core units at OHCYCF. As before, psychologists note that the younger youth are somewhat hesitant to be in formal treatment but are more likely to meet with psychologists in support of their work on their Case Plan. It is important to continue to track formal mental health treatment on core units as there are clearly youth who could benefit from treatment. It is especially important to assure that youth stepped down from residential settings are served, which is being done.

An area that needs to be examined is the involvement of family. There was only one youth who had any family involvement by psychology. While there were only two mental health youth, it is still an important role for psychologists to serve with those youth and, in some cases, with youth not designated as mental health. Psychologists have valuable expertise in working with families and, especially for youth unwilling to engage in individual work, family work can often be a useful substitute.

Case plans remain quite generic on the whole. It is primarily the goals and action steps that remain generic. That said, action steps showed some greater specificity. There is limited attention to mental health issues but there are few youth with significant mental illness, though greater attention could be paid to youth with certain kinds of psychological problems such as those related to impulse control and trauma. One notable improvement is that there is more attention to progress, though sometimes not to lack of progress.

Substance abuse program

This has been removed from the audit.

CONCLUDING COMMENTS

Given the limited amount of active treatment occurring at OHCYCF, it is not possible to comment on its quality. The integration with the IBTM continues to be the strength of the psychologists at OHCYCF and they have helped tremendously in this regard. The intakes need to be developed in terms of integrating the data into a succinct and user friendly formulation and in providing teams with targets for treatment and barriers that might interfere with treatment.

The most important thing is to assure that youth and their families needing psychological services receive them. While there is no clear deficit with regard to the youth, again because of the success of the IBTM, this needs to be monitored. And building up the family component is clearly indicated.

Psychiatric services are improved but there is still a small distance to go to get back to their previous quality. The telepsychiatry resource should solve the problem.

The quality of case planning with regard to mental health issues at least demonstrates that the case plans are not problematic with regard to mental health issues. But the overall focus on case planning is probably more important than a specific focus on case planning for mental health youth.

Respectfully submitted,

Bruce C. Gage, M.D.
12/23/15

VYCF Mental Health Audit Summary

November 2015 Audit

BACKGROUND

The *Farrell* law suit remedial plan addresses a number of clinical services, including mental health. For a more complete statement regarding background, please see previous Mental Health Audit Summaries. The remedial plan/consent decree addresses:

- Provision of mental health care
- Adequacy of policies and procedures
- Quality assurance and peer review procedures
- Staffing
- Sufficiency of ancillary staff
- Training, supervision, and discipline of clinicians
- Adequacy of mental health records
- Crisis management and suicide watch policies and procedures
- Use of mechanical restraints on mentally ill wards
- Adequacy of mental health care facilities
- Adequacy of mental health programs (including number of programming beds)
- Psychotropic medications
- Programs and services provided to wards in restricted housing units
- Initial screenings
- Substance abuse treatment

It is important to note that a number of audit items have been removed from the original audit owing to defendant's substantial compliance.

FACILITY AUDIT

VYCF continues to make great strides in organizing and improving their mental health services. There has been no slippage in the gains made previously, with the exception of moving away from the unified treatment plan on residential mental health units.

Facility staff continues to have difficulty spontaneously articulating the DJJ Mission and Guiding Principles, they continue to develop in their overall understanding of the IBTM principles and to have a better understanding of how to address mental health issues within the IBTM. DJJ has provided laminated IBTM cards and continues to focus on developing a more robust understanding of the principles of the IBTM.

There is notable growth in the individualization of treatment plans and case plans, which seems to be largely a result of greater collaboration between mental health and program staff as well as improvements in the formulations that drive individualization.

Facility Management and Mental Health

These items were removed from the audit. There is nothing to suggest that there has been slippage in this area.

Access to Mental Health

Staffing was also removed as an item and psychology and psychiatric staffing is unchanged and sufficient. Note that there has been limited staff turnover for some time, always a good sign. It is important to assure that the LPT staffing is maintained and that it should be treated as a post position.

In general, there was no evidence of problems with access to mental health services.

Clinical Policy Implementation

The new Mental Health Program Guide has been completed. Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is being used in the residential mental health units, though there have been challenges in using the group format that DJJ has addressed by developing an individual approach through consultation with experts.

There were no instances of emergency medication usage and no indication that it is not being used when it should be.

Clinician documentation is in line with policy expectations and community standards.

Suicide Assessment and Monitoring

The suicide monitoring policy is being followed more closely and documentation is much more complete and thorough, including reasons for placement on monitoring and for reducing monitoring. Monitoring was readily available 24 hours per day. Further, monitoring logs were almost universally available and complete. The only area of difficulty was with youth on FS, some of whom were monitoring longer than required and a few with missing monitoring. But as this status is, reasonably, being essentially discarded, this is not seen as an issue.

Use of Force

Part of this item was also removed. We saw no evidence of anything that would raise concern regarding use of force with mental health youth.

Staff continue to struggle with the item involving who has the authority to initiate controlled use of force. However, most staff know that there are a variety of steps to be taken and that authorization has to come from a superior.

Admission Mental Health Screening and Evaluation

DJJ has a sound mental health screening process so this was removed from the audit. It is completed reliably and timely.

Intake assessments done by VYCF, though few continue to improve and many are of high quality. There is more integration of the CA-YASI domains but formulations are beginning to have sufficient substance to guide treatment.

Placement and Treatment on Residential Mental Health Units

The placement of mental health youth was removed from the audit; there was no evidence of any problems with placement.

Since the last visit, VYCF has started the medication education group and is just beginning to offer Mood Matters and Express Yourself after training staff. As noted above, TF-CBT has been implemented and is offered on both the female unit and the male residential mental health unit. DBT is also offered on the female unit.

The move of the female population to a different unit has continued to help bring order and structure to that unit. But it must be added that unit staff are also working much more effectively and activities and groups seem to be occurring more reliably.

VYCF is no longer using a formal integrated treatment plan for the residential mental health. They report that the format was not useful; they plan to return to an integrated plan once a better format is created. Treatment plans are better integrated with case plans – there has been good progress here, especially on the female unit. There are more often clear targets for therapy and measurable goals. Notes reflect implementation of the approach specified in the treatment plan in most cases. As before, the number of quality case formulations continues to grow and is now present in most cases. However, it is not brought forward with the treatment plan so is not as readily available.

Psychotropic medication management continues to be sound. Coverage has not been an issue during this audit period with notes being done timely.

The timeliness of case plans has improved. As noted above, there is greater integration between the case plan and the treatment plan, though the case plans on core units and the male residential mental health unit lag somewhat behind the female unit. There continues to be evidence that the mental health issues of youth in residential mental health settings are being considered during case planning. There were no instances where there was inconsistency between the treatment plan and case plan and in a substantial minority of cases, they were well-integrated. But case plans remain fairly generic in most instances but attention to stages of change and specific skill development are beginning to appear more regularly. There is evidence of greater attention to progress related to goals but this has not resulted in any substantial changes in plans as progress is almost always indicated, though not always clearly supported by documentation.

Mental health staff are almost always represented at case planning meetings on the residential units.

Youth have growing awareness of the goals of their case and treatment plans. In some cases, they had a robust understanding of what they were working on and why. The continued improvement in this area is an important marker of the success of the program and the growing sophistication of the staff.

<u>Outpatient (Core Unit) Mental Health Treatment</u>

Psychologists' treatment plans for youth on core units were more numerous. While a small number of youth are receiving active psychotherapy, it is at a reasonable level at this time. Treatment plans were also more specific and charting was related to the plans in most cases.

Case plans were more hit or miss with regard to formally addressing how mental health impacts behavior and responsivity concerns. But there was no frank inconsistency with treatment plans. They are, as noted previously on the core units, very generic but in about half of cases demonstrated clear assessment of progress related to goals (a further step up from previous audits).

Psychologists were present less 50% of the time for youth receiving mental health services on core units. This may be a sampling problem but it bears monitoring.

Substance Abuse Program
This was removed from the audit. No problems were detected with regard to the program.

CONCLUDING COMMENTS

There continues to be steady improvement in mental health services with actual implementation of structured programming on the residential units proceeding. The quality of formulations, treatment plans, and case plans continues to slowly and steadily improve. Staff and youth are both more aware of individual treatment needs and how they are to be addressed. While many case plans remain generic, the progress is evident. Some case notes are very high quality and focused on relevant issues, demonstrating real development in the understanding of the process of treatment.

VYCF is doing very well at this point. There is no reason to change course. It is now mostly a matter of seeing through the initiatives still underway and focusing on quality improvement and sustaining the gains made already.

Respectfully submitted,

Bruce C. Gage, M.D.
12/23/15

Bruce C. Gage, M.D.
Puget Sound Mental Health
General and Forensic Psychiatry

IBTM Comprehensive Summary
December 2015 Audits

Progress towards completed implementation of the IBTM continues to be strong and steady. DJJ has taken measures to address problems at NACYCF with clear progress on the fidelity of the Reinforcement System (RS). At this point, there is solid overall understanding of the IBTM throughout DJJ. VYCF continues to be especially strong but this time it is OHCYCF staff that have made a leap forward. There continues to more resistance to elements of the IBTM at NACYCF (though a shrinking minority of staff) than at the other facilities but it is not as overt and supervisors are taking appropriate measures to address this and, notably, by endeavoring to use IBTM principles with staff (see supervisor interviews regarding their coaching of the RS). The important measures of improvements related to the IBTM continue: reduction in the use of force, reduction in BTP populations, reduced crisis calls and suicide watches, and (perhaps most importantly) improved relations between staff and youth. At this point, the IBTM is the DJJ program. The cultural shift is close to complete and little could derail it as long as DJJ continues its current processes and messaging.

The quality and fidelity of the Cognitive Behavior Therapy (CBT) continue to improve. DJJ is evaluating group leaders for proficiency in a systematic and thorough manner. The work that DJJ has done around the CBT groups is laudable. The problem of too many substitute facilitators remains and is related at least in part of staffing challenges. But DJJ continues to hold groups and has effective mechanisms for tracking groups.

The fidelity to the RS is improving everywhere. The late nights are being held consistently with fewer problems with cancellations and youth disrupting it with lengthy showers. The improvement at OHCYCF is especially notable, likely brought about due to supervisors and YCOs assuring they are held and that the right youth are being offered the incentive. The staff at OHCYCF are also conducting some wonderful structured activities during late nights including game tournaments and other group activities. The youth really enjoy these and most prefer these nights to the unstructured late nights.

NACYCF has also made progress on the RS and there are no longer reports of staff giving negative checks when youth ask for positive checks. There are some staff who are not participating in administering checks (or rarely) but this is getting more isolated. They are also doing some structured activities during late nights, primarily on the weekends.

The weekly incentive (goodie locker) is working fairly smoothly at this point. The monthly incentive is still used in varying ways, often more as a unit reward than as an individual incentive which, if done properly, is a reasonable and effective approach. But it should be done intentionally and in a structured manner should DJJ choose to do so. But it should not supplant the individual incentive.

Complete training in Motivational Interviewing (MI) is to still be accomplished but the plan has solidified. DJJ currently provides an 8-hour training module on MI during its annual in-service training for all staff. While this is no substitute for the complete training, which provides a degree of skill training that cannot be done in an 8-hour training, it is certainly worth retaining and has produced some benefit. As at the last audit, some staff are using MI principles in their interactions with youth and while staff have not yet gotten to the point of routine use of these principles on the units, there is notably growth here. Staff notes and action steps are starting to include MI language. Staff are also becoming much more attentive to progress and notes read more like reports of work with the youth than reports of youth behavior.

The biggest development since the last audit was the roll out of the new Level System (LS) to replace the Youth Incentive Program (YIP). There were some substantial computer problems that disrupted the process but staff and youth worked through it remarkably well and the problems have been largely corrected. It is too early to comment on its effectiveness. But it is notable that while there has been some grumbling from the youth about the need to continue to work at higher levels and about some youth losing levels due to fighting, the clear intent and fairness of the LS as it was written seems to be carrying the day but resistance may well still emerge.

The BTP Program Guide has been completed and RS coaching and mentoring are starting to be done routinely by supervisors as well as psychologists. The case planning initiatives are being rolled out as well (addressing both the process of case planning and the content of case plans). Similarly, DJJ has started to address the intake process. There are already improvements in the initial meetings with youth (which are no longer referred to as hearings) and psychologists are crafting formulations, some of which are quite good. But the intake process and resulting formulations are not yet driving the case planning process as much as would be beneficial. Yet the growth in the quality and treatment relevance of staff notes, most notably YCCs, is clear evidence that DJJ staff is already starting to understand what case plans should address.

DJJ continues to maintain robust QA processes, recently expanding the headquarters mental health QA. There has been no indication of backsliding on these processes or on implementation of change initiative since some of the audit items have been returned to the defendant for monitoring.

Before closing, it is important to make some comments about the sustainability and durability of the IBTM. The most important point to make is that the IBTM should not be viewed as a static program. As the agency grows in its sophistication, youth populations change, and new evidence-based programs become available, the IBTM will need to change. The central principles that will allow change to occur without risking devolving into old ways are maintaining a behavioral change and learning focus and sustaining good QA practices. This is best understood as being both a cultural and a messaging issue regarding the model supported by robust and targeted QA. The IBTM will never be “done”. This is why there has been so much emphasis on developing core structural elements such as the CBT groups, RS, and LS and on QA. The core elements serve to drive cultural change by giving staff (and youth) direct experience with the model. They learn through doing and coaching just as the youth must

practice their skills. And just as the youth can always get better, so can the IBTM. But once the agency has the core structural elements well in hand and has well-established QA, they are ready to be on their own. Greater refinement in case planning will come of its own as staff deepen their own understanding and develop their common language even further.

I do not have substantial concerns about most of the items remaining PC at this point as they reflect the stage of growth that the agency should demonstrate at this point. For as long as the core structures are tended, the model is messaged, and the QA continues, DJJ will continue to develop the program – and it will become ever more its own, with all of the pride and passion that attends a proud owner. But these are not things that require a monitor. It is now the will of leadership that will be the sustaining force. And in order for this to be real, they must be free to take complete ownership of their own program. They will be able to take it further than any external monitor could hope to.

Respectfully submitted,

Bruce C. Gage, M.D.