SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	)	CASE NO. RG03079344

TWENTY-SEVENTH REPORT OF THE SPECIAL MASTER

Nancy M. Campbell, Special Master
John Chen, Deputy Special Master
Virginia L. Morrison, Deputy Special Master
56 East Road
Tacoma, WA 98406
253-503-0684
nancy@nmcampbell.com

TABLE OF CONTENTS

APPENDICES

I. INTRODUCTION

The Special Master submits for filing the Twenty-Seventh Report of the Special Master. The sixth comprehensive report of the Sexual Behavior Treatment Expert (site visits March 2013) was reviewed in the Special Masterôs twenty-sixth report. The Sexual Behavior Treatment Expertôs addendum to the sixth round of audits (site visit August 2013) and comprehensive report is reviewed in this report and is attached as Appendix A. This report also reviews the *Farrell* Safety and Welfare Expertôs comprehensive report for his 2013 round of audits and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plan. The sixth comprehensive report of the Safety and Welfare Expert (site visits June, July and August 2013) is attached as Appendix B. Consistent with an agreement by the parties, the Special Masterôs report limits the summarization of the expert's reports and instead identifies the major areas of improvement as well as areas of concern.

The report begins with an update on the implementation of the Integrated Behavioral Treatment Model (IBTM) followed by the analysis of progress in the Sexual Behavior Treatment Program (SBTP) and a recommendation to transfer monitoring of the *Sexual Behavior Treatment Program Remedial Plan* to Defendant. Issues relating to progress in the *Safety and Welfare Remedial Plan* are reviewed, as is a proposal to transfer on-site monitoring to Defendant while retaining the services of the Safety and Welfare Expert to assist in the review of a targeted list of safety and welfare items. The report concludes with a review of items that the Special Master and the Mental Health Expert are responsible for monitoring.

II. INTEGRATED BEHAVORAL TREATMENT MODEL

A. Current Progress

The commitment to the IBTM change process is again evidenced by Defendantôs effort to ensure full staffing of the Central Office IBTM Team. During this reporting period, the Training Officer, Instructional Designer and an Associate Government Program Analyst/Staff Service Analyst (AGPA/SSA) were hired to bring the team to its full complement.[1] Three re-directed Youth Corrections Counselors (YCC) returned to their regular duties.[2] The rotation of line staff into the team is an excellent method for exposing staff members to the concepts and mission of the IBTM. Having come directly from working in facilities, they have credibility with their peers and can become resources when they return to operational roles.

The revised mission and vision has been sent out to all staff and while posted throughout the facilities, there is little indication of its integration into training materials, policy and procedures and communications. Defendant is encouraged to continue to use the mission and vision to help staff understand the purpose of the IBTM and how it must be implemented.

O.H. Close Youth Correctional Facility (OHCYCF) IBTM Audit

Having OHCYCF as the pilot site for the Cognitive-based Behavioral Treatment (CBT) implementation enabled the Mental Health Expert to fully assess this component of the IBTM in his first IBTM audit. Defendant and the Mental Health Expert worked for several months to develop a reliable and informative audit process for the IBTM. OHCYCF was chosen as the first site for the audit because it had fully implemented the

[1] *See* A.O 2.1, 2.2 and 2.3 e-mails verifying the hiring of staff to fill these positions.
[2] Director Minor has indicated that he would like to continue with staff rotations to provide opportunities for lower-level staff to better understand the reform efforts.

CBT groups, Introduction to Treatment, Skill of the Week and Advanced Practice. Many staff have also been trained in Motivational Interviewing (MI).

The Mental Health Expert interviewed staff and youth. The Special Master team joined the Mental Health Expert in meetings with the IBTM Central Office Team and facility staff as well as engaged in facility and file reviews. A team of auditors from the California Department of Corrections and Rehabilitationôs Office of Audit and Court Compliance (OACC) observed the audit process and participated in file reviews. The Mental Health Expertôs report found that Defendant is doing a good job of moving from a culture of a largely singular focus on accountability, control and remorse to one of attempting to promote behavioral and cognitive change that develop the skills needed to reduce criminal behavior. The culture change is evidenced in many ways including consistent intervention (CBT groups) delivery, youth intervention completion rates, lack of grievances, increased school attendance, youth feeling safe, greater interaction between youth and staff (as evidenced by observation and youth interviews), and a reduction in violence and use of force.

No facility has fully implemented the Reinforcement System (RS) and modifications to the level and case management systems required for full implementation of the behavior management system. The Mental Health Expert did review these IBTM components at OHCYCF and will provide feedback about them. As expected, the compliance ratings are higher for the implementation of the CBT groups than for elements of the behavior management system.

Implementation of the IBTM at N.A. Chaderjian Youth Correctional Facility (NACYCF) and Ventura Youth Correctional Facility (VYCF)

The IBTM administrative committee for both facilities meets consistently and demonstrates strong oversight of the implementation at NACYCF and VYCF.[3] With few exceptions, all of the 28 deliverables for the first five months have been completed.[4] Deliverables for the next six months are well underway. The committee continues to process a high volume of work and responds quickly and thoughtfully to the questions and concerns of the implementation units. Excellent meeting management and record keeping ensure there is not a significant delay when process changes are needed.[5] The team has created thoughtful plans to ensure training of staff at the two high core units, McCloud and Owens at NACYCF, and El Mirasol and Mira Mar at VYCF. All units are in the early stages of implementation.[6] Similarly, the implementation committees for each facility are functioning relatively well as are the other key committees.[7]

The following procedures have been finalized:

- clinic procedures to determine placement of youth.
- dosage for interventions.[8]

Evidence of the implementation of the youth placement procedures and the dosage for interventions is clear. Youth are being assessed for placement by using the California

[3] The Special Master periodically joins the administrative weekly committee meetings by phone and reviews agendas and products prepared for the meetings. The committee staff members are very forthcoming and share challenges and issues with the Special Master.

[4] *See* the Twenty-Seventh Report of the Special Master Comprehensive Guide with Deliverables (final) (2)(r). Exceptions include ensuring the IBTM overview is provided to all staff; processes for questions/answers (QA) for mental health and SBTP services, entrance and exit criteria for specialized programs, and protocols for a youth advisory council are not completed. All of these items are underway.

[5] For examples of meeting minutes of the administrative committee see AO 8.15 Meeting Minutes dated 6-16-13 and AO 8.19 Meeting Minutes dated 7-15-13.

[6] Unit implementation for both sites began July 1, 2013.

[7] The other committees include: Assessment/Case Planning, Behavior Management, Quality Assurance, and Treatment/Scheduling. Some of the facility committees appear to meet more consistently and complete more deliverables. That said, having facility staff run committees is a key step to ensuring ownership and is an excellent training strategy. This conclusion is reached by reviewing committee meeting minutes for this reporting period.

[8] *See* ACP 7.1 Clinic Procedures to Determine Initial Placement of Youth Final 06-30-13 and Intervention Criteria Form.

Youth Assessment Screening Instrument (CA-YASI). Dosage for interventions is determined by program placement. The guidelines are as clear as can be expected with the level of understanding that can be provided by todayôs risk and needs tools and other assessments.[9]

The implementation of the CBT groups (also referred to as resource groups) continues to be timely if not somewhat uneven. One of the greatest challenges for Defendant is to ensure the timely and consistent scheduling of the groups. In the past, Defendant has had a model of YCCs delivering groups of their choice. There were no evidence-based curricula and the quality of content, delivery and timing varied within and between units in a facility as well as across facilities. One of the key findings of the meta-analyses of programs that result in behavior change in youth and ultimately reduce recidivism is the need for fidelity to the program curriculum and this includes the sequence and timing of content delivery. It is essential that once started, a group is delivered consistently and in the sequence identified by curriculum designers. Hence the key measures of quality assurance include the groups being held timely, in sequence and the youth actually completing the series.

Early indicators of the implementation of the CBT groups at VYCF are promising. The girls unit, El Toyon (ET), has had no group cancellations for May, June and July.[10] This is particularly impressive considering the girls unit has more groups than

[9] The science of risk and need is not refined enough to only provide broad parameters for issues like program placement and dosage. Defendant is using current technology well and has to rely on professional judgment for circumstances when the data from assessments or research on dosage are not sufficiently clear.

[10] Data in this section is derived from the report, Group Data as Reported in Casework Monthly Reports, review of unit meeting minutes and in some instances, on-site interviews with youth and staff.

any unit in any facility.[11] Similarly the VYCF Behavior Treatment Program (BTP) has had no group cancellations for June and July. In contrast, San Joaquin's, (the NACYCF's low core unit) only data from July indicate one CounterPoint (CP) group had no cancellations in that month but Anger Interruption Treatment (AIT) had four out of 13 groups, almost a third of the groups cancelled. There is no data for August. There is no data for July or August for Toulumne, the intake unit, or for Kern, the Behavior Treatment Unit.[12] The implementation of the CBT groups at NACYCF appears to be struggling and Defendant is advised to provide the needed support to rectify this situation as soon as possible. OHCYCF continues to demonstrate consistent delivery of CBT groups.[13] The IBTM Administrative Operations committee is reviewing this issue and in the process of modifying the policy for group cancellation and make-up sessions.[14]

A challenge for the new sites is the introduction of the revised behavior management system at the same time as the CBT groups. Staff at OHCYCF had to focus only on implementing the groups as the RS was introduced to all facilities after the introduction of groups at OHCYCF. Again, there is evidence that VYCF is faring better in this regard. The girls unit and the BTP at VYCF have clearly adopted the RS. Both staff and youth accurately describe how the system works and there is ample

[11] In addition to AIT, CP, Pre-treatment, Skill of the Week, Advanced Treatment, Substance Abuse and Reentry, the girls unit provides Girls Moving On and Dialectical Behavior Therapy.

[12] A site visit to the Kern BTP in August 2013 unit by the Special Master suggests that few, if any, treatment groups have been provided on the unit because, despite having ample staff trained, only one staff person is delivering the groups.

[13] The BTP units are included because the IBTM Central Team has designed resource groups specifically for the BTP units. VYCF and OHCYCF are delivering these interventions. The Kern BTP unit is not delivering the intervention. Ample staff members are trained but are not facilitating the groups. This situation should be rectified immediately.

[14] *See* IBTM-Administrative Operations Committee 8-20-13

documentation to support their claims.[15] In fairness, the Mental Health Expert worked with the VYCF BTP for almost a year to help them design and to implement their RS so it is understandable that they have a deep and rich understanding of the RS. In contrast, the NACYCF units appear to be significantly less familiar with the concept; documentation was at best uneven and youth and staff frequently indicate a haphazard approach to delivery of reinforcers.

Implementing a program that requires a significant role change for staff is often difficult in the early stages and the problems identified at NACYCF are not surprising. It is somewhat surprising that NACYCF, that has the distinct advantage of having the IBTM Central Office Team readily at hand, is showing poorer results than VYCF that relies primarily on two staff members (one of whom is a full-time Program Administrator) to support the change efforts. It does appear that senior leaders at NACYCF need to spend more time with unit staff to help them understand both the ñwhyò behind the changes and to model what the change should look like.

Both the Special Master and the Safety and Welfare Expert have talked with various staff on these implementation units and have found clear evidence of beginning understanding of the process. As in the past, there is skepticism on the part of some staff. Such skepticism is understandable, healthy and a normal part of the change process.

The Special Master was impressed with first-line and mid-level managers' understanding of the process at Owens, a high core unit at NACYCF.[16] The Senior Youth Correctional Counselor (SYCC) and Treatment Team Supervisor (TTS) both

[15] The documentation of the system in both units is clear. The BTP also has an excellent system for inventory control of the ñgoodie closetò or incentives to ensure consistency in delivery and that the resources actually go to the youth. There are examples of resources for youth being diverted by some staff. The Special Master encourages the dissemination of this system to all units.

[16] The Special Master visited the unit in August 2013.

demonstrated a strong conceptual understanding of the IBTM. First-line and mid-level managers from the NACYCF implementation units have all completed the IBTM overview and Skill of the Week training and many have completed the full AIT course. Having this training ensures the unit leaders can model and coach desired changes for their staff. In contrast, VYCF has not trained all of the SYCC and TTS staff. Given the rotation of staff at the facilities, it is not wise to wait to train just the management staff involved with an implementation unit. All management staff needs to understand the theory and vision of the IBTM. One critical step is to engage them in the basic training about the IBTM philosophy and its interventions.[17]

If the level of training of staff is an indicator of the speed at which adoption of the IBTM will occur, NACYCF should move ahead quickly. Much to the surprise and disappointment of the Special Master, training records indicate that VYCF's mid and senior leaders are not trained in either the principles of the IBTM or the CBT where one finds the critical intervention content.[18] (See table below) It may also explain why VYCF has struggled in areas such as school attendance, higher rates of violence and use of force than the other facilities. It is hard to imagine how managers can model the IBTM if they have not been trained in it or how they can possibly perform quality ñassurance functions properly. It is equally difficult for the Special Master to understand why the Central

[17] Twenty-one of 23 staff members who completed the IBTM overview training at VYCF are from two units ï ET (15) and Mira Mar (MM) (6), two IBTM implementation sites. The managers of these units are to be congratulated for ensuring their staff is trained. In contrast, the senior leadership of the facility has clearly not understood the necessity of having management staff have at least a basic understanding of the IBTM by ensuring their attendance at a minimum the IBTM overview, Introduction to Treatment and the overview of AIT. Failure to train managers in MI is a huge missed opportunity to change the VYCF culture.

[18] Positions considered mid and senior management include Superintendent, Assistant Superintendent, Program Administrators, Supervising Case Work Specialists, and TTSs. Core programs include the IBTM Overview, Introduction to Treatment, MI and AIT, Core Correctional Practices (CCP) and RS. The one exception to this at VYCF is the ET, girls unit where training completion rates are excellent. *See* 28.3 ET Training Needs and Completion.

Office has allowed this situation to occur. In contrast, NACYCF has a higher percentage of mid and senior-level leaders trained in some or all of the core IBTM programs.

IBTM Training Completion[19]

IBTM Overview

Classification	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	1	100%	3	1	33%
Treatment Team Supervisor	4	3	75%	4	3	75%	4	1	25%
Senior Youth Correctional Counselor	6	4	67%	9	8	89%	9	2	22%
Casework Specialist	4	3	75%	11	11	100%	4	2	50%
Parole Agent I	10	9	90%	11	7	64%	12	0	0%
Youth Correctional Counselor	52	40	77%	92	30	33%	124	17	14%
Totals	76	59	78%	128	60	47%	156	23	15%

Introduction to Treatment

Classification	OHCYCF			NACYCF			VYCF[20]		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	1	100%	1	1	100%
Treatment Team Supervisor	4	0	0%	4	0	0%			
Senior Youth Correction Counselor	6	0	0%	9	3	33%	1	1	100%
Casework Specialist	4	1	25%	11	5	45%	2	2	100%
Parole Agent I	10	6	60%	11	4	36%			
Youth Correctional Counselor	52	3	6%	92	19	21%	10	9	90%
Totals	76	10	13%	128	32	25%	14	13	93%

[19] Data were derived from the facilitiesô training summaries forwarded by the IBTM Program Administrator to the Special Master via two emails on September 16, 2013.

[20] Facility data only include training provided to staff at ET unit. It is likely that staff in other living units received very little such training.

AIT

Classification	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	1	100%	3	0	0%
Treatment Team Supervisor	4	3	75%	4	2	50%	4	0	0%
Senior Youth Correctional Counselor	6	5	83%	9	7	78%	9	4	44%
Casework Specialist	4	4	100%	11	2	18%	4	0	0%
Parole Agent I	10	9	90%	11	8	73%	12	4	33%
Youth Correctional Counselor	52	49	94%	92	55	60%	124	48	39%
Totals	76	70	92%	128	75	59%	156	56	36%

Counterpoint

Classification	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	1	100%	3	3	100%
Treatment Team Supervisor	4	0	0%	4	3	75%	4	2	50%
Senior Youth Correctional Counselor	6	6	100%	9	5	56%	9	4	44%
Casework Specialist	4	3	75%	11	9	82%	4	2	50%
Parole Agent I	10	7	70%	11	6	55%	12	2	17%
Youth Correctional Counselor	52	41	79%	92	28	30%	124	32	26%
Totals	76	57	75%	128	52	41%	156	45	29%

Skill of the Week

Classification	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	1	100%	3	1	25%
Treatment Team Supervisor	4	4	100%	4	4	100%	4	1	25%
Senior Youth Correctional Counselor	6	4	67%	9	9	100%	9	2	22%
Casework Specialist	4	2	50%	11	10	91%	4	2	50%
Parole Agent I	10	6	60%	11	8	73%	12	1	8%
Youth Correctional Counselor	52	22	42%	92	78	85%	124	23	19%
Totals	76	38	50%	128	110	86%	156	30	19%

Advanced Practice

Classification	OHCYCF			NACYCF			VYCF		
	Staff	Trained	%	Staff	Trained	%	Staff	Trained	%
Supervising Casework Specialist				1	0	0%	3	0	0%
Treatment Team Supervisor	4	0	0%	4	0	0%	4	0	0%
Senior Youth Correctional Counselor	6	2	33%	9	2	22%	9	0	0%
Casework Specialist	4	3	75%	11	0	0%	4	0	0%
Parole Agent I	10	6	60%	11	4	36%	12	0	0%
Youth Correctional Counselor	52	7	13%	92	10	11%	124	0	0%
Totals	76	18	24%	128	16	13%	156	0	0%

Other Classifications Required to Attend Training

IBTM Overview

Classification	Stockton Complex[21]			VYCF[22]		
	Staff	Trained	%	Staff	Trained	%
Education Staff	180	100	56%			
Mental Health	20	15	75%			
Senior Psychologist	3	2	67%			
Staff Psychiatrist	1	0	0%			
Lieutenant	9	4	44%			
Sergeant	19	7	37%			
Totals	232	128	55%			

Skill of the Week

Classification	Stockton Complex			VYCF[23]		
	Staff	Trained	%	Staff	Trained	%
Mental Health	20	13	65%			
Senior Psychologist	3	2	67%			
Staff Psychiatrist	1	0	0%			
Totals	24	15	63%			

The Special Master recognizes that proximity makes it easier for NACYCF to get staff trained but in light of the availability of training provided to VYCF, she does not believe this is the entire reason for this notable difference. The leadership at NACYCF demonstrate an understanding that training is vital to engage staff in reform efforts.

[21] Staff members in these classifications are combined for the Stockton Complex.
[22] VYCF did not furnish this data. However, based on the training record of other classifications, it is likely very few, if any, of staff members in these classifications received training.
[23] *Ibid.*

Training is a vital component of successful change initiatives. Trained managers are essential to culture change. The Special Master encourages Defendant to schedule facility mid and senior managers to attend not just the overview sessions but also the full CBT programs. Leaders need to fully understand the program content if they are to provide needed coaching, mentoring and quality assurance functions. It is also possible that not having the University of Cincinnati Corrections Institute (UCCI) staff actively engaged with the launch at the two facilities has been detrimental. The Special Master encourages more active participation of the UCCI consultant team.

Progress in implementation of the CBT groups in NACYCF and VYCF is going well. Quality assurance efforts for these groups will be hampered by the failure to have the supervisors and managers responsible for these tasks trained in the programs they are ostensibly assessing. The Special Master encourages Defendant to have all first-level through senior managers trained immediately in the same classes that are being provided for line staff.

Case Management Process

Case planning is another matter. Both the Mental Health Expert and the Special Master have opined that there really is no case planning system in DJJ.[24] Ample risk and needs information is collected but rarely incorporated into any type of meaningful plan. The facilities have different labels for plans ranging from the case conference (actually an activity and not a plan) to the Individual Treatment Issues (ITI) to some very creative homegrown versions made by individual staff out of frustration at not having a

[24] The Special Master has commented on challenges with the case management system in past reports and the Mental Health Expert raised concerns at the exit conference for the OHCYCF IBTM audit. There are elements of case planning but no *system* that is consistently used.

meaningful case plan.[25] Most of the staff really do not understand what a meaningful case plan looks like and if they do, they do not record it anywhere that can be shared by unit staff.[26] And most confusing is the fact there does seem to exist a relatively good case plan that Defendant has purchased along with the CA-YASI. Why this plan is not used is indeed puzzling.

The critical failure in the case planning process is the inability of staff to translate the high level CA-YASI data into meaningful behavior targets with the youth. The case plan is done to the youth, not with the youth and that, of course, seriously limits its impact.[27] There are typically no behavioral targets for change but a list of activities that the youth should engage in. Most typically, these include attending victims awareness group, education or vocational programs, no Disciplinary Disposition Management System (DDMS), attending groups and perhaps something about not fighting or being aggressive.[28]

The confusion is best articulated in the fact that the staff members refer to the case plan as the case conference. The activity is believed to be the plan. Indeed the only place one finds evidence of what is anything akin to case planning is in the case conference document that records what happened in the case conference. There is good news in that it appears that case conferences are beginning to take place according to

[25] The Special Master observed a version made by a YCC in one of the BTPs that is better than anything she has seen in any of the many formal attempts made by Defendant.
[26] Frankly, given the high level of education of most of the Parole Agents and Case Work Specialists, this is simply baffling.
[27] It should be noted that this may not be the current process at the intake unit. The Special Master has not observed this unit recently. Interviews with youth and staff as well as the way case plans that exist are written make it clear that the process does not fully engage the youth.
[28] The Special Master is unclear whether the Victim Awareness Group was approved by UCCI. She has asked that UCCI review the content of this group and process (which appears to be some variant of restorative justice concepts) to determine if it is consistent with the principles and philosophy of the IBTM.

schedule more than in the past.[29] The bad news is that the structure of the process and the potential value of the outcome vary significantly.[30]

A thoughtful protocol for case planning is in development by the Central IBTM Team. The proposed guidelines for case planning are a step in the right direction.[31] The Special Master encourages Defendant to include the five skill sets identified in the original IBTM order in any guidance provided to staff. The skill sets are:

- Interpersonal/Social
- Stress Management
- Self Regulation
- Self-Monitoring
- Cognitive-Thinking

Behavior Management

In July of 2012, Defendant introduced a reinforcement system through its block training process. The training process reflected a lack of understanding of the concept and application of reinforcement by the trainers.[32] After the initial implementation period, Defendant assessed the implementation progress and found it to be unsatisfactory. Further inquiry resulted in the conclusion that the system was too complex. Consultation between the Mental Health Expert and the IBTM Central Office Team resulted in a simplified RS that is scheduled for implementation in November 2013.

[29] This conclusion is reached from a recent review of the BTP program files and some high core unit files. Case conferences are being held quite consistently in some units. This is a significant improvement from the past.
[30] The IBTM Administrative Team is working on the structure of the case conference.
[31] *See* ACP 13.5 Case conference written protocol and QA document 5-8-13 and ACP 12.3 Development of a written protocol to assist in coaching and mentoring staff in effective case planning.
[32] Twenty-Sixth Report of the Special Master, p. 8. This is a good example of experimenting, learning and modifying in a change process. Defendant did not just implement the RS and assume it was going well. Through monitoring, they determined the system required modification and worked to devise a better system.

Defendant has developed a thoughtful RS on-the-job-training (OJT) module that will be provided to all units.[33] The draft training is well done and provides useful information and support to staff about reinforcement strategies and procedures. A presentation, ñShaping Behaviorò has also been created to assist staff with the concept of how to use reinforcers to shape behavior.[34] The Shaping Behavior module is excellent. It provides concrete examples of how to define behavior targets. It is the type of training that will help staff help youth to identify concrete action steps that can be codified in a case plan.

Staffing Structure

One of the greatest impediments to implementing a more effective case management system is the current staffing model of the units. Corrections agencies have historically struggled with how to integrate the custodial (security) and treatment (program) functions. For decades, security and treatment roles were kept separate, typically resulting in confusing and inconsistent messages to incarcerated youth and adults. Many jurisdictions have moved to a model where unit staff are responsible for both functions. This is consistent with the IBTM behavior management model. Positive and negative reinforcements are used to shape behavior.

On paper, Defendantôs staffing model has a centralized security staff and unit line staffs are all ñcounselors.ò The YCC ostensibly carries a caseload and is typically responsible for a caseload of one to three youth. On the face of it, this makes sense, as the YCC is the person the youth interacts with the most in the unit. The problem is the Parole Agent (PA) or the Case Work Specialist (CWS) is the only unit member trained in

[33] Proof of practice 971 was provided to experts and the Special Master for review on September 10, 2013.
[34] BMS 8.8 Shaping Behavior (Draft) 7 12 13(6-10).

interpretation and use of the CA-YASI and creates the case plan. The YCC rarely attends the case conference where the progress of the youth is discussed. The case conference is typically led by the PA/CWS and attended by the SYCC, TTS and if available the supervising YCC. The latter rarely attends because case conferences are held to meet the schedules of the managers and PA/CWS not the YCC.[35] Without a well-documented case plan, it is nearly impossible for the YCC to understand through the Ward Information Network (WIN) or written record what is or is not the progress of a youth on his or her caseload. Further exacerbating the problem is the fact that the SYCC, TTS and sometimes the Program Administrator and/or Psychologist, but again typically not the YCC, attend the weekly unit meetings in which youth are reviewed.

Notably, what is well documented in both the WIN, the electronic record system, and the field file, the paper record, is the history of DDMS. While there is almost no meaningful treatment discussion in case notes or the case conference reports (typically the only facsimile of a case plan), there is detailed and well-documented history on disciplinary violations.[36] This is not surprising because prior to the IBTM, the primary measure of progress for a youth was solely the lack of disciplinary issues. Accurate behavioral descriptions of disciplinary problems and follow-up should continue but be complemented by the same for progress in positive skill and target behavior acquisition.

There is no policy or procedure that frames how often a YCC is to meet with the youth on his caseload, what they are to do in such meetings and no structure for the YCC

[35] This is further complicated by the fact that there is not a SYCC seven days a week on the morning and afternoon shifts.

[36] One notable exception in case file notes is the description by group facilitators of what they worked on in their group. There is growing documentation of the group content with the occasional reference to the participation of the actual youth whose file the case note is in. This is a positive trend. Defendant should encourage YCCs to specifically note the individual youth behavior in addition to the description of the general information and/or activities.

and PA/CWS to partner to mutually develop or at a minimum to share understanding of meaningful behavioral targets for the youth are. Much like the days of when YCCs led whatever resource group they had an interest in, YCCs determine what they will discuss with youth, when they will do it and how often. There is no system of any nature for any level of oversight or accountability regarding what a YCC does with his or her caseload.

In short, the YCC is somehow expected to help the youth without being a party to case plan development, individual or unit progress review. It is analogous to asking a line worker to assemble a computer without any directions. The supervisor who has no reliable method of sharing the directions is the only person who has access to them. The structure of this system is a recipe for confusion and frustration for the youth and staff.

It is actually quite amazing that the implementation of the CBT groups at OHCYCF is having such a significant impact on key program outcomes (these are discussed in section III, Safety and Welfare) given the incredible impediments that the staffing structure creates in achieving a consistent message to a youth about what he or she must do to develop desired skills and behaviors. The fundamental key to shaping behavior is consistency of reinforcement of desired behavior. Consistency is achieved only when all unit line and management staff share an understanding of what a youthôs behavioral targets are, how he or she is progressing toward them and a plan for how all team members need to support the youthôs progress. This plan includes both positive and negative reinforcers.

The lack of a reliable and useful case management system combined with an inefficient and ineffective staffing structure result in a system where youth rely primarily on the SYCC for most information regarding what they need to do to progress. In reality,

with the exception of those units where YCCs are facilitating the CBT groups, the YCCs function as security staff only and not treatment staff. While the first-line supervisor is always key to unit functioning, the burden placed on SYCCs in Defendantôs system is untenable. The SYCC is responsible for basic operational functions like staff coverage and is essentially the portal for the youth for treatment. In most juvenile corrections systems, security and treatment functions are spread more evenly throughout the unit staff.

Mental Health Program

During the last reporting period, Defendant had finalized a mental health implementation plan, completed the mental health definition and had begun work on training Psychologists in the definition.[37] In May 2013, the Psychologists were trained in the level of care and intake procedures.[38] After this training, Psychologists assessed all youth in core units to determine if a youth should be transferred to a mental health unit. The determination was made that if a youth in a mental health unit did not fit the mental health criteria, the youth would be allowed to stay in the youth's current unit to prevent unnecessary disruption of his or her program. Fortunately, there were very few youth who needed to be transferred.

A criterion for entrance and exit to a mental health unit has now been finalized.[39] This criterion ensures that only youth with a mental illness and not just behavioral disorders are transferred to a mental health unit. One of the challenges for any mental health unit in a juvenile corrections institution is preventing the transfer of youth to a

[37] Twenty-Sixth Report of the Special Master, p. 12. *See* MH Def OSM 9-18-13019 for an overview of the entire MH implementation plan.
[38] *See* LOC OSM 9-18-13020 and Intake OSM 9-18-13021.
[39] *See* Proof of Practice 963 and MH E&E OSM 9-18-13022.

mental health unit who have challenging behaviors but who are not truly mentally ill. Staff who do not know how to respond to the more exasperating and difficult behaviors often look to mental health as a resource for behaviorally challenging youth. The new definition prevents this and understandably has created concern among staff in core units. Mental health staff will be challenged to provide support to core unit staff for highly disruptive youth. The team is working on a proposal to have the Psychologists in the core and BTP units be better prepared to assist unit staff in developing intervention strategies for the more challenging youth.

The mental health task force has been exploring what evidence-based treatment programs exist for mentally ill youth.[40] The task force is working with the Mental Health Expert to assess and choose treatment modalities. In addition, work has begun on modifying mental health policies. The Mental Health leadership has also done an excellent job of getting Psychologists into basic IBTM training.

A. Next Steps

1. IBTM Audit Process

The Special Master is working with the Mental Health Expert to propose a schedule for the IBTM audits of NACYCF and VYCF. Unlike OHCYCF, the pilot institution for the CBT groups, NACYCF and VYCF will be audited prior to full implementation of the groups. The Special Master and the Mental Health Expert have agreed that the audit will only be done on the units that have begun implementation of the groups. As with OHCYCF, the behavior management and case management system changes will not be fully implemented at the time of the audits. The Special Master and

[40] *See* Evidence Based OSM 9-18-13023.

the Mental Health Expert believe the audit for NACYCF should be completed no later than November 2013 and January 2014 for VYCF.

2. Case Management

The IBTM Central Office Team and the IBTM Administrative Committee are developing plans to revise the current case management system. Defendant is encouraged to receive feedback from the Mental Health Expert, the UCCI consultants and any other relevant experts regarding how to improve the case management system.[41]

3. Training

Defendant should move immediately to ensure that all senior leadership is trained in the fundamentals of the IBTM and as soon as possible have them attend the full training of the CBT interventions. The principles of the IBTM require changes in the supervisory methods used by many managers, not just changes in the function and role of line staff. Defendant leadership cannot effectively model the principles of the IBTM or assume quality assurance functions effectively without such training. Further, Defendant should consider some form of group quality assurance and program management training for supervisors and managers. Managers need support to understand how to use unit and facility data to better assess compliance with the IBTM.

4. Staffing Structure

Defendant has persevered through another frustrating contracting process to hire a consultant to review the current unit staffing structure.[42] The Special Master encourages Defendant to include the Mental Health Expert and the UCCI consultants in this work.

[41] Defendant may want to consider including the contractor who provided the Effective Case Work training series in these discussions.

[42] This should be distinguished from the current staffing business rules. The business rules control areas such as medical, education and support functions that are included in the discussion of unit management.

5. Mental Health Program

Defendant needs to identify the treatment modalities for the mental health units as soon as possible and develop a plan for implementation. The research on evidence-based mental health programs for juvenile offenders is limited. Defendant is well staffed and equipped to make these decisions in consultation with the Mental Health Expert.

III. SEXUAL BEHAVIOR TREATMENT PROGRAM

The Special Master reported on the sixth round of compliance monitoring by the *Farrell* Sexual Behavior Treatment Program (SBTP) Expert in her twenty-sixth report.[43] The SBTP Expert, Dr. Barbara Schwartz, opined in her sixth comprehensive report that Defendant had achieved substantial compliance for two rounds at both facilities and the Central Office.[44] Dr. Schwartz concluded four audit items must come into substantial compliance[45] before she could recommend transfer of monitoring to Defendant.[46]

Three of the four items requiring substantial compliance stemmed from problems with turnover in Psychologists that resulted in poor group facilitation and a failure to adhere to the Program Guide.[47] Defendant sent Dr. Schwartz follow-up data documenting that the Psychologist positions had been filled and groups were being held pursuant to the Program Guide. Defendant also established additional quality assurance measures to ensure that services delivered were meeting professional standards.[48] Pursuant to an agreement by the parties, the expert made a site visit in August 2013 to observe group

[43] Twenty-Sixth Report of the Special Master, pp. 13-22.
[44] *Ibid*, p. 14.
[45] The items are: Central Office 8.1.1, NACYCF 4.4.4 and 4.6.4 and OHCYCF 4.13.2.
[46] *Ibid*, pp.15-16.
[47] *Ibid*, p.15.
[48] *Ibid*, p. 16.

facilitation, review staffing and to ensure that community committees existed at OHCYCF and were youth developed and driven.

Dr. Schwartz opined in her review of her group observations that ñAll of the groups that I observed were well run, incorporating the principles of successful group therapy.ò[49] She indicates that Defendant has created a state of the art program that may serve as a model for the country.[50] Via e-mail, Dr. Schwartz confirmed that Defendant is in full substantial compliance.[51] The Special Master recommends monitoring for the *Sexual Behavior Treatment Program Remedial Plan* be transferred to Defendant.

IV. SAFETY AND WELFARE

The Safety and Welfare Expert, Dr. Barry Krisberg, conducted a full round of site audits between June 2013 and August 2013. Data referred to as ñthe sixth roundò indicates this time period unless otherwise specified. Dr. Krisberg provided a draft of his comprehensive report to the parties and the Office of Special Master for feedback on September 15, 2013. The final comprehensive report for the sixth round of site visits is attached as Appendix B.

Dr. Krisberg used both objective and subjective measures to assess Defendantôs progress in achieving the purpose and intent of the *Safety and Welfare Remedial Plan*. The Safety and Welfare Remedial Standards and Criteria (ñstandards and criteriaò), developed by Defendant and Plaintiffôs counsel and approved by all parties, provide one measure of progress. During the past rounds of audits, the Safety and Welfare Expert used these standards and criteria to audit the DJJ facilities and the Central Office.

[49] SBTP DJJ AUDIT REPORT Aug 2013(2).
[50] *Ibid.*
[51] *See* Schwartz e-mail approval.

The Safety and Welfare Expert also used other quantitative data to assess Defendant's progress. These data include "Facility Safety Data" that are compiled in Defendantôs Computer Static (CompStat) system and the Performance-based Standards (PbS), a nationwide database that collects data on numerous outcome measures in two collection cycles each year. In addition, Dr. Krisberg made qualitative assessments of the progress of Defendantôs remedial efforts through personal observations during his site visits, interviews of youth and staff, and review of quantitative data.

Consistent with an audit protocol developed prior to the fourth audit round, the OACC conducted a pre-audit of each of the facilities and Central Office prior to the expertôs site visit. The OACC report assigned a rating for each audit item identified in the standards and criteria with explanation and rationale to support its ratings. The Safety and Welfare Expert and the Special Master reviewed and analyzed the OACC reports and spot-checked the data to assess the validity of the assigned ratings. Citing progress made, Dr. Krisberg, in his comprehensive report for the fifth audit round, transferred to Defendant most monitoring responsibility for the Central Office, the OHCYCF, and the NACYCF. Dr. Krisberg retained full monitoring responsibility for the VYCF. Therefore, during the sixth audit round, the scope of his review and the procedures applied at the Central Office and at the two facilities in the Stockton Complex were more limited in comparison to his review at VYCF.

A. Findings Overview

The Special Master agrees with Dr. Krisbergôs key findings and observations. In summary, Dr. Krisberg found:

- All three DJJ facilities and the Central Office have attained substantial compliance with the remedial plan requirements as measured by the standards and

criteria. OHCYCF and the Central Office have achieved the overall percentage of items in substantial compliance of 85% or greater in three successive audit rounds and NACYCF in two successive audit rounds. OHCYCF and the Central Office achieved an overall compliance rating of 100% during the sixth audit round. NACYCFôs overall percentage increased from 87% in the fifth round to 98% in the sixth round. At VYCF, the overall percentage was impressive but a bit lower at 84% and 90% in the fifth round and the sixth round, respectively.

- The quality of OACC audits continues to be exemplary. Of the total of 341items rated at the three facilities and the Central Office, Dr. Krisberg made 16 (4.7%) rating changes. Approximately 63% (17 of 33) of the rating changes were upgrades that occurred as a result of additional documentation and change in facility practices after the initial OACCôs audit and the expertôs qualitative judgment. One item (6%) was changed from ñnot applicableò to ñpartial complianceò and one item (6%) was changed from ñnot applicableò to ñsubstantial complianceò based on his qualitative judgment. One item (6%) was changed from ñpartial complianceò to ñnot applicableò and two items (12%) were changed from ñnon-compliantò to ñnot applicableò because the Safety and Welfare Expert believes the Mental Health Expert should reassess the criteria for determining compliance as a part of his IBTM monitoring responsibility.

- Based on the Central Office and the facilitiesô overall compliance ratings and his high degree of confidence in the quality of OACC audits, Dr. Krisberg suggests there is no longer a need for him to conduct further site visits and recommends transfer of monitoring responsibility to OACC based on the standards and criteria for all facilities and the Central Office. Dr. Krisberg also suggests that many provisions of the standards and criteria are outdated and recommends Defendant update them by incorporating outcome measures to assess performance and by eliminating non-value-added items.

- Although Defendant has achieved substantial compliance as measured by the standards and criteria, Dr. Krisberg has identified a number of outstanding issues that require more focused monitoring. The outstanding issues are discussed later in this report. Some of the issues are department-wide while others are specifically related to VYCF. During the remainder of Fiscal Year 2013-14, Dr. Krisberg intends to continue to monitor some of these issues by being kept apprised of Defendantôs progress and efforts and by reviewing data and documents.

- Dr. Krisberg also suggests the Mental Health Expert and the Special Master assume monitoring of some of the outstanding issues beyond the current fiscal year. These issues are either directly or indirectly related to implementation of the IBTM, which is the responsibility of the Mental Health Expert.

- Dr. Krisberg agrees with the Mental Health Expert that the implementation of the IBTM is progressing well at OHCYCF, as youth and staff interviewed

overwhelmingly commented positively about the program. Dr. Krisberg also found that IBTM implementation efforts appear to be progressing reasonably well at NACYCF and at VYCF. As both facilities are at an early stage of implementation, Dr. Krisberg urges a more aggressive implementation schedule at VYCF as he believes successful implementation of IBTM will alleviate and address some of the outstanding issues he identified at VYCF.

- Dr. Krisberg believes successful implementation of the IBTM is the key to Defendantôs reform progress. Dr. Krisberg found that while Defendant has made progress toward achieving substantial compliance as measured by the standards and criteria, facility safety data and PbS outcome measures show there have not been significant declines in violence and fear at the facilities. Dr. Krisberg cautioned that the PbS outcome measures are difficult to interpret because the results of youth safety survey during the last collection cycle vary significantly from the results of his youth interviews. Based on a review of certain key outcomes or performance indicators, he found a slight improvement in OHCYCFôs violence and use-of-force rates but little change at NACYCF and at VYCF. However, under the ñReview of Key Indicators of the Safety and Welfare Remedial Planò section of this report, the Special Masterôs analysis suggests fairly significant improvements have been made at OHCYCF and moderate improvements have been made at NACYCF and VYCFôs use-of-force rates. The more advanced implementation of the IBTM at OHCYCF may account for the improved outcomes measures at that facility.

B. Continuing Decline in Youth Population

The Safety and Welfare Expert noted in his comprehensive report that Defendantôs youth population continued to decline throughout Fiscal Year 2012-13 ï from 948 at the beginning of July 2012 to 733 at the end of June 2013. Dr. Krisberg further noted that the youth population appeared to stabilize from April 2013 through June 2013, which fluctuated in a narrow range of 733 to 742 and increased by 3 to 736 in July 2013. In August, the youth population declined by another 17 youth to 719.[52] This is a continuation of a similar declining trend in past years and the Safety and Welfare Expert continued to express concerns about the impact on staffing, staff morale, and on the availability of resources to support reform efforts.

[52] *See* Monthly Facility Population Table, August 2013.

Since the beginning of *Farrell* reform, Defendant has invested significant resources to fund various facets of the reform efforts. To date, five of the seven *Farrell* remedial plans have either been completed or at the final stage of completion. With respect to the *Safety and Welfare Remedial Plan*, the Special Master observed vast improvement during her tenure and strongly believes that youth in Defendantôs facilities are receiving treatment and services far superior than those housed in most county facilities.[53] It is also her opinion that some counties will eventually request or be compelled to seek services from state facilities.[54] Thus, while cognizant of the need to explore all options to keep costs in line with the declining youth population, the Special Master believes it is prudent for Defendant to maintain the current facility structure to facilitate reform while preserving flexibility to meet possible future needs. Other opportunities are available to reduce costs and the Special Master and the *Farrell* expert are available to offer advice and guidance to assist Defendant in exploring cost-saving measures without facility closure.

C. Review of Key Indicators of the *Safety and Welfare Remedial Plan*

In her twenty-fourth report, the Special Master indicated that it is appropriate to begin identifying and assessing the remaining tasks Defendant needs to focus on and undertake to bring the *Safety and Welfare Remedial Plan* to completion. Given the significant progress identified in the Safety and Welfare Expertôs latest comprehensive report, it is clear that this is an opportune time for the Court and the parties to reach

[53] County facilities are designed for shorter length of stay and thus do not typically have the resources to dedicate to issues such as education and specialized treatment. Counties vary considerably and some have excellent programs while others, because of limited numbers of youth, simply cannot afford to develop programs for one or two youth.

[54] For example, most counties have so few adolescent sex offenders and services in most communities do not exist for this population that the state is one of the few places where a high quality program exists. Past roadblocks such as cost have been eliminated yet others remain such as requiring registration of sex offenders if committed to the state. Appropriately Judge are reticent to label many adolescents with this label and as such, will not commit to the state despite having no viable community alternative.

agreement on a course of action for successful completion of the *Safety and Welfare Remedial Plan*.

Before discussing specific issues, the Special Master believes it is important for the Court to understand and appreciate the vast improvement in the climate at the facilities as a result of the reform effort. In his report entitled *"General Corrections Review of the California Youth Authority"* dated December 23, 2003, Dr. Krisberg found that few of the nearly 100 youth he interviewed felt safe and noted ñIt is abundantly clear from a range of data that I collected for this review, that the YA is a very dangerous place, and that neither wards nor staff feel safe in its facilities. One might easily conclude that an intense climate of fear permeates Californiaôs state youth corrections facilities.ò During his sixth audit round, the Safety and Welfare Expert and the Deputy Special Master together interviewed a total of 99 youth at the three facilities, which represented approximately 14% of Defendantôs youth population. None of the youth expressed any significant safety concern. The Special Master and the Deputy Special Master recently conducted youth and staff interviews at all three facilitiesô Behavior Treatment Program (BTP) units and certain high core units. These units house youth with the highest risk classifications and none of the youth or staff interviewed at these units expressed any safety concern. The *Safety and Welfare Remedial Plan* noted that safety and security are the foundation of a responsible justice system and that positive change can occur only when staff and youth feel safe. Moreover, as discussed in a latter section of this report regarding use of force, there is an encouraging trend of decreasing use-of-force rates at all three facilities. Defendant facilities clearly have changed from a

climate of fear to an environment perceived to be safe by youth and staff and thus are conducive to meaningful treatment and services.

The ñDashboardò of the *Safety and Welfare Remedial Plan* identifies six ñkey indicatorsò that the parties and the Court have jointly agreed to be priority action items. In her twenty-fourth report, the Special Master discussed Defendantôs progress on each of the priority action items. In this report, the Special Master again reviews the status of each of the priority items and the progress of each item is discussed below:

> Priority #1 ï Complete the design, implementation plan, and manual for the IBTM.

As with her previous quarterly reports, the Special Master discussed in detail Defendantôs efforts and progress in IBTM implementation in Section I of this report. In line with an agreement reached with the Safety and Welfare Expert, the Mental Health Expert has assumed monitoring responsibility for the IBTM. The Mental Health Expert, assisted by the Special Master and the Deputy Special Master, conducted an audit of OHCYCFôs IBTM implementation progress and concluded ñIt cannot be overemphasized that OHCYCF has made tremendous progress in implementing the IBTM. While there is work left to do, it is clear that the process of cultural change is well underway.ò

The Safety and Welfare Expert during his sixth audit round observed and made inquiries regarding the IBTM implementation progress at each facility and agrees with the Mental Health Expertôs assessment of OHCYCF. He also noted that NACYCF and VYCF appear to be making satisfactory progress toward implementation but cautioned that it is too early to reach any conclusion at this time. The Special Master will work with Defendant and the Mental Health Expert to schedule IBTM audits at NACYCF and at VYCF.

Priority #2 ï Design and implement a successful comprehensive gang control strategy.

In her twenty-fourth report, the Special Master noted that, in response to a study by nationally known expert Dr. Cheryl Maxon, Defendant convened the Gang/Race Integration and Violence Reduction workgroup comprised of staff members of various disciplines including education, mental health, treatment, and correctional safety to study and to respond to the report recommendations. The Safety and Welfare Expert participated in the workgroup by providing guidance and direction.

The workgroup members strongly believe that the primary means to address gang and violence in DJJ facilities is to ensure that Defendantôs approach to gang and race violence is fully consistent with the underlying principles of the IBTM and its related assessments and evidence-based interventions. Based on this premise, the workgroup developed consensus around a set of assumptions and an overall approach for considering Dr. Maxonôs study recommendations.

Consistent with the above framework, the workgroup developed a series of proposed approaches to address Dr. Maxonôs study report recommendations in each key area. Dr. Krisberg has reviewed the workgroupôs proposal and found it to be extremely thoughtful and fully agrees that the approach must be consistent with the principles of IBTM. Subsequently, Defendant has developed a ñGang-Race Integration and Violence Reduction Workgroup ï Implementation Planò to accomplish the approaches identified by the workgroup. The plan was circulated to the Safety and Welfare Expert and the Special Master for comment and finalized on September 16, 2013. The plan (Appendix C) is scheduled to be fully implemented by June 30, 2014 and some of the action steps outlined in the plan have already been completed.

In his comprehensive report, Dr. Krisberg recommends the Mental Health Expert assume monitoring of this issue as part of the IBTM audit. The Special Master agrees with Dr. Krisbergôs recommendation and will work with the Mental Health Expert to incorporate procedures to review this issue as a component of the upcoming IBTM audits.

Priority #3 ï Implement appropriate gender responsive program.

In her twenty-fourth report, the Special Master agreed with the Safety and Welfare Expert that Defendant needs to make a more concerted effort to identify and meet the programming needs of the female youth. The Special Master also indicated she will work with Defendant to identify and explore alternatives to ensure appropriate programs for the female youth in VYCF are being provided. The *Safety and Welfare Remedial Plan* calls for Defendant to consult with one or more national experts to begin development of gender specific programs and adoption of the Integrated Treatment Model for the female youth. When the remedial plan was adopted in July 2006, Defendant had approximately 130 female youth in its population.[55] The female youth population declined to 20 by the time of the Safety and Welfare Expertôs site visit to VYCF in late July 2013.[56] The Special Master has begun to assist Defendant in developing and implementing a program to meet the needs of the female youth.[57]

In December 2012, the Special Master and the Deputy Special Master conducted a site visit to El Toyan (ET) Hall and interviewed every youth and every staff member in

[55] *See* DJJôs Month Facility Population Report as of June 30, 2006.
[56] *See* DJJôs Monthly Facility Population Report as of July 31, 2013.
[57] The Special Master took a group of DJJ administrators to visit Washington and Oregon state juvenile systems. The Program Administrator now responsible for the girls unit at VYCF was on this trip. She has already implemented many of the program elements she observed in other state programs for juvenile females. The Program Administrator has consulted with the Special Master on several occasions.

the living unit. The results of the interview were summarized in a report and shared with Defendantôs management. To its credit, Defendant took immediate actions to address the concerns identified in the report to improve the conditions of the unit. A decision was made to place ET as the first unit to implement the IBTM and a new Program Administrator and a new Supervising Casework Specialist was appointed to oversee and manage the unit. The Special Master and the Deputy Special Master visited ET again in April 2013 and held separate meetings with youth and staff in group settings to acknowledge the progress and improvements and to clearly communicate program expectations.

The Special Master made return visits to ET and observed vast improvements in terms of appearance and conditions of the living unit, staff attitude and interaction with youth, and the quality of program and resource groups. In her twenty-sixth report, the Special Master highlighted many of the improvements as a part of the IBTM implementation progress including the entire unit staffôs participation in a five-hour training on gender responsivity[58] and that staff members are creating some innovative programs for the girls. A soothing room to help girls develop calming strategies, honor rooms beautifully decorated and a store where girls can ñshopò when they achieve behavioral targets serve as adjuncts to the behavior management program and are used to shape behavior and teach skills. The girls have chosen vibrant colors for the dining hall and hallways and proudly displayed artfully crafted posters identifying their treatment goals. Access to computers provides the girls assistance with homework, letter writing and playing games that develop skills. Elegant curtains and new furniture have been

[58] The training is a webinar of the National Institute of Corrections entitled Health Justice Women: Transforming Systems, Changing Lives.

ordered to soften the dayroom to make it more welcoming and safe. All of these changes have taken place in a matter of months and are a credit to the unit leadership and staff.[59]

The unit leadership and staff continue to make improvements to meet the needs of female youth.[60] The unit has an informal reinforcement system in place which is in the process of being formally adopted by the Central Office. The girls earn ñstarsò for positive behavior, which can be used to exchange for goods, many of which are female oriented, in ñStar Exchange Stores.ò A second additional Girls Moving On group has been added and is scheduled to start on September 20, 2013. As part of the soothing room initiative, the Program Administrator and a Youth Correctional Counselor are holding a ñsoothing groupò to provide calming strategies and techniques to six youth with history of high anxiety, aggression, and violence. The popularity of the honor rooms provides a great incentive as each week, numerous youth submit applications to compete for access to the two honor rooms. The girls who are chosen to stay in the honor rooms have access to television, special toiletries and modified program hours. As noted above, all IBTM resources groups are being completed timely and the Program Administrator notes that she has observed a change in staff attitudes and perception of the unit from a correctional setting to a treatment milieu.[61]

The Safety and Welfare Expert recommends the Mental Health Expert assume monitoring of the gender responsive issue as a part of the IBTM audit. Based on her recent site visits, the Special Master believes Defendant is making substantial progress in addressing this issue. She will assist the Mental Health Expert in bringing this issue to

[59] The Special Master has had two site visits to VYCF on May 8th and 28th, 2013 during which she has observed the progress in these areas.
[60] Observations of the Special Master during her site visit to the unit on September 6, 2013.
[61] Telephone conversation between Program Administrator Maria Harper and the Deputy Special Master on September 10, 2013.

closure during the upcoming IBTM audit of VYCF.

Priority #4 ï Reduce the rates of violence and Use of Force in all DJJ facilities.

The Safety and Welfare Expert, in his comprehensive reports, repeatedly identified reduction of violence and fear among staff and youth as at the heart of the *Farrell* case. The Special Master recognizes the criticality of this issue and has commented extensively about Defendantôs progress and efforts on this issue since her eighteenth quarterly report in July 2011. As the issue is complex, the Special Master believes it is useful to provide the Court with a brief overview of how this issue has evolved.

Shortly after the adoption of the *Safety and Welfare Remedial Plan*, Defendant began to take actions to meet the requirements delineated under ñAction Planò of Section 3 -- Reduce Violence and Fear. Specifically with respect to use of force, the Action Plan calls for Defendant to:

- Revise the Use-of-Force policy as necessary to be consistent with the *Safety and Welfare Remedial Plan*, including policies and procedures relating to accommodations in the use of force for mentally and physically ill youth.
- Implement a Use-of-Force Review Model and create and operate a Violence Reduction Committee at each facility.
- Provide training on crisis management to all direct-care staff.
- Adopt a database to track all incidences of violence and use of force.
- Develop formats and procedures for reporting results on a quarterly basis and share the results with Plaintiff, the Special Master, and the *Farrell* experts.

After the first three rounds of *Safety and Welfare Remedial Plan audits*, most of Defendantôs facilities were found to be in substantial compliance for the above items as measured by the standards and criteria. However, while policy and procedures clearly

were in place, Plaintiff continued to express concerns about the effectiveness of the process, particularly with respect to mentally ill and disabled youth. On July 24, 2009, Plaintiff wrote to the Special Master, the Safety and Welfare Expert, the Mental Health Experts, and the Disability Expert to request an investigation into Defendantôs practices of using force against youth with mental illness and/or mental retardation, including concerns raised by the Los Angeles County Public Defenderôs Office. Plaintiff also requested the *Farrell* experts investigate Defendantôs progress in implementing the Mental Health Remedial Plan requirement that pepper spray is not to be used against youth on psychotropic medication in any controlled use-of-force situations. The *Farrell* experts issued a report in April 2010 that identified a number of disturbing findings and the Special Master suggested a more in-depth review was necessary and appropriate. As a result, Defendant in September 2010 initiated a self-commissioned study by a multi-disciplinary team of staff members and, at Defendantôs request, the Office of the Special Master participated in the study. Two other *Farrell* experts, the Safety and Welfare Expert and the Disability Expert, also were invited and participated in the study.

The study group released a report in April 2011 with 28 observations and 99 recommendations. In response, Defendant formed an implementation group to develop a plan to implement the study groupôs recommendations. The key action steps include:

- Revise the Use-of-Force Policy.
- Provide training on the new policy and other training about force prevention.
- Require a Crisis Intervention Plan (CIP) to be developed for every youth in the system. The plan is to be updated at each case conference or after each use-of-force incident.

- Require each living unit to conduct weekly meetings of multi-disciplinary staff to identify means to prevent force incidents and to discuss youth behavior and treatment related issues.

- Revamp the force review process at the department (DFRC) and at the facility (FRC) levels to direct more focus and attention on force prevention and review of trends and patterns to prevent use of force.

- Require each youth to be interviewed after each force incident to gain youth's perspective on why force occurred and how force could have been prevented.

As previously noted, the Special Master has closely monitored and reported to the Court Defendantôs progress on this issue Since July 2011. At times she has provided candid comments and observations but largely has acknowledged that Defendant was making a concerted effort and has achieved significant progress on all aspects of the issue. Defendant revised the ñCrisis Prevention and Management Policyò with considerable input from Plaintiff, the Special Master, and the *Farrell* experts. Core Correctional Practice Training and Crisis Intervention and Conflict Resolution Training have been given to all direct-care staff.[62] A CIP has been developed for every youth and is updated regularly. Weekly multi-disciplinary staff meetings are held regularly. Defendant has developed quality control measures to ensure that CIPs are updated regularly, their quality meets standards, and that the weekly living unit meetings are relevant, useful, and reflect participation by multi-disciplinary staff members.

The Safety and Welfare Expert and the Deputy Special Master attend DFRC meetings regularly and the Deputy Special Master attended FRC meetings at each of the three facilities. Defendantôs Deputy Director provides leadership and attends each DFRC meeting in person or through conference calls. Both the Safety and Welfare Expert and the Deputy Special Master found vast improvement in thoroughness of the cases

[62] Core Correctional Practice Training was provided to DJJ trainers by the IBTM consultants from UCCI. The DJJ trainers then provided training to staff.

reviewed, the quality of the review processes in terms of focus on prevention and follow-up to assist staff to change practices. In addition, it is clear from the cases reviewed that CIPs are being referred to during force incidents and that youth are interviewed after the force incidents, even though the quality of the interview notes continues to be uneven. This could be improved over time through more mentoring, coaching, and sharing of best practices. Monthly and quarterly reports are prepared and Defendant is working on a protocol for more in-depth analyses of use-of-force trends and patterns as a means to prevent future incidents.

Given the significant efforts Defendant devoted to improve the process, one would expect a fairly significant decline in the use-of-force rates at the facilities. However, in his comprehensive report, the Safety and Welfare Expert reviewed the CompStat data over a 30-month period of January 2011 through June 30 2013 and found the use-of-force rate declined slightly at OHCYCF but essentially remained flat at NACYCF and VYCF. Dr. Krisberg also commented on the fact that the rates at VYCF often were two or more times higher than the rates at OHCYCF and NACYCF.

Dr. Krisberg utilized two approaches in his analysis. First, he averaged each facilityôs monthly use-of-force rates for the first six months of 2011, 2012, and 2013 and compared the six-month average rates from year to year. Second, instead of comparing the rate on a month-by-month basis for the 30-month period, he compared the rates of last month of each calendar quarter to review trends and patterns.

The Special Masterôs analysis suggests OHCYCF has made significant progress in reducing use of force beginning in June 2012. She compared the monthly use-of-force rates of the three facilities over a two-year period of July 2011 through June 2013 (see

table below). Her analysis shows that during an 11-month period from July 2011 through May 2012, OHCYCF only had two months (February and March 2012) when rates went below .20. Over the next 13 months, OHCYCF had eight months in which rates were below .20. Moreover, every spike in OHCYCFôs monthly rate was followed by a substantial decline in the following month, which suggests management is capable of taking action to stabilize the situation promptly. There is greater rate volatility at OHCYCF given its lower youth population in comparison to NACYCF and VYCF. For example, OHCYCFôs rate increased from .18 in May 2013 to .23 in June 2013 when the actual number of force incidents increased by two, from 10 to12. Therefore, a few more incidents could show the rate spiked temporarily, but should not cause significant alarm when the rate promptly returned to its normal pattern. The Special Master believes IBTM implementation at OHCYCF is partially responsible for the improvement.

Facility Use-of-Force Rates (Per 100 Youth Days)[63]

	FY 2011-12 Use-of Force-Rate (100 Youth Days)				FY 2012-13 Use-of Force-Rate (100 Youth Days)			
	OHCYCF	NACYCF	VYCF	All[64]	OHCYCF	NACYCF	VYCF	All
July	.25	.30	.61	.35	.18	.25	.33	.26
August	.37	.32	.89	.43	.15	.26	.48	.31
September	.37	.33	.74	.43	.24	.32	.59	.39
October	.22	.39	.88	.46	.42	.29	.63	.44
November	.23	.32	.58	.34	.13	.22	.51	.30
December	.26	.18	.60	.32	.06	.16	.48	.25
January	.33	.28	.49	.37	.30	.25	.53	.36
February	.18	.28	.38	.29	.21	.32	.48	.35
March	.18	.38	.46	.36	.11	.14	.61	.30
April	.22	.27	.55	.37	.09	.24	.69	.37
May	.23	.25	.70	.43	.18	.36	.73	.45
June	.09	.24	.53	.31	.23	.33	.42	.33
Average	.24	.30	.62	.37	.19	.26	.54	.34

[63] Compiled by the Office of Special Master based on CompStat data.
[64] Rates include use-of-force data for the Southern Youth Correctional Reception Center and Clinic from July 2011 until its closure in October 2012.

Data in the above table indicate a fairly substantial decline in the average rates at OHCYCF (21%) and modest decline at NACYCF and VYCF (13%) between the two fiscal years. However, CompStat data for July 2013 show encouraging results for VYCF as its rate declined from .73 in May 2013 to .42 in June 2013 and .24 in July 2013. Over the 30-month period of January 2011 through June 2013, VYCFôs use-of-force rate was as high as .89 in August 2012 and had only three months when its rate went below .46 -- .38 in February 2012, .33 in July 2012, and .42 in June 2013. The rate then declined significantly to .24 in July 2013. The decline between June 2013 and July 2013 was partially caused by summer school recess as 11 force incidents occurred in the school area during June 2013 whereas none was reported in July 2013. Increased dialogue between staff and youth is also posited as another cause of the rate decline. VYCFôs monthly reports for May, June and July 2013 also show that staff members are increasingly using dialogue with youth to avoid having to use force. According to the following table, approximately 50% of incidents in May 2013 that required response from security personnel were resolved through dialogue between staff and youth. The percentage increased to 57% and 69% in June 2013 and July 2013, respectively, while the number of security responses decreased. Even though the data are not sufficient to establish a definitive trend, the significant rate decline over a three-month period is very encouraging, and management should take the opportunity to further reinforce the benefit of continuing the use of dialogue and interaction between youth and staff.

Comparison of Force Incidents Averted through Dialogue -- VYCF[65]

	May 2013		June 2013		July 2013	
	Dialogue	Force Used	Dialogue	Force Used	Dialogue	Force Used
Mental Health Youth	46 (52%)	43 (48%)	22 (55%)	18 (45%)	15 (65%)	8 (35%)
Non-Mental Health	50 (48%)	54 (52%)	69 (58%)	50 (42%)	38 (70%)	16 (30%)
Total	96 (50%)	97 (50%)	91 (57%)	68 (43%)	53 (69%)	24 (31%)

In their analyses, both the Special Master and the Safety and Welfare Expert used use-of-force rate per 100 youth days to ensure comparability in light of the constant fluctuation in the youth population. To place the rates in perspective, the following table shows the correlation between rates and actual number of incidents at the three facilities during April, May, June, and July 2013:

Actual Number of Force Incidents at Each Facility

	April (Rate)	May (Rate)	June (Rate)	July (Rate)
OHCYCF	5 (.09)	10 (.18)	12 (.23)	9 (.17)
NACYCF	18 (.24)	28 (.36)	24 (.33)	28 (.38)
VYCF	52 (.69)	55 (.73)	30 (.42)	18 (.24)
Total	75 (.37)	93 (.45)	66 (.33)	55 (.27)

The Special Master believes Defendantôs overall approach to the use-of-force issue is very sound and, with further refinements, will enable Defendant to achieve the desired outcome consistent with the purpose and intent of the *Safety and Welfare Remedial Plan*. While policy has been revised and training provided to staff, changes do not occur overnight and require constant reinforcement. Reinforcement in the form of meaningful case reviews at the DFRC and FRC level are taking place. Analyses of trends and patterns on a regular basis and taking preventive measures at the department and the facility level are starting to take place which will further enhance the effectiveness of the

[65] From Monthly Use of Force Totals for Mental Health, compiled by DJJ through data in the May, June, and July 2013 Use of Force monthly reports.

process. Addressing adolescent behavior issues, particularly in a gang-entrenched environment,[66] is complex, challenging, and time consuming, and staff need constant mentoring and coaching. As demonstrated with the experience at OHCYCF, implementation of the IBTM at NACYCF and VYCF should help the facilities to further reduce the need to use force.

In his fifth round comprehensive report, the Safety and Welfare Expert opined that the use of force is still too high at the facilities. Defendant, in its response, rightfully asked the question of what would be the appropriate target goals for force reduction. In reviewing the above data, the Special Master suggests that use of force is reasonable at OHCYCF. Over a 13-month period, except for October 2012 when it had 26 incidents, OHCYCFôs use-of-force numbers ranged from a low of three cases in December 2012 to a high of 16 cases in January 2013. Following the high of 26 incidents in October 2012, OHCYCF had seven incidents in November 2012. Following 16 incidents in January 2013, the number of cases declined to 10 and six in February and March 2013, respectively. Very few of OHCYCFôs force incidents involved a single youth. Given the high percentage of youth with gang involvement [67] living in an open dorm setting, it is not possible to completely eliminate the need to use force, and OHCYCFôs numbers appear reasonable.

The Special Master also suggests the rate of use of force at OHCYCF is a realistic target goal for the other two facilities. The recent decline in VYCFôs use-of-force rate demonstrates that there are ample opportunities to significantly reduce the need to use force and further analyses of trends and patterns will help Defendant to identify targets

[66] Defendantôs WIN system data show 75% of its youth population are gang members or gang associates.
[67] *Ibid.*

for change. Successful implementation of the IBTM at the two facilities should also reduce the need to use force.

In her twenty-fourth and twenty-fifty quarterly reports, the Special Master identified two key areas of focus for force incident reduction: single youth incidents and use of chemical agents on youth with mental health designation. Upon further review of data for May, June, and July 2013, it appears that these issues are not problematic at OHCYCF, but remain of concern at NACYCF and at VYCF.[68] These two issues are discussed below:

Single Youth Incidents

Single youth incidents typically stem from youth who initially failed to follow staff instructions then later escalate into situations perceived by staff to pose an immediate threat to the safety and security of the youth or staff. As the criteria of what constitutes an immediate threat is highly subjective, it is difficult to second-guess staff members in exercising of their judgment to use force when they perceive there is an immediate threat. However, there appears to be significant discrepancy among the facilities in their practice of using force against a single youth as the percentage of single youth incidents at OHCYCF is consistently far below the percentages at the other two facilities. Over the three-month period of May, June, and July 2013, the overall percentage of incidents involving a single youth at OHCYCF was approximately 9% (two of 22) whereas the percentages at NACYCF and VYCF were 46% (37 of 80) and 50% (50 of 101), respectively. Clearly, this is an area where opportunities exist to reduce the

[68] Data during this period show no instance of staff using chemical agents against youth with mental health designation and two of 22 use-of-force incidents (9%) were single youth incidents. While the goal should be no single youth incidents, there may be instances where such incidents are unavoidable. The Deputy Director told the Deputy Special Master that only one youth at OHCYCF qualifies under the new mental health definition as of September 9, 2013.

number and rate of force incidents. For May, June, and July 2013, the overall use-of-force rates at NACYCF and VYCF would have been fairly close to the rates at OHCYCF if these two facilities had the same number of single youth incidents as OHCYCF.

Single Youth Incidents – May, June, and July 2013[69]

May 2013	**OHCYCF**	**NACYCF**	**VYCF[70]**	**Total**
Total Security Responses[71]	37	94	115	246
Security Responses Without Force Used	27	66	60	153
Total Use-of-Force Incidents	10	28	55	93
Single Youth Use-of-Force Incidents	0	10	31	41

June 2013	**OHCYCF**	**NACYCF**	**VYCF**	**Total**
Total Security Responses[72]	51	102	77	233
Security Responses Without Force Used	39	78	47	164
Total Use-of-Force Incidents	12	24	30	66
Single Youth Use-of-Force Incidents	1	12	11	24

July 2013	**OHCYCF**	**NACYCF**	**VYCF**	**Total**
Total Security Responses[73]	21	107	47	175
Security Responses Without Force Used	12	79	31	122
Total Use-of-Force Incidents	9	28	16	53
Single Youth Use-of-Force Incidents	1	15	8	24

[69] Compiled by the Office of Special Master using the facilitiesô monthly reports.
[70] Data in this column do not agree with data contained in a table in earlier section of this report entitled ñComparison of Force Incidents Averted through Dialogue ï VYCFò because numbers in this table are based on actual number of incidents whereas the numbers in the prior are by number of youth involved in incidents.
[71] Number of times security staff had to respond to alarm codes.
[72] *Ibid.*
[73] *Ibid.*

Use of Chemical Agents against Youth with Mental Health Designation

The *Safety and Welfare Remedial Plan* calls for caution in the use of chemical agents against youth with certain mental or physical conditions. Defendant in turn adopted a policy that prohibits the use of chemical agents against youth with a mental health designation in a ñcontrolled use of forceò situation. However, recent yearsô data show that only a handful of incidents were considered ñcontrolledò each year and thus, from a practical standpoint, there has been little, if any, distinction between mental health youth and non-mental health youth when chemical agents were applied.

A review of the facilitiesô May, June, and July 2013 monthly reports show no instance of use of chemical agent against youth with mental health designation during those months at OHCYCF. This may be because very few youth at OHCYCF have mental health designations.[74] However, at NACYCF, 47 of 80 (59%) incidents that occurred during the three-month period involve chemical use of force and 23 of the 47 (49%) were against youth with mental health conditions. Rather than identifying the type of force (i.e., chemical, physical, mechanical, etc.), used during each incident, VYCFôs monthly reports identify the type of force used against the number of youth during the month. During the three-month period, VYCFôs monthly reports show chemical agents were used against 78 youth, of whom 34 (44%) were with mental health designations.

In his comprehensive report, the Safety and Welfare Expert recommends requesting the Mental Health Expert to monitor this issue since there may be a significant restructuring of mental health units and a reduction in the number of youth qualified under the new mental health definition. Efforts should be undertaken to develop more

[74] The Deputy Director told the Deputy Special Master on September 9, 2013 that only one youth at OHCYCF qualifies under the new mental health definition.

effective ways to interact with mentally ill youth that do not require the use of force. The Special Master agrees with the Safety and Welfareôs recommendation and urges Defendant leadership to take prompt action to start addressing this issue.

Priority #5 Establish a realistic plan for the closure of current DJJ facilities and their replacement.

Given the continuing declining trend of youth population and budget constraints, it is unrealistic to expect any new facility to be constructed to replace the existing ones. In her twenty-fourth report, the Special Master suggested that, with a modest investment, options are available for Defendant to convert the existing facilitiesô living units into more therapeutic and treatment-oriented settings.

Defendant has been innovative on this issue by actively engaging youth in renovation and redecoration projects in the living units. As identified in the Safety and Welfare Expertôs comprehensive report, the recently completed projects at the Glenn Hall at OHCYCF and the ET unit at VYCF demonstrate much could be done to improve the look and feel of a unit without incurring significant expenses. The Youth Construction and Renovation Program at VYCF is another example in making needed renovation with youth involvement, which provides useful job experience to youth while making facility improvement at nominal costs.

Defendant also ordered new dayroom furniture to replace the prison-like furniture at ET and at the low-core units throughout the system to turn the units into more therapeutic settings. Despite the improvements, the Special Master agrees with the Safety and Welfare Expert that much more could be done. To facilitate closure on this issue, the Safety and Welfare Expert recommends Defendant to develop a definitive and time-specific renovation plan to complete this task. The Safety and Welfare Expert also

recommends the Special Master assume monitoring responsibility on this issue. The Special Master agrees with Dr. Krisbergôs recommendations and will work with Defendant to develop the plan. Once adopted, the Special Master will monitor Defendantôs implementation progress of the plan.

Priority #6 ï Successfully pilot and refine the BTP model.

The *Safety and Welfare Remedial Plan* prescribed the BTP model to provide intensive behavior treatment intervention for certain youth exhibiting violently disruptive behavior who do not meet the criteria for intensive mental health treatment. The BTP model replaces the Specialized Management Program (SMP) unit to address SMPôs shortcomings identified in Dr. Krisbergôs December 23, 2003 report of Defendantôs correctional practices.[75] The report noted that Defendant had two restricted housing programs ï SMPs and temporary detention (TD). During the sample period of the Safety and Welfare Expertôs review, approximately 10% of Defendantôs youth population was placed in restricted housing programs. The average length of stay for youth in SMPs ranged from 52 days to 70 days depending on the facility and the average length of stay for TD was close to four days. The report noted that youth in restricted programs often lived in rooms with deplorable conditions and that time spent outside of their rooms were almost always in full mechanical restraints or in a cage. Youth said they spent most of their time sleeping or reading. The Safety and Welfare Expert also noted that ña major challenge of the restricted programs is the apparent lack of clear and coherent treatment programs that would transition wards back to their living units.ò[76]

[75] *See* report of General Corrections Review of California Youth Authority by Dr. Barry Krisberg, December 23, 2003, pp. 54 ï 61.
[76] *See* report of General Corrections Review of California Youth Authority by Dr. Barry Krisberg, December 23, 2003, p. 60.

Based on July 2013 data, the average length of stay of youth housed in BTP units was 71 days, 95 days, and 251 days at OHCYCF, NACYCF, and VYCF, respectively.[77] The disproportionally high average length of stay at VYCF is caused by a handful of youth with extremely lengthy BTP stays.[78] Defendant replaced the TD program with the Treatment Intervention Plan (TIP) program and the average length of stay for all youth on TIP was two days.[79] Based on the number of youth being housed in BTPs and on TIP, the Special Master estimates eight percent to 10 percent of Defendantôs youth population are in restricted housing units at any one time.

As a result of concerns expressed by Plaintiff regarding certain youth with very lengthy stays in BTP units, particularly at VYCF, the Special Master and the Deputy Special Master in August 2013 and September 2013 conducted three site visits to the three facilities to more thoroughly review the BTP operations. The Special Masterôs review identified a number of positive developments at all three BTPs. The Senior Youth Correctional Counselor at each BTP has excellent rapport with youth in the unit and staff members are making concerted efforts to provide treatment and services to youth. None of the youth reported any safety concerns or mistreatment by staff and some even indicated a preference for the BTP setting, as they believe more treatment and services are being provided at the BTP than the core units. At the same time, the Special Master identified a number of conditions that merit further management attention. Most of the issues relate to treatment-related issues such as case planning, case management and file management. Criteria and strategy for transitioning youth out of BTP is another area that

[77] *See* PoP 966, Behavior Treatment Program Monthly Report for July 2013.
[78] During the Special Masterôs site visit to VYCF on September 5, 2013, the BTP unit had seven youth with lengthy stays at the unit. Two of the youth were in the BTP unit for almost two years.
[79] *See* PoP 968, Treatment Intervention Plan (TIP) Analysis for the Month of July 2013.

needs to be strengthened. The Special Master will prepare a separate report of her findings and recommendations and confer with the parties to develop a course of action to accomplish the purpose and intent of the BTP program.

D. Next Steps

In his comprehensive report, the Safety and Welfare Expert identified three department-wide issues that remain outstanding: the IBTM, physical plant and conditions of living units, and use of force. Monitoring of the IBTM implementation has already been transferred to the Mental Health Expert and the Special Master will work with Defendant and the Mental Health Expert to schedule audits at NACYCF and VYCF as promptly as feasible to establish benchmarks and proactively identify issues for resolution. The Special Master is willing to assume monitoring of the physical plant and the conditions of living units and will work with Defendant to develop a plan to bring closure to this issue.

Regarding use of force, from a department-wide perspective, the two key outstanding issues are use of force against single youth and use of chemical agents against youth with a mental health designation. Based on data presented in this report, these issues appear to be less relevant at OHCYCF because of the very few single youth force incidents and no youth with a mental health designation in the facility. However, continued monitoring is still needed at NACYCF and VYCF, and the Safety and Welfare Expert and the Special Master will continue to examine data and monitor Defendantôs practices in the upcoming months.

In addition to the department-wide issues discussed above, the Safety and Welfare Expert identified a number of issues at each facility, which he characterizes as

ñopportunities for improvement.ò For OHCYCF and NACYCF, his comments are advisory and no further monitoring is necessary. However, he believes the issues at VYCF are more serious and more focused monitoring is needed. In examining these issues, it is the opinion of the Special Master that all could be reasonably addressed during the remainder of the fiscal year through a concerted effort by Defendant. The Special Master will work with the Safety and Welfare Expert to determine the nature and extent of monitoring efforts needed at VYCF. After consultation with the Safety and Welfare Expert, the Special Master will arrange a meeting with the parties to reach agreement on the appropriate course of action to bring the remaining issues to closure.

The Special Master agrees with Dr. Krisberg that OACC should assume monitoring of all facilities and the Central Office in accordance with standards and criteria of the remedial plan. The Special Master also opines that Defendantôs Central Office and OHCYCF have reached substantial compliance and full monitoring should be transferred to Defendant. The role of Central Office is to prescribe policy and provide leadership, oversight, support, and assistance when needed. It has achieved an overall rating of 100% of audited items in substantial compliance and the results of the Safety and Welfare Expertôs sixth round of audits clearly demonstrate that leadership is effective. OHCYCF also achieved an overall rating of 100% of audited items in substantial compliance. Of the three department-wide issues identified by the Safety and Welfare Expert, the IBTM has been transferred to the Mental Health Expert and the Special Master is to assume monitoring of the facility plant issue. As previously discussed, the Special Master believes use of force is reasonable at OHCYCF and no further action on this issue is needed at the facility.

Transfer of full monitoring to Defendant of the Central Office and OHCYCF should enable Defendant to focus more attention and effort on issues at NACYCF and VYCF and, equally importantly, on the IBTM implementation and on delivery of treatment and services to youth throughout the system. As previously noted, Defendant facilities have changed from a climate of fear to an environment perceived to be safe by youth and staff. Defendantôs focus should be directed to improving the quality of treatment and services, which should in turn, further enhance the safety and security of the facilities and better serve the needs of youth in the system.

V. TRANSFER OF MONITORING - OUTSTANDING ISSUES

As *Farrell* reform continues to progress, the parties, the Special Master, and the *Farrell* experts identified several issues that merit transfer of monitoring responsibility for operational and logistical reasons. These issues and progress are discussed below:

A. IBTM Implementation

The parties, the Special Master, and the Safety and Welfare and Mental Health Experts agree that the Mental Health Expert should assume monitoring of Defendantôs IBTM implementation progress. As previously noted in this report, the Mental Health Expert, assisted by the Special Master, has completed an audit of OHCYCF and is in the process of finalizing his report detailing the results of his findings. The Special Master will work with Defendant and the Mental Health Expert to schedule audits at NACYCF and VYCF. The Special Master will continue to assist the Mental Health Expert in the upcoming IBTM audits.

B. VYCF Attendance Issues

On July 19, 2013, the parties entered into a stipulated agreement that dismissed the *Education Remedial Plan* and those portions of the Consent Decree related to education with the exception of the audit items related to attendance for general and special education at VYCF. The parties agreed that these items can be monitored by the Special Master as a part of the IBTM segment of the *Safety and Welfare and Mental Health Remedial Plans.*

As VYCFôs school term did not start until August 8, 2013, the Special Master believes it is premature to assess progress at this time as there is insufficient data to establish trends or patterns. The Special Master will report on this issue in her next quarterly report.

C. Physical Plant and Conditions of Living Units

The Safety and Welfare Expert recommends the Special Master to assume monitoring of Defendantôs efforts and progress to convert the existing facilitiesô living units into more therapeutic and treatment-oriented settings. The Special Master agrees to assume this responsibility. Providing the parties are in agreement, the Special Master will work with Defendant to develop a definitive and time-specific renovation plan to complete this task and monitor the progress of implementation.

D. Use of Chemical Agents

The Safety and Welfare Expert recommends that the Mental Health Expert assume monitoring of use of chemical agents against youth with mental health illness and youth with disabilities as a part of his future audit of the *Mental Health Remedial Plan*. Providing the parties are in agreement, the Special Master will work with the Mental Health Expert in incorporating this issue into his future audits.

VI. CONCLUSION

Good progress continues to be made in the implementation of the IBTM CBT groups. Training efforts are well underway at the new implementation sites at VYCF and NACYCF. VYCF is demonstrating consistent delivery of CBT groups at the initial implementation units. The VYCF girls unit is to be commended for making significant progress in a very short period of time. This is perhaps the first time that the Special Master can say the girls are not an afterthought in this largely male system.

The Special Master supports the recommendation of the Sexual Behavior Treatment Expert to transfer monitoring of the *Sexual Behavior Treatment Remedial Plan* to Defendant. Defendant is to be commended not just for completion of program implementation but for the high quality of the program.

Significant gains have been made in Safety and Welfare. OHCYCF continues to excel in many areas. OHCYCF has not only achieved substantial compliance in the Safety and Welfare audits for three rounds but achieved a100% compliance in this round.

Both the Mental Health Expert and the Safety and Welfare Expert have opined that the IBTM is being embraced at OHCYCF and is likely responsible for positive intermediate measures for recidivism reduction that include: youth feeling safe, a reduction in the rate of violence and use of force, increased school attendance, consistent delivery of CBT interventions and completion of interventions by youth, a relatively consistent use of a multi-disciplinary team to address youth needs that consistently includes educators and beginning to renovate units to make them less institutional. As a result of this progress, the Safety and Welfare Expert believes that monitoring of this facility should be transferred to Defendant. The Special Master supports this as well as

the expertôs recommendation to transfer monitoring of the Safety and Welfare Central Office items to Defendant.

Defendant has sustained substantial compliance in Safety and Welfare audits at NACYCF for two rounds and achieved substantial compliance at VYCF this round. Given the consistently high quality of the OACC audits and congruence with the Safety and Welfare Expertôs audits, the expert believes that monitoring of these facilities pursuant to the standards and criteria can now be conducted by OACC. There remain several items that have not achieved substantial compliance that continually need to be addressed. The Special Master agrees with the Safety and Welfare Expertôs recommendations regarding the following issues:

> IBTM: Transferred to the Mental Health Expert who continues to monitor its progress.
>
> Physical plant and living unit conditions: Transferred for monitoring to the Special Master.
>
> Use of force: The Safety and Welfare Expert and Special Master will continue to monitor use of force at NACYCF and VYCF.
>
> Use of chemical agents: The Mental Health Expert will monitor the use of chemical agents against mentally ill and disabled youth.

In addition, the Safety and Welfare Expert has identified several outstanding issues specifically related to VYCF that require more focused monitoring during the remainder of the 2013-14 fiscal year. The Special Master will work with the parties and the Safety and Welfare Expert to determine the most appropriate approach to address these issues.

The transfer of some aspects of monitoring of a remedial plan to another expert or the Special Master has worked effectively in other remedial plans. The Special Master

believes this approach will work well again. In this case, the Safety and Welfare Expert is being asked to continue to work on the critical issue of use of force for two facilities.

The Special Master respectfully submits this report.

Dated: October 21, 2013

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Nancy M. Campbell
Special Master

AUDIT REPORT
Sexual Behavior Treatment Program
Division of Juvenile Justice, CDCR
August 29 and 30, 2013
Barbara Schwartz Ph.D.

This SBTP audit was conducted with the limited purpose of evaluating the quality of the core groups. This was the only area of concern noted in the last audit. On the 29th and 30th of August I evaluated five groups conducted by five different psychologists with the assistance of other staff members.

First Group---This group was conducted by Dr. W. who is a recent hire. This group was for youth living on the Humboldt Unit at O.H. Close on August 29, 2013 from 10:45 am to 11:50 pm. Initially the youth seemed disengaged. They are primarily in the early stages of treatment. Most did seem to have something to present and Dr. W. encouraged participation among most of the group members. She presented an exercise that she had adapted from one of the standard ones in the curriculum. However, her adaptation was confusing and this confusion was expressed by the youths, myself and the YCC. After this exercise was postponed until the afternoon group, a youth presented on his delinquency history. There was an honest discussion among the youth on how committing a crime can make one feel powerful. On the whole the group was well led, engaging most of the youth. This psychologist seems enthusiastic about her work and open to training and feedback.

Second Group---This group was conducted from 1:40 pm until 3:00 pm with youth from Eldorado Unit at O.H. Close by Dr. P. with the assistance of Parole Agent Swanson. The youths discussed hobbies and the extent to which competition can influence participation in various activities. One member was recalcitrant and refused to participate stating that he was upset over various seemingly insignificant issues. Other members and the leader gave him appropriate feedback. Another member was initially reluctant to present his apology letter. However, with encouragement he did present it as a "rap." He received lots of positive reinforcement from the group. The group then played Emotional Charades in which everyone including myself participated. Even the sullen group member had a good time. The group was well led and therapeutically beneficial.

Third Group----This group was conducted with youth from the Eldorado Unit at O.H. Close by Dr. A. with the assistance of Supervising Caseworker Garcia who was very active in the process and ran from 4:00 pm until 5:30 pm. Dr. A. is a new, very enthusiastic staff member. Initially a youth presented a graph of the major positive and negative influences in his life. This exercise, an Ecomap, is a Stage 7 assignment. Next the group role played a scene where a neighbor confronts a youth about being a sex offender who just moved into the neighborhood. There was an active discussion on empathizing with the concerns of the neighbor and how best to handle these situations. The youths then role played a scene of explaining being a sex offender to a girl friend. This was a very serious group with active participation by all members. Dr. A. did a good job of leading the group and Mr. Garcia was active and encouraging.

Fourth Group---This group was conducted with youth from American Unit at N.A. Chadjerdian by Dr. P. and YCC Rhodes from 2:00 pm until 3:30 pm. One member presented an assignment on his trauma and presented being beaten by his stepfather. The group and leaders were empathetic and gave helpful feedback. The group then did one of the exercises from the curriculum, "My Strengths---Your Strengths" where everyone including the staff taped a piece of paper to their backs and each member wrote a word describing one of their strengths of the paper. The members then read the words, and everyone seemed to enjoy the activity. The group was skillfully led and therapeutically beneficial.

Fifth Group---This group was conducted for another groups of youth in the American Unit at N.A. Chaderjian by Dr. Al. and YCC Baker and lasted from 4:00 pm until 5:30 pm. Initially the group focused on a member doing an exercise about letting go of issues which are weighing him down. As he listed off unresolved issues, Dr. Al. placed large rocks in a bag wrapped around his leg. The youth then had to walk around dragging several pounds of rocks. He then dealt with letting go of these old issues as the rocks were removed. The other group members were actively involved in giving feedback. Then there was a very special event, celebrating the graduation of a group member. This youth was given the opportunity to choose how to celebrate this occasion. Being a Native American and active in Chad's Native American group, he invited the group's sponsor, the youth who is apparently a leader in the group and the facility chaplain. All members including staff and guests gave him farewell feedback, and he reciprocated. The individuals from the Native American group brought drums and they joined the graduate in drumming, singing and praying. Then we all enjoyed Navajo Tacos including fry bread, which had been prepared by the group members. Of all of the groups I have participated in, this was probably the most unusual. It was particularly rewarding to see this group operating so well as it was one of the more troublesome groups from the previous audit.

Summary----All of the groups that I observed were well run, incorporating the principles of successful group therapy. I utilized the SBTP Core Group Facilitator Coaching/Observation Form, which was comprehensive and useful. I was initially concerned that the groups were engaging in experiential exercises solely for my benefit. However, there was evidence in various group rooms and in the comfort level of the group members that these types of exercises are being used routinely. The groups followed the outline of the curriculum. The new psychology staff are bringing enthusiasm and a commitment to following the new curriculum. Dr. Bowlds and her current staff have achieved a state-of-the-art program for youth with sexually problematic behavior, which can serve as a model for the whole country. I am pleased and proud to grant it a 100% compliance rating.

Farrell v. Beard
Safety and Welfare Remedial Plan
Final Comprehensive Report by Dr. Barry Krisberg
September 13, 2013

Purpose

The goal of this report is to offer the Court and the parties observations on the progress made and the challenges faced by the Division of Juvenile Justice (DJJ) in its efforts to implement the Safety and Welfare Remedial Plan. The report contains data that were generously provided by DJJ staff and compiled with the assistance of the Office of Special Master (OSM).[1]

Data for this report also come from a series of site visits that were made to DJJ facilities during July and August 2013. I also conducted an audit of DJJ headquarters activities that were intended to meet the requirements of the *Farrell v. Beard* Consent Decree. Deputy Special Master John Chen accompanied me on each of the site visits and the headquarters audit. Annette Herring, of the California Department of Corrections and Rehabilitation's Office of Audits and Court Compliance (OACC) conducted a pre-audit of each of the facilities and DJJ headquarters prior to my site visit and issued a report. The OACC report assigned a rating for each audit item identified in the Safety and Welfare Standards and Criteria with an explanation and rationale to support the assigned ratings. Mr. Chen and I reviewed and analyzed the OACC report and performed spot checks to validate the OACC ratings. In cases where our ratings differed from the OACC's ratings, we sought to identify and explain the differences. The results are discussed in greater detail in a latter section of this report.

I visited every open DJJ facility with the exception of the Pine Grove Camp. In my last comprehensive report, I recommended that routine monitoring responsibility for DJJ headquarters and the two facilities in the Stockton Complex be transferred to OACC with the exception of the items covering the Integrated Behavior Treatment Model (IBTM), strategies designed to reduce the use of force, the improvement of substandard physical facilities in DJJ, and the implementation of an evidence-based gang strategy.[2]

My most recent facility site visits lasted one to two days for each location. I retained the full safety and welfare monitoring responsibility for Ventura Youth Correctional Facility (VYCF) and the site visit there lasted four days. During all my facility visits, I toured the living units, paying special attention to the high core and restricted housing units. I also conducted interviews with DJJ managers and staff, and Mr. Chen and I together interviewed between 25 to 39 youth at each facility who were selected at random from the daily facility roster. Youth interviews were

[1] Assistance in compiling data was provided by John Chen of the OSM. Special Master Nancy Campbell was generous in her time to discuss many of the issues identified in this report. In addition, I want to extend my appreciation to Doug Ugarkovich and Tammy McGuire who coordinated the assembling of information from DJJ. Many other DJJ staff contributed to the information used for this report. The opinions expressed in this report are solely my own.

[2] See Twenty-Fourth Report of the Special Master, p. 16.

conducted in private and confidential settings. After the site visit, I provided an informal debriefing to DJJ headquarters staff and facility managers. I also reviewed reports produced by the OSM and other Court experts in areas that overlapped with my audit responsibility in the Safety and Welfare Remedial Plan.

I had total and open access to any and all information that I requested from DJJ. There was also a range of research and management reports produced by DJJ that were shared with me. Periodically, I received information from the plaintiff's counsel and other interested advocates who expressed concern about treatment of specific youth in DJJ. I generally discussed these matters with DJJ top managers and requested additional reports and data to the extent appropriate to enable me to evaluate these situations. I also received regular updates on CompStat data for every facility and had complete access to all reports from the Performance-based Standards (PbS) data collection. I was regularly invited to and attended DJJ headquarters meetings that involved the progress and issues related to the *Farrell* remedial plans. I also regularly participated in monthly Departmental Force Review Committee (DFRC) meetings. I met with and discussed issues with Director Michael Minor and Deputy Director Anthony Lucero when I deemed these meetings necessary. I worked in close collaboration and shared regular information with the Special Master Nancy Campbell and the Mental Health Expert Dr. Bruce Gage.

In this report, I have not attempted to cover all of the items in the Safety & Welfare Remedial Plan. I chose to focus on critical aspects of the Safety & Welfare Remedial Plan that are particularly noteworthy or pose greatest challenges for DJJ. I will offer some qualitative and quantitative indicators of performance measures as well as my opinions and suggestions to help facilitate DJJ's effort to achieve and sustain meaningful reform.

DJJ Youth Population Continues to Decline

In my last comprehensive report, I commented on the decline in DJJ youth population that posed significant challenges for DJJ's management in determining the most appropriate organizational structure and resource level to implement reform in a cost-effective manner. I also commented on the uncertainty of the future population trend as the Governor's budget proposal for Fiscal Year 2012-13 that called for the counties to pay $125,000 per year for each youth they committed to the state system.

The $125,000 per year charge was reduced to $24,000 when the FY 2012-13 Budget was adopted. The amount is extremely modest when considering the actual cost of housing youth in state facilities and the costs that counties would need to spend for placements in local facilities or in private programs. Moreover, with *Farrell* reforms underway, I believe that most DJJ facilities provide superior educational, mental health and treatment services than many county facilities. Nevertheless, the counties continue to be reluctant to send more youth to DJJ.

State juvenile facilities continued to experience a population decline throughout Fiscal Year 2012-13 as indicated in the following table:[3]

	Budgeted	Actual
July 2012	1179	930
August 2012	1172	905
September 2012	1166	899
October 2012	977	877
November 2012	977	837
December 2012	977	811
January 2013	977	797
February 2013	838	776
March 2013	839	764
April 2013	840	742
May 2013	841	740
June 2013	845	733

The above table suggests the drop in the DJJ youth population slowed in April 2013. In July 2013, the DJJ youth population was 736 in comparison to a budgeted number of 694 youth. However, the four-month data are insufficient to establish a conclusive trend at this time.

As DJJ's youth population continues to decline, there undoubtedly have been expectations to cut costs in proportion to the population decrease. In the short term, this may be difficult to accomplish without impeding program quality and reform progress. Moreover, further budget cuts will negatively impact staff morale by raising further uncertainties, rumors and speculation about additional facility closure. In some instances, staff members also expressed anxiety about possible closure of living units in certain programs. For example, as a result of a change in state law requiring all youth committed to Defendant's Sexual Behavior Treatment Program (SBTP) to be indefinitely registered as sex offenders, many judges understandably are reluctant to sentence youth to the program. This in turn caused the total SBTP youth population to decrease from 163 in June 2012 to 129 in June 2013 with corresponding decline of 25 youth (from 142 to 117) residing in the SBTP residential units.[4] As of September 24, 2013, DJJ contemplates the potential closure of a SBTP unit if the population continues to decline. Staff members in the SBTP program understandably are discouraged about the possibility of having to downsize such a well-developed program that appears to be the state-of-the-art and is delivering valuable services to youth. Nevertheless, despite these uncertainties, staff morale in general remains fairly high, which can be credited to the strong leadership and good management at DJJ

Stability in DJJ Leadership Positions

DJJ's leadership team remained intact with the exception of the resignation of VYCF's Superintendent in July 2013. In my opinion, the stability in leadership positions is one of the key

[3] From DJJ's Monthly Facility Population Table.
[4] *See* email of September 3, 2013 from Dr. Heather Bowlds to Deputy Special Master John Chen.

factors in DJJ's ability to make significant progress toward reform while continuing to confront the many difficult challenges. In my last comprehensive report, I commented positively on Director Minor's proven leadership and management skills in dealing with the various stakeholders involved in the *Farrell* lawsuit. I continue to have full confidence in Director Minor's commitment and capacity to responsibly carry out *Farrell* reform activities. During the past year, Director Minor and his leadership team have continued to realign resources to sustain and advance reform effort. Deputy Director Anthony Lucero has joined the DJJ top management team and has been a major positive influence on implementing the needed *Farrell* reforms.

Overall, I have noticed a gradual change in the staff and management culture, particularly at the O.H. Close Youth Correctional Facility (OHCYCF) where the IBTM resource groups have been implemented at all living units. More staff members are beginning to understand and appreciate the need for reform. I expect further improvements as DJJ continues to refine and expand the IBTM throughout the facilities.

As to the adequacy of budget resources, there is one important concern. DJJ has over the years created certain administrative and documentation requirements solely to demonstrate compliance with the provisions of various *Farrell* remedial plans. In my opinion, these micro-level documentation activities may have been critical in earlier times, but today these requirements collectively impose a fairly significant workload impact on staff adding little measurable value in terms of the quality of youth treatment and services. Given the scarcity of state resources, DJJ must explore means to achieve greater program and operational efficiencies in a number of areas. As DJJ has reached substantial compliance in several areas, and assumed self-monitoring of various remedial plans, I expect Director Minor and his management team will streamline and eliminate activities that add little or no value and redirect those resources to youth treatment and services. Most critical is to keep the living unit sizes small and to preserve good direct-care staff to youth ratios.

The Standards and Criteria of the Safety and Welfare Remedial Plan and most other remedial plans were developed many years ago and many of the provisions are either completed or no longer relevant. DJJ should work with the parties and the OACC to review and modify the Standards and Criteria as deemed necessary. I encourage the Court and DJJ to place more focus on the use of outcome measures to assess progress and performance, which would be more meaningful and will reduce the need to maintain some of the voluminous documentation needed to demonstrate compliance.

DJJ's Compliance with S&W Standards and Criteria

In the early days of the *Farrell* Consent Decree, many questioned the commitment and capacity of DJJ to fully meet the necessary reform agenda. The Safety and Welfare Standards and Criteria were developed to provide a very detailed blueprint of the specific activities and actions that DJJ needed to demonstrate compliance. The original list of Safety & Welfare Standards and Criteria was long and extensive.

I am pleased to report that DJJ has achieved an overall rating of substantial compliance for all three facilities and headquarters as measured by the Standards and Criteria of the Safety and Welfare Remedial Plan. With the exception of VYCF, other facilities and DJJ headquarters have attained an overall rating of 85% of substantial compliance on audited items for two successive Safety & Welfare audit rounds.

OHCYCF and headquarters received a 100% compliance rating and N.A. Chaderjian Youth Correctional Facility (NACYCF) received a 98% compliance rating during the sixth audit round. At VYCF, the overall rating was still impressive but a bit lower at 84% and 90% for fifth round and sixth round, respectively.

The results of the three most recent Safety & Welfare Remedial Plan audit items are indicated in the following tables:

Percentage of Audit Items in Substantial Compliance (SC), Partial Compliance (PC) and Non-Compliance (NC) – Rounds, Four, Five, and Six

OHCYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 4	89%	7%	4%
Round 5	91%	9%	0%
Round 6	100%	0%	0%

NACYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 4	8%	15%	1%
Round 5	87%	13%	0%
Round 6	98%	2%	0%

VYCF

	Percentage in SC	Percentage in PC	Percentage in NC
Round 4	67%	19%	14%
Round 5	83%	17%	0%
Round 6	90%	8%	1%

Central Office

	Percentage in SC	Percentage in PC	Percentage in NC
Round 4	85%	13%	2%
Round 5	92%	7%	1%
Round 6	100%	0%	0%

While the Safety & Welfare Standards and Criteria compliance percentages is but one of the tools to measure the overall success of DJJ's reform efforts, other indicators also suggest significant progress has been made toward accomplishing the purpose and intent of the Safety

and Welfare Remedial Plan. For example, virtually every youth the Deputy Special Master and I interviewed during this last audit round stated he or she felt safe at the facility, which is encouraging, given past numbers of youth who feared for their safety. In addition, an overwhelming portion of youth that we interviewed said they now attend some resource groups regularly and that they find the sessions very useful. Most youth also said they enjoy school and like their teachers. Some DJJ staff members also informed me that, while they initially were highly skeptical, they now fully embrace reform after having first-hand experience in observing the positive impact of reform implementation on youth. This is especially true at OHCYCF where the implementation of IBTM has been operating for the longest period of time. Other staff report that they value the early training in the IBTM and welcome the opportunity to implement these concepts throughout DJJ.

Other Positive Reform Indicators

During my site visits of the facilities and through youth and staff interviews, I identified a number of very positive developments at each facility. I have reported these conditions to the parties at previous observations after each site visit. My Observation Reports for OHCYCF, NACYCF and VYCF are included as Appendices A, B, and C, respectively. Some of the more noteworthy developments include:

OHCYCF

- The implementation of IBTM is continuing to progress very well at OHCYCF and the youth reported great value in the groups and counseling that they are receiving. The IBTM is going through a "revitalization" given some staffing changes but the program is continuing at an acceptable level of implementation. The management team at OHCYCF is working well together and staff morale seems quite good. Staff seems to have genuinely bought into the IBTM philosophy although they recognize that there is more work to be done to meet the high standards for treatment services set by Defendant's leadership, OSM, and the *Farrell* experts.

- The reentry program at OHCYCF is excellent. Every youth I interviewed said he has met with the Reentry Program Coordinator who has been very helpful in developing a re-entry plan. Each youth also said the Reentry Coordinator is highly dedicated and very resourceful in exploring alternatives to help youth with transition from DJJ. I have reviewed Reentry Program Implementation Plan, which calls for reentry planning starting with the placement of a youth into DJJ. The plan is exceptional and I believe the DJJ program could become a statewide and even a national model.

- The physical plant at OHCYCF has improved in terms of cleanliness. The "cool down rooms" are in better shape. I was particularly impressed with the conversion of the day room at Glenn Hall. With encouragement from staff, the guidance of the highly creative and talented Youth Incentive Coordinator, and with a very nominal budget, youth at the Glenn Hall painted and decorated, which drastically improved the look and feel of the

living unit. All youth expressed great pride with the new living unit setting and their role in the remarkable transformation of the unit. The concept and approach of allowing youth to be creative in making improvements to the living unit has great potential and should be emulated throughout Defendant's facilities.

- The youth that we interviewed uniformly reported that they were feeling safe and in general reported that staff members are acting in a very professional manner. Most youth stated that they do seek out staff for advice and help when they are anxious or under stress. The facility managers are analyzing incidents of serious fights or staff assault and staff are using agreed-upon protocols to respond. Tensions between the high core units have led to some recent group disturbances and require careful orchestration of movements for outside recreation.

- The youth continue to have very positive things to say about the school program. Most youth reported that the school at OHCYCF is very much like a school in the community. The teachers are perceived as caring about the young residents and try to help them. A few youth expressed concern about the impact of possible budget cuts on funding for current college courses. OHCYCF had approximately 50 youth in residence with either a high school diploma or had passed the General Educational Development (GED) test and it is important for these youth to have opportunities to further their education.

- The youth in the Behavioral Treatment Program (BTP) unit seemed generally well-cared for. Restrictive programs are used sparingly at OHCYCF and daily education and counseling are regular parts of these programs. The youth get lots of out-of-room time and lots of outside recreation.

- Grievance system seems to be working as designed. Most of the youth report that they have no major problems and do not really need the grievance system.

NACYCF

- The initial implementation living unit sites for IBTM are making good progress and are receiving staff and management support. Management at NACYCF makes good use of data in their ongoing management meetings; NACYCF managers clearly are committed to the IBTM and want it to succeed.

- NACYCF's BTP Unit appears to be well run. Youth seem well-cared for and some residents actually prefer being in the BTP unit compared to their experiences in the high core units. Defendant needs to work on building more incentives for these young people to facilitate their transition off the BTP units.

- Youth consistently praise the new reentry services and groups. It is a first-rate program, well designed and well delivered. The young people said the Reentry Coordinator is an extremely dedicated individual who works tirelessly in providing sound advices and in

delivering valuable counseling and direct services. Most NACYCF youth reported very positive ratings for Youth Correctional Counselors, Parole Agents, and Case Managers – the youth find these staff accessible, helpful, and concerned for their successful return to the community. Virtually all of the residents reported that help with reentry is the most important service they are receiving at NACYCF.

- There is continued positive feedback about the NACYCF school program. Youth expressed the need for more college classes and are very concerned about the potential budget cuts and the possibility of reducing college offerings in the near future. Overall, the teachers are viewed as very helpful and concerned with the youth's future.

- There are many work opportunities and some excellent vocational programs, especially in computer repairs (Free Venture), landscaping and warehouse management. It is encouraging to see NACYCF youth work outside the fence and to have access to work assignments at the OHCYCF.

- There have been modest but significant improvements in the physical conditions at NACYCF in some living units. Most of the rooms meet the minimal *Farrell* standards in terms of conditions, and there is clear evidence that substandard rooms have been decommissioned.

- Most young people at NACYCF feel safe but they told us that there are still lots of fighting among the youth. Youth at mental health units feel less safe than others. When major disturbances occur, staff members work to return youth to regular programming fairly quickly.

VYCF

- IBTM implementation is off to a promising start at the female program at El Toyan (ET) Hall and efforts are underway to expand IBTM to one or more high core units. I encouraged the facility to embark on a more aggressive effort to fully implement the IBTM with the support of DJJ management as I believe the IBTM approach could resolve many of the issues identified during my site visit such as youth violence, the use of force (UOF) and fewer disciplinary issues. The facility's IBTM implementation effort needs close monitoring for quality assurance and I recommend that the Mental Health Expert monitor VYCF's IBTM implementation progress.

- There has been significant progress in operation of and conditions in the BTP. Youth report they are getting more out-of-room time and are attending resource groups on a regular basis. Youth like the new behavioral reinforcement system and staff are reporting positive behavior changes. Youth perceive staff, particularly the Senior Youth Correctional Counselor (SYCC) to be fair and helpful.

- Physical plant has improved at the BTP (Monte Vista), El Mirasol (EM), and ET largely due to recent renovation and redecoration efforts. The transfer of youth from the deplorable conditions at Casa Las Caballeros (CLC) to Miramar is also very positive and should improve morale at that unit. I suggest that VYCF management consider the current upgrades at the facilities at OHCYCF and NACYCF that were designed to humanize the living units, especially the common areas. Youth residents were provided with a modest budget and allowed to creatively make improvements in the day rooms of some living units.

- The youngsters that we interviewed often spoke highly of the resource groups conducted and services provided by the Reentry Coordinator. However, that person had a very large number of youth who wanted her attention and she could only deliver a small portion of such services. The reentry services provided by other VYCF staff members were inconsistent at best.

- The school program was rated highly by most of the youth that we interviewed and more youth are obtaining their high school diplomas or GEDs than in the recent past. There is a growing need for more college classes and vocational programs at VYCF.

Opportunities for Improvement

While each of the DJJ facilities has made significant progress toward reform, I also noted a number of areas needing improvement, particularly at VYCF. Full implementation of the IBTM could resolve some of these issues. They are discussed below:

OHCYCF

- While there were uniform positive reactions from the youth about the resource groups, especially Impact, AIT and the Interactive Journaling, many youth found the Counterpoint groups to be of less value and the skill level of group leaders needs to be improved.

- The facility remains shorthanded in terms of administrative and plant management staff. This was created by some retirements but is being rectified. There are no large numbers of vacancies in direct-care positions.

- Very few youth get regular family visits. This issue of isolation from community connections remains a key issue.

NACYCF

- More than half of the youth feel that the grievance system is not working to solve issues of importance to them. DJJ has done additional staff and youth training to deal with this issue, but I believe that further progress in terms of youth confidence in the grievance

process can only be addressed through better daily communication and interaction between the youth and staff. DJJ reported that, of the 102 grievances that were filed from January 2013 through September 2013, 24 were granted, 18 were compromised, 30 were withdrawn, and 30 were denied. Nevertheless, there is still a perception among some youth that the grievance system is not useful.

- Very few youth get more than occasional visits and some received none. Face-to-face family interactions are limited to a small number of residents.

- The Incentive System is delivered in an uneven manner by direct-care staff and is not well understood by the youth.

- Youth complain about "favoritism" by staff because rules are not consistently followed by different staff members – for example, some staff offer lots of incentive opportunities while others are still focused on managing the Disciplinary Decision Management System (DDMS) process.

- There are several living units that need physical repairs to floors and other parts of the units.

- Some units still mostly rely on living unit common areas to provide counseling and small and large groups.

- Some youth find safety by staying in their rooms, hanging around staff and keeping away from other youth. Some of these youth would prefer to be housed in a protective custody unit.

- There apparently are a few staff members who engage in verbal abuse and jokes of a sexualized nature. All Defendant staff members need urgent and intensive training on the new Prison Rape Elimination Act (PREA) rules.

VYCF

VYCF's Force Review Committee (FRC) had a fairly significant backlog of cases to be reviewed largely due to the high number of force incidents in comparison with the other facilities. The FRC has managed to eliminate its backlog of cases to be reviewed by conducting meetings more frequently and the recent reduction in the number of use-of-force incidents, possibility due to summer recess. Based on the Safety and Welfare Expert's observation through his participation in DFRC, the Ventura FRC needs to devote greater emphasis on force prevention before and after the incident rather than narrowly focus on whether force was "in compliance with policy." There must be greater attention to use of force in single youth incidents and use of chemical agents on youth with mental health conditions. More attention should be paid to preventing and avoiding the use of force in single youth incidents. DJJ's the headquarters staff continues to

monitor the facility's progress through DFRC review of cases and participation in the FRC meeting to provide additional guidance, training, and coaching.

- Drug and contraband issues remain very troubling at VCYF. Both youth and staff interviewed (including the Chief of Security) acknowledged that this is a serious issue and needs immediate management focus and attention. Defendant needs to develop a comprehensive action plan to address this problem.

- While conditions have improved at the BTP, there is still a need to work on exit and entrance decision-making criteria, as apparently neither the youth residents nor the staff have a clear understanding of such criteria. Moreover, Defendant should reassess its protocol for transitions out of the BTP especially for the longer staying youth, and revisit the evidence for the value of loss of privileges such as visiting, canteen, and program time for the therapeutic mission of the BTP.

- Approximately 50% of youth interviewed said the grievance system does not work for them. As with NACYCF, this issue needs to be addressed through better daily communication and interaction between youth and staff. DJJ reported that, of the 63 grievances that were filed from January 1, 2013 through September 4, 2013, 24 were granted, 11 were compromised, six were withdrawn, two returned for informal resolution, one was changed to a Staff Misconduct Complaint, and 17 were denied. Nevertheless, there is a perception among some youth that the grievance system is not useful.

- The reentry services at VYCF need to be better coordinated and quality assurance measures should be installed to consistently deliver useful and meaningful services. Youth want and need more help in this area. Reentry services must be central to and closely allied with the overall IBTM program.

- The facility should reassess its youth with disability program procedures to ensure youth with mental health conditions are getting meaningful staff assistance to help them maneuver through grievance hearings, DDMS hearings, case conferences, and board hearings.

- High core units are still very troubled, particularly the Miramar living unit. The staff members at VYCF still rely on limiting full programming, single youth programs, and several separate groups to manage fighting. It is unclear if VYCF staff members are using the Crisis Resolution Teams (CRT) to maximum advantage to prevent youth-on-youth assaults.

- Other than the BTP's daily reward of additional hours of program time in the evening, there appear to be little formalized incentives at the other VYCF units. The female unit is much closer to the implementation of a formalized reinforcement system.

- Very few youth get more than occasional visits and some received none. Face-to-face family interactions are limited to a small number of residents.

- Except for a few recently renovated and remodeled units, the conditions at the other VYCF units remain poor and in need of vast improvements.

The Quality of OACC Audit Continues to be Exemplary

As with my previous audit rounds, I again found the work of OACC auditors to be exemplary during the sixth round of audits and my need to make rating adjustments have been very minimal as indicated in the following table:

Rating Changes by the OSM and the Safety and Welfare Expert

	OHCYCF	NACYCF	VYCF	Central Office
NC to SC				1
PC to SC	3	3	1	2
SC to PC			1	
NA to PC			1	
NA to SC			1	
PC to NA		1		
NC to NA		1	1	
Variance/Total	3/66 (5%)	5/67 (7%)	5/71 (7%)	3/137 (2%)

Of the total of 341 items audited at the three facilities and the Central Office, I made a total of 16 (4.7%) rating changes. Approximately 63% (17 of 33) of the rating changes were upgrades that occurred as a result of additional documentation and change in facility practices after the initial OACC's audit and my qualitative judgment. One item (6%) was changed from NA to PC and one item (6%) was changed from NA to SC based on my qualitative judgment. One item was changed from PC to NA (6%) and two items (12%) were changed from NC to NA because I believe the Mental Health Expert should reassess criteria for determining compliance as a part of his IBTM monitoring responsibility.

Based on OACC's performance over the last three rounds of audits, I have full confidence in OACC's ability to continue performing future audits with professionalism and objectivity on safety and welfare matters. I would be very comfortable with OACC assuming full monitoring responsibility for the Safety and Welfare Remedial Plan based on criteria specified in Standards and Criteria. As previously noted, I believe many of the provisions in the Standards and Criteria are outdated and cumbersome and suggest the tool be revamped to provide more focus on outcome measures. I am available to provide advice and consultation when needed.

While OACC should assume full monitoring responsibility, there are a number of outstanding safety and welfare issues that require continuous and more focused monitoring. Some of the issues are department-wide and others are specific to VYCF. I believe some of the issues can be

monitored by the Mental Health Expert as a part of his IBTM audit while other issues could be addressed by the Special Master. These issues are discussed in latter sections of this report.

Reducing Fear and Violence

Reducing the levels of violence and fear among staff and youth in DJJ facilities has always been at the heart of the *Farrell* case. While DJJ has made progress toward achieving substantial compliance as measured by Standards and Criteria of the Safety and Welfare Remedial Plan, a review of certain key outcomes or performance indicators found fairly significant progress at OHCYCF but only marginal improvement in fear and violence reduction at NACYCF and at VYCF. I believe improvement in this area is closely connected with the successful and full implementation of the new UOF protocol and the IBTM at all DJJ facilities.

Use of Force

DJJ has made a concerted effort to reduce the unnecessary or excessive use of force in its facilities. As a regular participant of the DFRC, I have witnessed significant progress during the past six months in the focus and direction of a multi-disciplinary approach in examining every facet of the incident with emphasis on prevention and possible policy implications. The DFRC has recently adopted a protocol for review of trend and patterns, which should enhance the effectiveness of the review process. As the process continues to evolve, I intend to continue to participate in DFRC to assist DJJ to further refine the process in the upcoming months.

Through my participation at DFRC, I also had the opportunities to closely examine the quality of review by the FRC. I found the review by OHCYCF's FRC to be thorough, complete and with an appropriate focus on force prevention. The fact that OHCYCF has had much fewer force incidents is likely the key factor in allowing the FRC to devote greater attention as incidents occur. I found the review by NACYCF's FRC also to be thorough but not quite as consistent as those completed for OHCYCF. At VYCF, the FRC review process is still very much a work in progress and requires further mentoring, coaching and close monitoring by DJJ Central Office. I understand there has been recent improvements at VYCF but have not had the opportunity to personally observe and determine the extent of improvements at this point.

I agree with the Special Master that the two key outstanding issues are UOF against single, non-compliant youth and the use of chemical agents in mental health units. Through my participation in the DFRC, I intend to work with DJJ in addressing the issue involving single youth incidents in the upcoming months. As the configuration of mental health units has yet been finalized, I suggest the Mental Health Expert assume monitoring of this issue as a part of his IBTM and mental health audit efforts.

Looking at data in UOF for each DJJ facility during 2011-2013 is quite instructive. Considering the first two quarters of data from each of these years, it appears that there has been a slight reduction in the rate of UOF at OHCYCF, but the data from NCACYCF and VYCF show little change in their UOF rates. It is also worth noting that for each of these six-month intervals, the

rate of UOF per youth is more than twice as frequent at VYCF when compared to NACYFC and OHCYCF.

A more detailed review of CompStat data over the last 30 months suggests a decline in UOF rates at OHCYCF and NACYCF with the exception of the most recent quarter of data. DJJ management should monitor these trends and determine whether there are any systemic issues that caused the sudden spike of force incidents at the two facilities. At VYCF, the UOF rate remained fairly consistent across the entire two and a half years of data. Over the last 30 months, the use-of-force rates at VYCF constantly have been several times higher than the UOF rates at OHCYCF and NACYCF.

I have been advised by DJJ management that most recent data suggest a decline in the UOF incidents at all of its facilities, but this may be partially due to the school vacation. It will be important to see if there is an upsurge in UOF when school is back in session. In the upcoming months, I will continue to monitor this issue through my participation in DFRC meetings.

Use of Force (Rate per 100 Youth Days)

	Mar 11	June 11	Sept 11	Dec 11	Mar 12	June 12	Sept 12	Dec 12	Mar 13	June 13
All DJJ Institutions	.41	.32	.43	.32	.36	.31	.39	.25	.30	.33
OHCYCF	.26	.15	.37	.26	.18	.09	.24	.06	.11	.23
NACYCF	.33	.29	.33	.18	.38	.24	.32	.16	.14	.33
VYCF	.75	.56	.74	.60	.46	.53	.59	.48	.61	.42

Youth-on-Youth Violence

Comparing the first six months of data on youth-on-youth for FY 2011-2013 shows the rate to remain constant at NACYCF, an initial decline at OHCYCF, and an increase in the rate of youth violence at the VYCF. In 2013, the rates of youth-on-youth violence were lowest at NACYCF and highest at VYCF.

DJJ's CompStat data indicate that, while there have been periodic fluctuations, the overall rate of youth-on-youth violent incidents remained fairly constant over the last 30 months. However, there appears to be a slight declining trend in the rate of violence at OHCYCF and NACYCF, but there has been an increasing rate of youth-on-youth violence at VYCF since the beginning of 2012 with the exception of the most recent quarter. As with the UFO data, the rates of youth violence are much higher at VYCF than at the other DJJ facilities.

	Mar 11	June 11	Sept 11	Dec 11	Mar 12	June 12	Sept 12	Dec 12	Mar 13	June 13
All	.50	.35	.46	.30	.42	.40	.49	.37	.48	.41
OHCYCF	.62	.45	.94	.66	.40	.24	.31	.25	.24	.27
NACYCF	.52	.30	.34	.18	.35	.31	.33	.27	.31	.19
VYCF	.57	.41	.37	.28	.50	.59	.79	.56	.83	.44

Level 3 DDMS Cases

A similar pattern emerged when looking at the most serious (Level 3) DDMS cases. Level 3 DDMS cases involve very violent behavior and serious violations of DJJ rules. Although these rates could fluctuate significantly from quarter to quarter, the overall DJJ rate remained fairly constant in recent years. From the beginning of 2011 through the end of Fiscal Year 2013, the rate of Level 3 DDMS infractions declined at OHCYCF, and saw less of a change at NACYCF or VYCF. The rate of Level3 DDMS violations at VYCF is twice as high at other DJJ facilities,

In the four most recent quarters, there appears to be a high correlation between youth-on-youth violence rates and Level 3 DDMS. In my last Safety & Welfare Comprehensive Report, I said I was encouraged by the data in the June 2012 quarter showing that VYCF appeared to be less reliant on using Level 3 DDMS to respond to youth behavior issues. The Level 3 DDMS rate at VYCF more than doubled in the three subsequent quarters before dropping in the second quarter of 2013.

Level 3 DDMS (Rate per 100 Youth Days)

	Mar 11	June 11	Sept 11	Dec 11	Mar 12	June 12	Sept 12	Dec 12	Mar 13	June 13
All	8.3	5.8	10.7	7.4	7.1	5.9	6.6	7.2	8.1	8.5
OHCYCF	2.6	1.5	3.7	2.9	1.5	1.6	0.7	1.5	1.4	2.0
NACYCF	1.7	1.8	2.3	1.3	2.3	2.4	1.7	1.5	1.8	3.2
VYCF	4.0	2.5	4.7	3.2	3.4	1.9	4.2	4.3	4.8	3.3

Group Disturbances

The number of group disturbance incidents in DJJ declined sharply between 2011 and 2012, and remained fairly constant in 2013. During the first six months of 2012, DJJ facilities reported 20 group disturbances in comparison to 40 such incidents during similar period in 2011. The decline in youth population may be a factor in the reduced number of group disturbances. There were 22 group disturbance incidents during the last six months of 2012 and 27 such incidents during the first six months of 2013. Note that of the 27 group disturbance incidents in the first six months of 2013, 18 (67%) occurred at VYCF, five (19%) at NACYCF and four (14%) at OHCYCF.

Group Disturbances from July 2012 through June 2013

	Jul 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	June 13	Total
All	5	2	4	6	1	4	3	7	1	3	9	4	49
NACYCF	1	1	0	2	0	0	0	0	0	0	3	2	9
OHCYCF	1	1	2	1	0	1	1	3	0	0	0	0	10
VYCF	3	0	2	3	1	3	2	4	1	3	6	2	30

Lockdowns and Limited Programs

DJJ facilities had a total of 43 lockdowns and limited programs in the first six months of 2013 in comparison to 43 and 26 such cases during comparable period in 2012 and 2011, respectively. Lockdowns are supposed to be rare occasions involving very serious threats to the facility security and safety of youth and staff that require restriction of all youth to their rooms or dormitory beds in a living unit. Limited programs consist of short-term suspension of any operation, procedure, service or function to prevent or control a disruption of a segment of youth residents within a living unit.

DJJ had no lockdowns during July 2012 through June 30, 2013. Of the 45 limited programs during this period, OHCYCF accounted for 20, NACYCF for 14, and VYCF 11 cases. Group disturbances often lead to lockdowns and limited programs. It is interesting to note that VYCF by far had the largest number of group disturbances but with the fewest lockdowns and limited program during the one-year period. DJJ management may wish to review the practices at VYCF to assess the lessons learned there that could be applied at the other facilities.

Lockdowns and Limited Programs from July 2012 through June 2013

	Jul 12	Aug 12	Sept 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13	Apr 13	May 13	June 13	Total
All	6	2	6	1	0	4	2	4	0	3	13	4	45
NACYCF	1	1	0	0	0	1	0	0	0	2	6	3	14
OHCYCF	4	1	4	1	0	1	2	2	0	0	5	0	20
VYCF	1	0	2	0	0	2	0	2	0	1	2	1	11

PbS Data about Youth and Staff Safety Concerns

PbS contains many outcome measures that, among other things, survey youth and staff for their safety fear. Over time, there have been significant disparities in PbS survey rates from collection cycle to collection cycle that are difficult to interpret. For example, between the October 2012 and April 2013 collection cycles, the percentage of youth who reported that they feared for their safety declined from 24% to 9%, even though I did not notice a significant change in the facility's climate between my fifth round and sixth round site visits. The percentage of youth

with safety concerns at NACYCF and VYCF during the recent collection cycles is inconsistent with my youth interview results. PbS data show that 19% and 28% of youth at NACYCF feared for their safety during the October 2012 and April 2013 collection cycles, respectively. PbS data also show that 31% and 24% of youth at VYCF feared for their safety during the October 2012 and April 2013 collection cycles, respectively. None of the youth I interviewed expressed any serious safety concerns.

Safety 13 – Percent of interviewed youth who report that they feared for their safety within the last six months while at this facility.

	April 2009	October 2009	April 2010	October 2010	April 2011	October 2011	April 2012	October 2012	April 2013
OHCYCF	20%	28%	22%	38%	21%	23%	22%	24%	9%
NACYCF	31%	32%	23%	32%	28%	18%	23%	19%	28%
VYCF	15%	27%	33%	37%	44%	19%	18%	31%	24%
Field Avg	16%	18%	23%	22%	20%	19%	19%	20%	19%

The safety concern among staff remained fairly constant at all facilities over time with some temporary spikes. Despite the significant spike in the April 2013 collection cycle, there is significant disparity between OHCYCF and the other DJJ facilities as staff at OHCYCF constantly have had the lowest safety concerns.

Safety 14 -- Percent of staff who report that they feared for their safety within the last six months.

	April 2009	October 2009	April 2010	October 2010	April 2011	October 2011	April 2012	October 2012	April 2013
OHCYCF	6%	11%	19%	8%	14%	14%	4%	3%	11%
NACYCF	20%	16%	18%	15%	20%	28%	21%	16%	22%
VYCF	21%	15%	25%	32%	17%	23%	25%	19%	20%
Field Avg	16%	17%	20%	23%	23%	23%	22%	23%	23%

At DJJ's request, the Safety and Welfare Expert included the "PbS Field Average" of these outcome measures for comparison purposes. The PbS field average is a compilation of statistics from just those juvenile justice agencies that participate in PbS. The Safety and Welfare Expert urges extreme caution in using this data for the following reasons:

- These numbers are from a non-random sample of facilities that participate in PbS and the data collection methodology and definitions differ among the facilities.

- Many of these PbS facilities are very small, non-secure, short-term holding or placement facilities and they house very different types of youth.

- A better comparison would be to PbS facilities with larger youth populations and much longer length of stays.

- The PbS field average varies based on which facilities join or leave PbS each time period.

Other Safety and Welfare Issues that Require Additional Consideration

In addition to the issues identified above, I have made additional observations of issues for consideration by the parties and the Court. Each observation is discussed below:

Implementation of IBTM

I found the implementation of IBTM to be proceeding well at OHCYCF, as youth and staff interviewed reacted and commented positively about the program. My observations are consistent with the results of the recently completed audit by the Mental Health Expert.

Despite my previous misgivings about the overall management at VYCF, both VYCF and NACYCF appear to be making satisfactory progress toward IBTM implementation. As the IBTM is still at the very early stage of implementation, much more monitoring is needed, which will be assumed by the Mental Health Expert. I am available to provide assistance and support upon request.

Youth Classification and Assessment System

In my last Safety &Welfare Comprehensive Report, I expressed a concern about the reliance on the California Youth Assessment Screening Instrument (CA-YASI) to make security assignments to living units and as the main assessment tool for the IBTM implementation. I stated that CA-YASI has neither been proven to be reliable nor valid. My interviews with staff at OHCYCF suggest that there is still little real understanding by DJJ staff of the CA-YASI and how it could be utilized to drive effective treatment programs. Spending more money on CA-YASI seems a poor investment, especially given the findings produced by UC Irvine researchers and the judgment of Cheryl Maxson who looked at gang issues. I advised DJJ to consider replacing CA-YASI with another assessment system. The tools that are provided without usage charges by the University of Cincinnati Corrections Institute (UCCI) appear to be a viable and more cost-effective option.

To date, DJJ continues to plan to use CA-YASI as the assessment instrument for the IBTM. There is an argument for not changing the assessment tool right now because there are too many "moving pieces" to implementing the IBTM. But if DJJ wants to continue to use CA-YASI, there is an urgent need to substantially upgrade the knowledge of how to use this approach among the Youth Correctional Counselors, treatment teams and top DJJ managers. The question is whether it is wise to invest more in supplemental training or to switch to training by UCCI.

DJJ pointed out that the validation study of CA-YASI was still taking place and the final report is anticipated in the near future. The preliminary results of that validation study suggest that the

CA-YASI is reasonably good at predicting the frequency of serious institutional infractions but that its value is very suspect as a tool to guide rehabilitation programming and reentry planning.

Ultimately, I agree with the Special Master that the decision to continue to revise the CA-YASI belongs to the DJJ management but I am available to meet with DJJ managers to consider options and to summarize the research literature on this issue. For the purposes of the *Farrell* case, the CA-YASI is acceptable as a tool to make initial assignments to youth to different living units. The most important issue for DJJ is to effectively implement a regular reclassification process that is based on the actual behavior and progress shown by the youth residents.

The DJJ Grievance System

As noted in my last Safety &Welfare Comprehensive Report, I led a team including the OACC staff to conduct a review of DJJ's grievance system as a result of youth at VYCF who overwhelmingly expressed dissatisfaction with the grievance system. The audit team found DJJ's current grievance policy and procedures can be effective if they are appropriately carried out as was in the case at OHCYCF. However, a large number of youth do not understand the process. The audit team recommended additional training for youth and staff to better communicate and interact with each other when issues/problems surface.

While the recommended training has been provided, approximately half of youth interviewed at VYCF and NACYCF during the sixth audit round told us that they do not find the grievance process helpful to them. I think that DJJ has done what was asked of them in this area but that further improvements will be seen only as the IBTM is more fully implemented across all of DJJ.

Gender Responsive Programming

DJJ's female youth population continues to decline to 20 youth during my site visit in late July 2013. As with my previous site visits, I found that female youth at ET appear to be happy with the attention and services they have been receiving. All of these youth are actively involved in various resource groups that include: Individual Counseling, Alcoholics Anonymous, Narcotics Anonymous, Girls Moving On, Women Incarcerated Still Enduring, Anger Interruption Training, Dialectical Behavior Therapy, Community Labor Experience and Responsibility (CLEAR), Interactive Journaling, Bridge to Success, and vocational training in animal grooming. In addition, the living unit is implementing the IBTM and Skill of the Week is being offered.

VYCF recently appointed a new Program Administrator and a new Supervising Casework Specialist (SCWS) to oversee the female living unit. Both individuals appear to me to be highly energized, innovative, and sensitive to gender specific issues. Some of the rooms on the female unit have been decorated and new furniture for the dayroom has been ordered. The Special Master in September 2013 visited the living unit and reported that the new Program Administrator and the new SCWS are fully capable of developing and implementing a program that meets the specific needs of female youth. I respect the Special Master's opinion and recommend that she continue to periodically monitor the progress of the unit. In addition, the Mental Health Expert should monitor this issue as a part of the IBTM implementation.

I previously provided DJJ checklist of the best national standards on the core components of an evidence-based gender responsive model that they could use as a self-assessment tool. The Special Master may wish to consider using some or all sections of the checklist as a basis to measure progress.

Towards a DJJ Comprehensive Gang Strategy

DJJ retained Dr. Cheryl Maxson of UC Irvine, a nationally renowned expert on gangs in California, to conduct an analysis of gang issues and make recommendations. Dr. Maxson and her team have completed the study and issued a report that in essence recommends a strategy of focusing on youth behavior issues and progress toward treatment goals rather than youth gang involvement and affiliations. DJJ has created an internal task force, which has formulated an action plan to address Dr. Maxson's recommendations. I have reviewed the action plan and found it to be completely in line with Dr. Maxson's report and the principles of IBTM. I believe that DJJ has done all that was asked of them in the gang area under the *Farrell* Consent Decree. What needs to be accomplished now is an active implementation of the new DJJ gang approach. As a part of his IBTM monitoring effort, the Mental Health Expert may wish to periodically assess DJJ 's progress in implementing the action plan.

Family Involvement

I believe this issue is still a work in progress even though DJJ apparently is marginally in compliance with the Safety and Welfare Remedial Plan requirements. The Safety and Welfare Remedial Plan identified family involvement as one of the key principles of the plan. The Standards and Criteria identify two audit items pertaining to this issue. First, the facilities are to organize quarterly family visiting events. In addition, the facilities are to facilitate ongoing family phone contact, which has been determined to be at a minimum of four times a month or approximately once each week.

In general, the facilities have been able to organize the quarterly family visiting events on a fairly constant basis. While there still is a great disparity over the practice of family phone calls among the living units, almost all youth interviewed stated they have been receiving at least four phone calls each month. However, as noted under the "Opportunities for Improvement" section of this report, very few youth get more than occasional visits and some received none. Face-to-face family interactions are limited to a small number of residents.

I believe family involvement is even more important as DJJ proceeds to expand the implementation of IBTM to all facilities. I urge DJJ management to consider exploring other means to encourage and promote family contact to beyond organizing the quarterly family visiting events and sometimes sporadic phone contacts. I have reviewed the SBTP Program Guide and found the protocol for family involvement to be extremely well-designed. As a part of IBTM implementation, DJJ management should consult with the Mental Health Expert in adopting an approach patterned after the SBTP Program Guide for family involvement.

Improving DJJ Facilities

During my site visits, I found that conditions significantly improved at some of the recently renovated and redecorated living units. In addition, I understand furniture pieces have been ordered to improve some of the living units. However, as with the comments in my prior reports, I found the outmoded and deteriorating DJJ facilities continue to be a major problem that impedes reform. Space limitations and "prison-like" environments are likely to continue to frustrate significant efforts to improve the quality of care at DJJ.

As previously noted, I believe the approach used in the conversion of the day room at Glenn Hall has a great potential to improve the look and feel of the living units without incurring significant costs. With encouragement from staff and a very nominal budget, youth at Glenn Hall painted and decorated and drastically transformed the dayroom into a setting they are proud of. The concept of allowing youth to be creative in making improvements to the living unit should be emulated throughout the Defendant's facilities.

Significant investments are still needed to upgrade and renovate the deteriorating conditions of most DJJ living units. Given the budget reality, I recognize DJJ cannot address all the shortcomings immediately. However, I do believe it is necessary and appropriate for DJJ to develop a specific plan of action to improve all facilities within a target timeframe of perhaps two years. According to DJJ, it has a plan to modernize and renovate all living units at VYCF within five years. In addition, it is in the process of preparing a Correction Action Plan (CAP) that will address the physical plant issues promptly. I would recommend tasking the Special Master to monitor DJJ implementation progress and report to the Court periodically.

Recommendations

I am very impressed with the quality of the OACC audit and recommend full transfer of monitoring of Safety and Welfare Standards and Criteria to DJJ. I also recommend DJJ and OACC to work collaboratively to review and update the Standards and Criteria of the Safety and Welfare Plan to direct more focus on using outcome measures to assess performance and eliminate duplicative, non-value added audit items.

In addition, I have identified a number of issues that will require more focused monitoring beyond the procedures identified in the Standards and Criteria. Some of the issues are department-wide while other issues are specific to VYCF. I anticipate being actively involved in DJJ's effort in resolving many of these issues during the remainder of this fiscal year. I do not envision any routine Safety and Welfare audit site visits as I believe I can exercise my oversight responsibility by being apprised of DJJ's progress by the OSM and the top DJJ managers and by reviewing applicable data and documents. Of course, should the need arise, I am available to conduct additional site visits to review Safety and Welfare concerns at the request of the plaintiff, the Defendant or the Special Master.

Although I believe most of these Safety and Welfare outstanding issues can be fully addressed during the remainder of this fiscal year, there are several longer-term items. Beyond this fiscal

year, I believe the Mental Health Expert and the Special Master should together assume monitoring responsibility for most of the outstanding issues. I recommend the Mental Health Expert, the Special Master and I, in consultation with the parties, meet to develop a plan to ensure smooth transition of monitoring responsibility. The outstanding issues include the following:

Department-Wide Issues

IBTM

The Mental Health Expert has assumed monitoring responsibility for IBTM. As a part of his efforts, the Mental Health Expert should also monitor DJJ's progress in implementing a gang strategy and devise a protocol for more family engagement, both of which should be in line with the IBTM principles. In addition, the Mental Health Expert and the Special Master should together assess the adequacy of DJJ's effort in addressing gender responsive issues as a part of the IBTM audit of VYCF.

Physical Plant and Conditions of Living Units

Defendant should prepare a plan to make physical plant improvements and acquisition of furniture and equipment (e.g., computers) to make the units more functional and less "prison-like." The plan shall include:

- A schedule that identifies all improvements and acquisitions to be completed during FY 2013-14 and FY 2014-15 and, at the minimum, provides:
  1. Timeframe for completion of each task/purchase identified in the schedule.
  2. The amount of funds (and the funding source) needed to complete each task in the schedule.
  3. If funds have not yet been provided in the adopted budget, identify the funding source or explain how the task will be funded.

- OSM should assume monitoring of Defendant's implementation progress during the next two fiscal years.

Use of Force

- Analyze use-of-force trend and pattern -- This is still a work in progress and by October 31, 2013, Defendant should, in consultation with the Safety and Welfare Expert and OSM, adopt a protocol and procedures for reviewing trend and pattern at the FRC and the DFRC level. The Safety and Welfare Expert will continue to monitor implementation through participation in DFRC through remainder of fiscal year 2013-14.

- Force incidents involving single, non-complaint youth -- Defendant should examine its current policy on this issue and identify means to significantly curtail such incidents. Use of force against single youth should rarely occur. If such events do occur, they should be

under a controlled setting with proper prior approval. The Safety and Welfare Expert will continue to monitor implementation through participation in DFRC through remainder of fiscal year 2013-14.

- Use of chemical agent – Defendant should comply with the Safety and Welfare Remedial Plan by compiling a list of youth with physical limitation (i.e., asthma, chronic heart condition) and mental health issues (i.e., psychotropic medication) who should not be exposed to chemical agents unless involved in group disturbance. Transfer monitoring of this issue to the Mental Health Expert.

VYCF-Specific Issues

- Review by the FRC is too limited with little focus on prevention – Defendant should provide further mentoring and coaching to the VYCF FRC members. The Safety and Welfare Expert will continue to monitor the quality of review through participation in DFRC.

- Lack of quality assurance in the reentry program that resulted in gaps and inconsistencies – Defendant should identify means to coordinate the activities of the facility's Reentry Coordinator, Parole Agents, and Casework Specialists and devise appropriate quality assurance measures.

- Contrabands and drugs – Defendant is well aware of this problem and is taking action to address it. Defendant should develop a plan to address this issue, including action steps to reduce the flow of drugs into the facility and proactive intervention by the living unit staff when evidence suggest youth are using drugs (i.e., marijuana odor). Contrabands and drugs impact many aspects of the Safety and Welfare Remedial Plan, such as use of force against a single youth, DDMS, and gang involvement. I intend to continue to take primary responsibility to monitor Defendant's implementation progress and outcome measures.

- Wards with Disabilities Program – Defendant recently merged the functions of the Disability Coordinator and the Grievance Coordinator into one position. In light of the above-noted observation about the grievance system and questions about the extent of involvement of the Disability Coordinator and staff assistant in case conferences and hearings, Defendant should reassess the functions and duties of these two positions and staff them accordingly.

- High Core Unit (Miramar) – Conditions at this unit have improved and the unit is no longer on limited program status at the time of the Safety and Welfare Expert's site visit. However, much more needs to be done and the unit is at the beginning phase of implementing IBTM. The Mental Health Expert should assuming monitoring of this issue. As the Mental Health Expert's audit of VYCF's IBTM implementation effort is not expected until January 2014, the OSM will in the meantime conduct periodic reviews

to assess the conditions of the living unit. I intend to stay involved in terms of monitoring youth safety and UOF at these units.

- BTP – Youth at the BTP units uniformly complained about the lack of exit criteria. Staff also expressed frustration that they have not been able to transition youth out of BTP due to administrative reasons. OSM will conduct a review of the BTPs at all facilities and, in consultation with me and the Mental Health Expert, make recommendations.

- Incentive Program – The Mental Health Expert should assume monitoring of this issue as a part of IBTM. The BTP has a well-defined program reenforcement system. However, despite months of efforts, staff are unable to produce a level system. The female program is at the beginning phase of implementing such a program. This issue needs to be addressed at the departmental level.

California Department of Corrections and Rehabilitation
Division of Juvenile Justice
Safety and Welfare Remedial Plan Audit
Central Office

Conducted by Barry Krisberg, Ph.D.
Farrell Safety and Welfare Expert
With assistance from
John Chen, Deputy Special Master
August 12, 2013

Introduction

On August 12, Farrell Safety and Welfare Expert Barry Krisberg conducted his sixth round of audit of the Central Office's progress toward implementation of the Safety and Welfare Remedial Plan. Deputy Special Master John Chen assisted Dr. Krisberg in this audit and Annette Herring from the Office of Audits and Court Compliance (OACC), Tammy McGuire, Associate Director, and Doug Ugarkovich, Parole Agent III, *Farrell* Litigation Coordinator, answered the audit team's inquiries and provided all necessary documentation. This report presents the findings and observations of Dr. Krisberg.

During his fifth round of audit, Dr. Krisberg found the Central Office had achieved an overall rate of substantial compliance in excess of 85% for two successive rounds of audit. He also found the work of OACC during the 60-day preliminary review continues to be thorough, professional, and objective. In his 2012 Annual Comprehensive Report, Dr. Krisberg transferred monitoring responsibility for the Central Office's Safety and Welfare Remedial Plan to OACC with the exception of IBTM, reducing use of force, and implementation of an evidence-based gang strategy.[1] Thus, the scope of the sixth round of audit was limited to the following procedures:

- Discussed with Central Office management staff to gain an understanding of progress of certain key issues.
- Discussed with OACC staff for clarification on issues identified during the OACC audit.
- Performed limited reviews of documents and files that support OACC's ratings.
- Reviewed actions taken by Defendant to address issues identified in the OACC's report that are less than substantial compliance.

Review of OACC's Ratings

The Safety and Welfare Expert's review of OACC's 60-Day review report of Central Office's compliance with the Safety and Welfare Remedial Plan and the supporting documents found OACC's ratings to be accurate and reliable. In their audit, conducted during June 25 -27, 2013, OACC auditors found the facility to be in substantial compliance for 134 of 137 audited items (98%) and in partial compliance or non-compliant for 3 of 137 audited items (2%). The three items that were found to be in less than substantial compliance were:

- Item 2.1.4a – "Policies updated per schedule." Of the 33 policy bulletins and temporary departmental orders identified by Defendant's policy unit as in need of annual update, 17 (52%) were determined to be current at the time of the OACC audit. OACC rated this item in partial compliance.

[1] See Twenty-Fourth Report of the Special Master, p. 16.

- Item 3.1h – "Begin semi-annual and quarterly custody reclassification." Within 120 days of initial classification, all youth are to be reclassified at Case Conference using the WIN reclassification process. Defendant's records documented that case conferences had been held. However, it could not provide documentation showing reclassification took place after the case conference due to a malfunction of the Treatment Need Assessment (TNA) machine. The TNA machine tabulates test results and assigns initial classification in WIN. The system could not be updated without the initial classification. OACC rated this item non-compliant.

- Item 7.5 – "convert existing or build new facility if unable to contract." – The Safety and Welfare Remedial Plan specifies that if Defendant is unable to contract for services for some or all female youth, it shall either convert all or part of an existing facility or build a new facility to provide rehabilitative services to female youth. OACC rated this item in partial compliance.

The Safety and Welfare Expert, based on his qualitative judgment, found all three items to be in substantial compliance. For the audit item regarding the annual policy update (Item 2.1.4a), the Safety and Welfare Expert in his fifth round audit report recognized that this requirement may be too cumbersome and suggested Defendant to develop an alternative schedule whereby some of the policies may be updated less frequently. Defendant has developed a revised schedule that calls for some policies to be updated annually while others bi-annually or tri-annually. Based on the revised schedule, which the Safety and Welfare Expert approved, Defendant is in substantial compliance.

For the audit item regarding quarterly custody reclassification (Item 3.1h), the Safety and Welfare Expert noted that case conferences had been held and reclassification took place during the case conferences. The fact that Defendant could not document such activities because of a machine malfunction is not a major cause of concern. Moreover, this item was found to be in substantial compliance in all five previous audit rounds and should remain in substantial compliance in absence of evidence suggesting otherwise.

As for the issue regarding converting or building new facility for female youth (Item 7.5), the Safety and Welfare Expert believes the drastic reduction in the female youth population since the adoption of the Safety and Welfare Remedial Plan renders this requirement unnecessary. During his August 2013 site visit to the female living unit at the Ventura Youth Correctional Facility (VYCF), the Safety and Welfare Expert found vast improvement in the conditions of the living unit as a result of creative initiatives undertaken by staff and youth in the unit. Further upgrades are being considered and anticipated, including ordering of new furniture for the dayroom. IBTM implementation has recently begun at the living unit and the Mental Health Expert will monitor the progress of implementation efforts.

Follow-Up of Previously Identified Issues

In his 2012 Comprehensive Report, the Safety and Welfare Expert transferred monitoring of Central Office Safety and Welfare Remedial Plan to OACC with the exception of IBTM,

reducing use of force, and implementation of a gang strategy. The status of each of these three issues is discussed below:

Implementation of IBTM – IBTM is taking place at O.H. Close Youth Correctional Facility (OHCYCF) and the program is extremely well-received by both youth and staff throughout the facility. This observation is consistent with the findings of the Mental Health Expert in his recently completed audit of OHCYCF's IBTM implementation progress. As implementation has just begun, it is not feasible to measure progress at N.A. Chaderjian Youth Correctional Facility (NACYCF) or VYCF. However, both youth and staff interviewed in general appear to be receptive to the model. The Mental Health Expert will assume monitoring the progress of IBTM implementation and the Safety and Welfare Expert is available to provide support when deemed necessary.

Reducing Use of Force – The Safety and Welfare Expert and the Deputy Special Master have regularly participated in the Department Force Review Committee (DFRC) meetings during most of 2013. Both have noted vast improvement in the quality of the case review at DFRC. In addition, review of cases completed by each facility's Force Review Committee (FRC) show steady improvement at OHCYCF and NACYCF. However, VYCF's FRC process, while improved, remains a work in progress and merits further attention. The DFRC has developed a protocol for analyzing use-of-force trend and patterns, which is in the process of being finalized and utilized in future DFRC meetings. As identified in the Twenty-Fifth and Twenty-Sixth Reports of the Special Master, the issues of use of force against non-compliant youth and the use of chemical agents in mental health units remain outstanding and need resolution. In addition, the Safety and Welfare Expert suggests Defendant reassess its policies regarding the use of medical restraints and body searches to ensure consistency with IBTM principles. The Safety and Welfare Expert and the Deputy Special Master will continue to monitor progress by attending DFRC meetings in the upcoming months.

Implementation of a Gang Strategy – In his 2012 Comprehensive Report, the Safety and Welfare Expert noted that, in response to a study report by Dr. Cheryl Maxson of UC Irvine, Defendant has created an internal task force to formulate an action plan to address Dr. Maxson's recommendations. The Safety and Welfare Expert participated in the task force in providing advice and consultations. The task force developed an implementation plan in April 2013, which is in the process of being finalized. The Safety and Welfare Expert has reviewed Defendant's implementation plan and concluded that it is consistent with Dr. Maxson's recommendations and IBTM principles.

Outstanding Issues

In his 2012 Comprehensive Report, the Safety and Welfare Expert found the outmoded and deteriorating facilities continue to be a problem that impedes reform. Furthermore, because of budget constraints, it is unrealistic to expect a significant infusion of funds to immediately address all of the facilities' physical plant shortcomings.

In her twenty-fourth report, the Special Master suggested that, with a modest investment, options are available for Defendant to convert the existing facilities' living units into more

therapeutic and treatment-oriented settings.[2] The Safety and Welfare Expert shares the Special Master's belief and Defendant's recent experience in remodeling the Glenn Hall at OHCYCF amply demonstrates that this approach is feasible. With encouragement from staff and a very nominal budget, youth at the Glenn Hall painted and decorated, which significantly improved the look and feel of the living unit. All youth expressed great pride with the new living unit setting and the role they played in the remarkable transformation of the unit. Similar efforts are underway at VYCF's El Toyon Hall for female youth, which have already shown highly encouraging results at the time of the Safety and Welfare Expert's site visit at the end of July 2013.

The Safety and Welfare Expert urges Defendant to, in consultation with the other *Farrell* Experts and the Special Master, develop a plan to make physical plant improvements and acquisition of furniture and equipment (e.g., computers) to create an environment that is more conducive to IBTM implementation at the living units. The plan should include the following:

- A schedule that identifies all improvements and acquisitions to be completed during FY 2013-14 and FY 2014-15 and, at the minimum, provides:

    1. Timeframe for completion of each task/purchase identified in the schedule.

    2. The amount of funds (and the funding source) needed to complete each task in the schedule.

    3. If funds have not yet been provided in the adopted budget, identify the funding source or explain how the task will be funded.

Conclusion

Based on the above findings and observations, the Safety and Welfare Expert concludes that Defendant's Central Office has achieved substantial compliance as measured through Standards and Criteria of the Safety and Welfare Remedial Plan. The Safety and Welfare Expert found the quality of OACC audits continues to be exemplary, as he did not identify any need to change OACC's ratings except for the aforementioned issues in which OACC ratings were upgraded through the Safety and Welfare Expert's qualitative judgment. The Safety and Welfare Expert believes it is no longer necessary for him to perform further onsite monitoring of Central Office unless he is specifically requested by Defendant, Plaintiff, or the Special Master to review certain issues.

The Safety and Welfare Expert opined that, based on the current youth population and the number of remaining facilities, Defendant's Central Office has ample resources to oversee and carryout the *Farrell* reform activities. While Defendant's Central Office has demonstrated compliance, there remain important issues to be addressed that are about outcome measures, which may not be resolved by the compliance ratings alone. The issues primarily involve adequacy of casework planning, quality and consistency in the delivery of treatment and services, and interaction between youth and staff. IBTM is the key to addressing these issues. The Safety and Welfare Expert is confident that the Mental Health Expert will properly guide

[2] *See* Twenty-Fourth Report of the Special Master, p.21.

and assess Defendant's implementation progress. The Safety and Welfare Expert is available to provide advice, consultation, and support when deemed necessary.

Although improvements have been made, the Safety and Welfare Expert remains concerned about the outmoded and deteriorating conditions at some of the living units. Defendant should, in consultation with the other *Farrell* Experts and the Special Master, develop a plan to provide an environment conducive to support IBTM implementation with targeted completion date of June 30, 2015. The Special Master should monitor Defendant's implementation effort and periodically report to the Court of progress and challenges.

As it continues to expand implementation of IBTM, Defendant should periodically reassess its processes and documentation requirements to identify, streamline, and eliminate any unnecessary work that were created solely for the purpose of demonstrating compliance and that had provided little added-value. The resource savings should be redirected to providing more treatment and services to youth. As the Safety and Welfare Remedial Plan Standards and Criteria were developed in 2006, it would be appropriate to examine the documents to explore less cumbersome means for measuring performance and assessing compliance to minimize the workload on the facility staff. The Safety and Welfare Expert is available to provide advice and support in this endeavor.

Appendix B

California Department of Corrections and Rehabilitation
Division of Juvenile Justice
Safety and Welfare Remedial Plan Audit
N.A. Chaderjian Youth Correctional Facility

Conducted by Barry Krisberg, Ph.D.
Farrell Safety and Welfare Expert
With assistance from
John Chen, Deputy Special Master
June 12 - 13, 2013

Introduction

On June 12 - 13, 2013, *Farrell* Safety and Welfare Expert Barry Krisberg conducted his sixth round of audit of the N.A. Chaderjian Youth Correctional Facility's (NACYCF) progress toward implementation of the Safety and Welfare Remedial Plan. Deputy Special Master John Chen assisted Dr. Krisberg in this audit, and Annette Herring from the Office of Audits and Court Compliance (OACC) and Doug Ugarkovich, Parole Agent III, *Farrell* Litigation Coordinator, answered the audit team's inquiries and provided all necessary documentation. This report presents the findings and observations of Dr. Krisberg.

During his fifth round of audit, Dr. Krisberg noted that NACYCF had an overall percentage of 84% and 87% of items in substantial compliance during the fourth and fifth rounds, respectively. He also found the work of OACC during the 60-day preliminary review continues to be thorough, professional, and objective. In his 2012 Annual Comprehensive Report, Dr. Krisberg transferred monitoring responsibility for the NACYCF's Safety and Welfare Remedial Plan to OACC with the exception of the IBTM, reducing use of force, implementation of an evidence-based gang strategy, and refinement of the Program Service Day.[1] Thus, the scope of the sixth round of audit was limited to the following procedures:

- Discussed with NACYCF's management staff to gain familiarity with the conditions and issues at the facility.
- Discussed with the OACC staff for clarification on issues identified during the audit.
- Performed sample reviews of documents and files that support OACC's ratings.
- Reviewed actions taken by NACYCF to address issues identified in the OACC's report that are less than substantial compliance.
- Toured the facility's living units.
- Conducted youth interviews. The Safety and Welfare Expert and the Deputy Special Master interviewed a total of 35 youth in seven living units. The youth in the two Sexual Behavior Treatment Units (SBTPs) were not interviewed since the SBTP Expert completed her audits of the two SBTP units in March 2013.

Review of OACC's Ratings

The Safety and Welfare Expert's review of OACC's 60-Day review report of NACYCF's compliance with the Safety and Welfare Remedial Plan and the supporting documents found OACC's ratings to be accurate and reliable. In their audit, conducted during May 6 - 9, 2013, OACC auditors found the facility to be in substantial compliance for 60 of 67 (90%) audited items and in partial compliance and non-compliant for seven of 67 (10%) of the audited items.

[1] See Twenty-Fourth Report of the Special Master, p.16.

The six items that were found to be in partial compliance and the one item found to be non-compliant were:

- Item 2.4.3 – "Vocational Specialist." This item was rated to be in partial compliance because the newly appointed Vocational Specialist indicated that it was difficult to accomplish his assigned role with a full class-time roster and was assigned responsibilities not outlined in his duty statement.

- Item 3.1c – "Male youth classified as high risk for institutional violence separated from low risk youth based on initial custody classification analysis." This was rated partial compliance because the facility could not document this procedure which was performed for 27 of 104 youth in the review period due to a malfunction in the Treatment Needs Assessment (TNA) machine.

- Item 3.1j – "Male youth classified as high risk for institutional violence separated from low risk youth based on initial, interim classification and reclassification." This is the same issue as the Item 3.1c and was rated partial compliance.

- 6.1a – "Convert Chaderjian to a Special Treatment Unit." This item was rated in partial compliance until all living units convert to a rehabilitative model through IBTM.

- 6.7a – "DJJ Integrated Behavior Treatment Model." This item was rated non-complaint as IBTM overview training was provided to 131 of 291 (45%) of required staff.

- 6.7g – "Other key treatment components." Defendant has identified this item to include: Crisis Intervention and Conflict Resolution, Cognitive Behavioral Primer, Aggressive Interruption Training, Counterpoint, and Group Facilitation." As of March 2013, OACC found a cumulative compliance percentage of 59% in training for these treatment components and rated this item to be in partial compliance.

- 8.5.11a – "All direct care staff trained in grievance system." OACC found that 238 of 344 required staff completed training on "Youth Grievance System and Staff Misconduct Complaints" and rated this item to be in partial compliance.

The Safety and Welfare Expert concurred with OACC's ratings. Moreover, he found that some of the above issues have been resolved while other are being addressed as NACYCF continues to expand implementation of IBTM. With respect to the item related to the Vocational Specialist (Item 2.4.3), the Deputy Special Master interviewed the incumbent Vocational Specialist and concluded that his duties had been restructured so that he could fully carry out the responsibilities of his position. For the two items related to youth risk classification (Items 3.1c and 3.1g), the Safety and Welfare Expert noted that both items have been found to be in substantial compliance during the last five audit rounds. The fact that the facility was unable to document such activities for some youth because of a temporary machine malfunction does not

pose a serious concern as clearly such activities have been performed. These three items should be considered in substantial compliance.

Three of the above items (6.1a, 6.7a, and 6.7g) are directly related to IBTM. As Defendant has just begun to implement IBTM at NACYCF, the fact that some staff members have not received all required IBTM training is not unexpected. In the upcoming months, the Mental Health Expert will monitor NACYCF's IBTM implementation progress, which will address the above noted items. As noted in his 2012 Comprehensive Report, the Safety and Welfare Expert defers monitoring of IBTM to the Mental Health Expert.

The issue regarding all direct-care staff trained in youth grievance system (Item 8.5.11a) remained unresolved at the time of the Safety and Welfare Expert's site visit. In his 2012 Comprehensive Report, Dr. Krisberg attached a report discussing the results of a review of Defendant's grievance system conducted by him, the Deputy Special Master, and OACC staff members. The report identified widespread youth dissatisfaction of the grievance system at NACYCF and at the Ventura Youth Correctional Facility and recommended additional training for youth and staff to better communicate and interact with each other when issues/problems surface. During this site visit, more than 50% of youth interviewed continued to complain that facility staff members are unresponsive and the system has little value. For future training opportunities, Defendant should consider reviewing the grievance training curriculum to ensure it is consistent with the IBTM principles.

Issues Identified in the Safety and Welfare Expert's Fifth Round Report

In his 2012 Comprehensive Report, the Safety and Welfare Expert transferred monitoring responsibility for the NACYCF's Safety and Welfare Remedial Plan to OACC with the exception of the IBTM, reducing use of force, implementation of an evidence-based gang strategy, and refinement of the Program Service Day (PSD). Upon further reflection, Dr. Krisberg concluded that these are not facility-specific issues and thus should be addressed at the departmental level. The Mental Health Expert will monitor Defendant's progress in IBTM implementation, which includes continuous refinement of the PSD. The Safety and Welfare Expert will discuss reducing use of force and implementation of gang strategy in his report of Defendant's Central Office audit.

Other Observations

Based on youth interviews and tour of the facility's living units, Dr. Krisberg made the following observations regarding the facility's operations and conditions:

<u>Noteworthy Accomplishments</u>

1. NACYCF's Behavioral Treatment Unit (BTP) appears to be well run. Youth seem well cared for and some residents actually prefer being in the BTP unit compared to their experiences in the high core units. Defendant needs to work on building incentives to facilitate youth transition off the BTP units.

2. Youth consistently praise the new reentry services and groups. It is a first-rate program, well designed and well delivered. The youth report that reentry is the most important service that they are receiving at NACYCF.

3. There is continued positive feedback about the school program. Youth expressed the need for more college classes and are very concerned about budget cuts and the possibility of reducing college offerings in the near future. Overall, the teachers are viewed as very helpful and concerned with the future of the youth.

4. Most NACYCF youth gave very positive ratings to Youth Correctional Counselors, Parole Agents, and Case Managers – they find them accessible, helpful, and concerned for their successful reentry.

5. There are many work opportunities and some excellent vocational programs, especially in computer repairs (Free Venture), landscaping and warehouse management. It is encouraging to see NACYCF youth work outside the fence and to have access to work assignments at the O.H. Close Youth Correctional Facility (OHCYCF).

6. It is encouraging that NACYCF youth in "A phase" status have access to the OHCYCF's pool and can utilize the Recreation Center at OHCYCF.

7. The pilot sites of IBTM are making good progress and are receiving staff and management support.

8. Management at NACYCF make good use of data in their ongoing management meetings. NACYCF top managers are committed to the IBTM and want it to succeed.

9. The UOF review process is detailed, taken very seriously by management and they are up to date on case reviews.

10. There have been modest but significant improvements at NACYCF in some living units. Most of the rooms meet the minimal *Farrell* standards in terms of conditions, and there is clear evidence that substandard rooms are decommissioned.

11. While there have been some major disturbances at NACYCF, the staff are working to return youth to programming fairly quickly.

12. Most youth feel safe but admit that there are still lots of fighting among the youth. Youth at Mental Health units feel less safe than others.

13. Youth generally value the resource groups, especially Impact and Aggressive Interruption Training (AIT).

14. Religious services are very important and praised by the youth.

Opportunities for Improvement

1. There were three very serious group disturbances in May 2013 and the violence levels, while down, are still too high.

2. More than half the youth feel that the grievance system is not working to solve issues of importance to them.

3. Very few youth get more than occasional visits and some received none. Face-to-face family interactions are limited to a small number of residents.

4. The incentive system is delivered in an uneven manner and is not well understood by the youth.

5. Youth complain about "favoritism" by staff because rules are not consistently followed by different staff members – for example, some staff will offer lots of incentive opportunities and others are still focused on managing the Disciplinary Decision Management System (DDMS) process.

6. There are several living units that need physical repairs to floors and other parts of the units.

7. Some units still mostly rely on living unit common areas to provide counseling and small and large groups.

8. Some youth find safety by staying in their rooms, hanging around staff and keeping away from other youth. Some of these youth would prefer to be housed in a protective custody unit.

9. There are still a few staff who engage in verbal abuse and jokes of a sexualized nature – complaints to supervisors sometimes lead to staff being assigned to other units. All Defendant staff members need urgent and intensive training on the new Prison Rape Elimination Act (PREA) rules.

10. NACYCF still uses referrals to adult court to manage serious rule violations without very strong evidence that this is anything but a short term fix.

11. There are complaints about the food in terms of too small portions and poor quality.

12. A-phase youth at NACYCF want more opportunities to earn placements in Forestry Camps.

Conclusion

Based on the above findings and observations, the Safety and Welfare Expert concludes that NACYCF is continuing to make steady progress toward compliance with provisions of the

Safety and Welfare Remedial Plan. The facility has achieved an overall rate of substantial compliance in excess of 85% for two successive rounds of audit as measured by Standards and Criteria of the Safety and Welfare Remedial Plan. Moreover, the Safety and Welfare Expert found the quality of OACC audits continues to be exemplary as he did not identify any need to change the OACC's ratings except for the aforementioned issues. Some of the ratings were upgraded because of more updated information that occurred after the OACC's audit or through the Safety and Welfare Expert's qualitative judgment. The Safety and Welfare Expert believes it is no longer necessary for him to perform further onsite monitoring of NACYCF unless he is specifically requested by Defendant, Plaintiff, or the Special Master to review certain issues.

The Safety and Welfare Expert opined that while the facility has demonstrated compliance as measured by Standards and Criteria, there remain important issues to be addressed at NACYCF that are about outcome measures, which may not be resolved by the compliance ratings alone. The issues primarily involve adequacy of casework planning, quality and consistency in the delivery of treatment and services, and interaction between youth and staff. IBTM is the key to addressing these issues. The Safety and Welfare Expert is confident that the Mental Health Expert will properly guide and assess Defendant's implementation progress. The Safety and Welfare Expert is available to provide advice, consultation, and support when deemed necessary.

As it continues to pursue implementation of IBTM, Defendant should periodically reassess its processes and documentation requirements to identify, streamline, and eliminate any unnecessary work that were created solely for the purpose of demonstrating compliance and provided little added-value. The resource savings should be redirected to providing more treatment and services to youth. As the Safety and Welfare Remedial Plan Standards and Criteria were developed in 2006, it would be appropriate to examine the documents to explore less cumbersome means for measuring performance and assessing compliance to minimize the workload on the facility staff. The Safety and Welfare Expert is available to provide advice and support in this endeavor.

Appendix A

California Department of Corrections and Rehabilitation
Division of Juvenile Justice
Safety and Welfare Remedial Plan Audit
O.H. Close Youth Correctional Facility

Conducted by Barry Krisberg, Ph.D.
***Farrell* Safety and Welfare Expert**
With assistance from
John Chen, Deputy Special Master

June 10 - 11, 2013

Introduction

On June 10 - 11, 2013, *Farrell* Safety and Welfare Expert Barry Krisberg conducted his sixth round of audit of the O.H. Close Youth Correctional Facility's (OHCYCF) progress toward implementation of the Safety and Welfare Remedial Plan. Deputy Special Master John Chen assisted Dr. Krisberg in this audit and Annette Herring from the Office of Audits and Court Compliance (OACC) and Doug Ugarkovich, Parole Agent III, Farrell Litigation Coordinator, answered our inquiries and provided all necessary documentation. This report presents the findings and observations of Dr. Krisberg.

During his fifth round of audit, Dr. Krisberg found that OHCYCF has achieved an overall rating of substantial compliance in excess of 85% for two successive rounds of audit. He also found the work of OACC during the 60-day preliminary review continues to be thorough, professional, and objective. Thus, in his 2012 Annual Comprehensive Report, Dr. Krisberg transferred monitoring responsibility for the OHCYCF's Safety and Welfare Remedial Plan to OACC with periodic consultation from the Safety and Welfare Expert.[1] Thus, the scope of the sixth round of audit was limited to the following procedures:

- Discussion with OHCYCF's management staff to gain familiarity with the conditions and issues at the facility.
- Discussion with OACC staff for clarification on issues identified during the OACC audit.
- Performed limited reviews of documents and files that support the OACC's ratings.
- Reviewed actions taken by OHCYCF to address issues identified in the OACC's report that are less than substantial compliance.
- Toured the facility's living units.
- Conducted youth interviews. The Safety and Welfare Expert and the Deputy Special Master interviewed a total of 25 youth in five living units. The youth in the two Sexual Behavior Treatment Units (SBTPs) were not interviewed since the SBTP Expert completed her audits of the two SBTP units in March 2013.

Review of OACC's Ratings

The Safety and Welfare Expert's review of OACC's 60-Day review report of OHCYCF's compliance with the Safety and Welfare Remedial Plan and the supporting documents found OACC's ratings to be accurate and reliable. In their audit, conducted during April 2 -5, 2013, OACC auditors found the facility to be in substantial compliance for 63 of 66 audited items (95%) and in partial compliance for three of 66 audited items (5%). The three items that were found to be in partial compliance were:

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[1] See Twenty-Fourth Report of the Special Master, p. 16.

- Item 6.7a – Complete Training for Integrated Behavior Treatment Model (IBTM). As of March 11, 2013, training records indicated 104 of 138 required staff (75%) have received IBTM Overview training.

- Item 6.7g – Complete IBTM training for "other key treatment components." DJJ has identified "other key treatment components" to include: Crisis Intervention and Conflict Resolution, Cognitive Behavioral Primer, Aggressive Interruption Training, Counterpoint, and Group Facilitation." As of March 2013, OACC found a cumulative compliance percentage of 78% in training for these treatment components.

- Item 8.5.5.a – Facility Grievance Coordinator prepares monthly reports. OACC's review found OHCYCF was only able to provide documentation supporting eight of 11 (73%) monthly reports that were prepared over the 11-month period of May 2012 through March 2013.

The Safety and Welfare Expert found OHCYCF had already addressed all three above issues by the time his site visit took place. On the two issues related to IBTM training (Items 6.7a and 6.7g), the Mental Health Expert conducted his audit of OHCYCF's IBTM implementation progress on June 5 – 7, 2013. Based on more updated training summary, he has found both items to be in substantial compliance. As for the issue related to the Grievance Coordinator's monthly reports, the facility staff produced the missing reports as well as the monthly reports for May and June 2013 to demonstrate compliance. Thus, OHCYCF achieved an overall rating of 100% as measured by the Standards and Criteria of the Safety and Welfare Remedial Plan.

Other Observations

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Based on youth interviews and tour of the facility's living units, Dr. Krisberg made the following observations regarding the facility's operations and conditions:

1. He was very impressed with the conversion of the day room at Glenn Lodge to a home-like environment. This illustrates what staff and youth can do when they are working together for a common purpose.

2. The IBTM is going through a "revitalization" given some staffing changes at OHCYCF but is continuing at an acceptable level of implementation.

3. The youth continue to have great things to say about the school program; there are some college courses and some concern the funding for the college classes may be reduced due to budget issues. They had 50 graduates recently and the youth report that the school is very much like a school in the community. The teachers are caring and try to help the youth.

4. The management team at OHCYCF is working well together and staff morale seems quite good. Staff seems to have genuinely bought into the IBTM philosophy although they recognize that there is more work to meet the high standards for treatment services set by Defendant's leadership and the *Farrell* experts.

5. There have been a few serious fights and a very serious staff assault at OHCYCF. The managers are analyzing these events and using agreed upon protocols to respond. Tensions between the high core units have led to group disturbances and require careful orchestration of movements for outside recreation.

6. The youth interviewed uniformly reported as feeling safe and that staff were acting in a very professional manner.

7. Youth stated that they do go to staff for advice and help when they are anxious or under stress.

8. Very few youth get any visits. This issue of isolation from community connections remains a key issue.

9. Two of the older youth at OHCYCF want to transfer to N. A. Chaderjian Youth Correctional Facility (NACYCF) because they would prefer single rooms and believe that the immaturity of some OHCYCF youth leads to conflicts.

10. There were uniform positive reactions to the resource groups, especially Impact, AIT and the Interactive Journaling. Counterpoint groups are less valued and the skill level of group leaders needs to be improved.

11. The physical plant had improved in terms of cleanliness. The 'cool down rooms" are in better shape.

12. Youth are very positive about the reentry programming and get great service from the Reentry Program Coordinator. The emerging Reentry Program at OHCYCF could become a statewide and even a national model.

13. OHCYCF has created a Family Council that included six to seven families who meet monthly.

14. The facility remains shorthanded in terms of administrative and plant management staff. This was created by some retirements but is being rectified. There are no large number of vacancies in direct-care positions.

15. The youth in the Behavioral Treatment Program (BTP) unit seemed generally happy and well-cared for. The main complaint was to have more visits and more commissaries.

16. Food was rated as passable.

17. The grievance system seems to be working as designed. Most of the youth report that they have no major problems and do not really need the grievance system.

18. The youth understand the new Incentive System and report that they like it.

19. The youth get lots of out-of-room time and lots of outside recreation.

20. Gardening and landscaping activities continue to be positively received by the youth and the staff.

21. Restrictive programs are used sparingly and school and counseling are regular parts of these programs.

22. Most youth seem to be getting an acceptable level of pro-social activities during the day.

23. Religious services are well utilized and valued by the youth.

24. There is a need to increase vocational offering and to expand work opportunities after school hours and for graduates.

25. The youth give positive ratings to medical care and value the mental health services that are provided.

26. Data from PbS and Compstat show some trending improvements in UOF and violent incidents.

Conclusion

Based on the above findings and observations, the Safety and Welfare Expert believes OHCYCF has made significant improvements and demonstrated that it has the capacity to facilitate successful implementation of IBTM. Moreover, the Safety and Welfare Expert found the quality of OACC audits continues to be exemplary as he did not identify any need to change OACC's ratings except for the aforementioned issues where the ratings were upgraded because of more updated information that occurred after the OACC's audit. The Safety and Welfare Expert believes it is no longer necessary for him to perform further onsite monitoring of OHCYCF unless he is specifically requested by Plaintiff, Defendant or the Special Master to review certain issues.

As it continues to pursue implementation of IBTM, Defendant should periodically reassess its processes and documentation requirements to identify, streamline, and eliminate any unnecessary work that were created solely for the purpose of demonstrating compliance and provided little added-value. The resource savings should be redirected to providing more treatment and services to youth. As the Safety and Welfare Remedial Plan Standards and Criteria were developed in 2006, it would be appropriate to examine the documents to explore less cumbersome means for measuring performance and assessing compliance to minimize the

workload impact of the facility staff. The Safety and Welfare Expert is available to provide advice and consultation.

Appendix C

California Department of Corrections and Rehabilitation
Division of Juvenile Justice
Safety and Welfare Remedial Plan Audit
Ventura Youth Correctional Facility

Conducted by Barry Krisberg, Ph.D.
Farrell Safety and Welfare Expert
With assistance from
John Chen, Deputy Special Master
July 29 – August 1, 2013

Introduction

From July 29, 2013 through August 1, 2013, *Farrell* Safety and Welfare Expert Barry Krisberg conducted his sixth round of audit of the Ventura Youth Correctional Facility's (VYCF) progress toward implementation of the Safety and Welfare Remedial Plan. Deputy Special Master John Chen assisted Dr. Krisberg in this audit, and the Office of Audits and Court Compliance (OACC) and Doug Ugarkovich, Parole Agent III, *Farrell* Litigation Coordinator, answered the audit team's inquiries and provided all necessary documentation. This report presents the findings and observations of Dr. Krisberg.

During his fifth round of audit, the Safety and Welfare Expert noted that VYCF had an overall percentage of 67% and 84% of items in substantial compliance during the fourth and fifth rounds, respectively. He also found the work of OACC during the 60-day preliminary review continues to be thorough, professional, and objective. However, despite improvements in the overall percentage of items found to be in substantial compliance between the fourth and fifth rounds, Dr. Krisberg found VYCF remains a work in progress. Unlike the Central Office and the two facilities in the Stockton Complex where he transferred monitoring responsibility to OACC, Dr. Krisberg retained full monitoring responsibility for VYCF. Therefore, the report for VYCF contains a rating for all audit items identified in the Standards and Criteria of the Safety and Welfare Remedial Plan with appropriate comments (see attachment).

The following procedures were performed during the sixth round of audit:

- Discussed with VYCF's management staff to gain familiarity with the conditions and issues at the facility.
- Selected VYCF staff members for interview to follow-up on issues identified during the audit and to clarify issues noted in the OACC's 60-days report.
- Performed sample reviews of documents and files that support the OACC's ratings.
- Reviewed actions taken by YYCF to address issues identified in the OACC's report that are less than substantial compliance.
- Toured every living unit within VYCF.
- Conducted youth interviews. The Safety and Welfare Expert and the Deputy Special Master interviewed a total of 39 youth in nine living units.

Review of OACC's Ratings

The Safety and Welfare Expert's review of OACC's 60-Day review report of VYCF's compliance with the Safety and Welfare Remedial Plan and the supporting documents found OACC's ratings to be accurate and reliable. In their audit, conducted during May 20 - 24, 2013, OACC auditors found the facility to be in substantial compliance for 64 of 71 (90%) audited

items and in partial compliance and non-compliant for seven of 71 (10%) of the audited items. The Safety and Welfare Expert made the following adjustments to OACC' ratings:

- Item 8.3.2b – "Ongoing family phone contact facilitated." OACC rated this item in partial compliance because the facility could not produce adequate documentation to support youth who have received the mandated number of phone calls. OACC also noted that all 21 youth randomly selected for interview stated that they did receive the mandated phone calls. Youth interview results of the Safety and Welfare Expert and the Deputy Special Master also found that all youth have received at least the mandated number of phone calls. In certain living units, such as El Toyan, youth reported that staff often encouraged them to make family contacts as often as feasible. This item is rated in substantial compliance.

- Item 6.7g – "Other key treatment components." As a part of its IBTM implementation effort, Defendant identified "other key treatment components" to include the following training modules: Crisis Intervention and Conflict Resolution (CICR), Cognitive Behavioral Primer (CBP), Aggression Interruption Training (AIT), Girls Moving On (GMO), CounterPoint, and Group Facilitation. OACC rated this item non-compliant because the cumulative compliance rating for all these training modules is 41%. As the IBTM implementation has just begun at VYCF in March 2013 and was limited to one living unit, it is unrealistic to expect all staff at the facility to be fully trained on all modules. The Safety and Welfare Expert believes the Mental Health Expert, who is responsible for monitoring the IBTM implementation progress, should reassess the criteria for determining compliance for this item. The Safety and Welfare Expert rated this item not applicable pending the Mental Health Expert's upcoming IBTM audit.

- Item 3.3b – "Create Violence Reduction Committees at each facility." OACC rated this item not applicable because the function of Violence Reduction Committee has been reassigned to the Force Review Committee (FRC). Both the Safety and Welfare Expert and the Deputy Special Master have been actively participating in the Department Force Review Committee (DFRC) and are impressed by Defendant's current efforts to develop a module to conduct more meaningful reviews of trend and patterns at the FRC level and at the DFRC level. However, at the time of the site visit, there was no evidence of consistent and meaningful review during VYCF's FRC meetings. This item is rated in partial compliance until the module is fully developed and implemented.

- Item 6.5a – "Full implementation" of Behavior Treatment Program (BTP). OACC rated this item in substantial compliance because the BTP unit met the staffing requirement of the business rule, does not exceed the maximum allotted youth, and has a BTP PSD schedule in place. The Safety and Welfare Expert believes it is premature to conclude that full implementation of BTP has been completed. Although VYCF's BTP operation has vastly improved in recent months, the youth population ranges from 22 to 24 in recent months while the Safety and Welfare Remedial Plan specifies future BTP living units will be limited to eight to 16 youth as

guided by contemporary standards of care and national standards for special populations. Moreover, most youth and staff interviewed said they do not have a clear understanding of exit criteria and the issue of apparently excessive length of stay for some youth in BTP requires further assessment. Finally, the unit management was tasked with developing an incentive level system and over a year later has not created a final draft of such a system. The Safety and Welfare Expert recommends the parties meet to agree on a course of action required for "full implementation." In the meantime, this item is rated in partial compliance.

- Item 9.2.4 – "Youth in TD receive all mandated services as listed in the Restricted Program Policy section 7210." OACC did not rate this item because Section 7210 identified 14 specific services and it is not feasible to capture data to demonstrate compliance for all 14 services. Instead of TD, Defendant now uses the Treatment Intervention Program (TIP) to house youth in need of a temporary restricted program. Unlike the TD program where youth were housed in restricted programs months at a time, an overwhelming number of youth are taken off TIP within three days, often within the same day. None of the youth interviewed voiced any concern about not receiving mandated services while on TIP. Based on the Safety and Welfare Expert's observation, this item is rated in substantial compliance.

Other Observations

Based on youth interviews and a tour of the facility's living units, Dr. Krisberg made the following observations regarding the facility's operations and conditions:

1. There has been progress in operation of and conditions in the BTP but there is still need to work on exit and entrance decision making criteria, as apparently neither the youth nor the staff has a clear understanding of such criteria. Moreover, Defendant should reassess its protocol for transitions especially for the longer staying youth, and revisiting the value of loss of privileges such as visiting, canteen, and program time for the therapeutic mission of the BTP.

2. VYCF's FRC has managed to eliminate its backlog of cases to be reviewed by conducting meetings more frequently and the recent reduction in the number of use-of-force incidents, possibility due to summer recess. Based on the Safety and Welfare Expert's observation through his participation in DFRC, the FRC needs to devote greater emphasis on force prevention before and after the incident rather than narrowly focus on whether force was "in compliance with policy". There must be greater attention to use of force on single youth incidents and use of chemical agents on youth with mental health conditions. More attention should be paid to preventing and avoiding the use of force in single youth incidents. The Safety and Welfare Expert recently learned that, due to more mentoring and coaching by staff members from the Central Office, the quality of FRC review has improved. However, he has not had the opportunity to observe and determine the extent of improvement. He will follow-up on this issue through his participation in future DFRC meetings.

3. Drug and contraband issues remain very troubling at VCYF. Both youth and staff interviewed (including the Chief of Security) acknowledged that this is a serious issue and needs immediate management focus and attention. Defendant needs to develop a comprehensive plan to address this problem.

4. Physical plant has improved at the BTP (Monte Vista), El Mirasol (EM), and El Toyan (ET) largely due to recent renovation efforts. However, the conditions at the other units remain poor and in need of vast improvement.

5. Approximately 50% of youth interviewed said the grievance system does not work for them. I conclude this issue could only be resolved through better communication and interaction between youth and staff.

6. The female program at ET is vastly improved. I suggest that VYCF consider the approaches at the facilities in the Stockton Complex to humanize the living units, especially the common areas, by providing youth with a modest budget and allow them to creatively make improvements.

7. The youth interviewed spoke highly of the groups conducted and services provided by the Reentry Coordinator. However, she could only deliver a small portion of such services and the reentry services provided by other staff members are inconsistent at best. The reentry services need to be better coordinated and quality assurance measures should be installed to consistently deliver useful and meaningful services. Youth want and need more help in this area. Reentry services must be core to the overall IBTM program.

8. The facility should reassess its Youth with Disability Program procedures to ensure youth with mental health conditions are getting meaningful staff assistance to help them maneuver through grievance hearings, DDMS hearings, case conferences, and board hearings.

9. High core units are still very troubled, particularly at Miramar. The staff members at VYCF still rely on limited programming, single youth programs, and several separate groups to manage fighting. It is unclear if VYCF staff are using the CRTs to maximum advantage on this issue.

10. There has been some progress on vocational programming, and many youth have part-time work assignments. Given the age of youth and the large number of high school graduates, there should be a greater focus and priority placed on college programs and more advanced vocational offerings.

11. VYCF could expand the animal grooming program for the males.

12. VYCF should continue to explore the feasibility of creating a full college program because of the large number of high school graduates, not just some course offerings.

13. There appears to be little difference between high-core and low-core unit programs in terms of Program Service Day, school, and treatment offerings.

14. Youth interviewed could not distinguish the differences between high-core and low-core units except that the low-core units have less fighting and they are less at risk of getting DDMS.

15. IBTM implementation is off to a promising start but needs close monitoring for quality assurance. Many of the issues raised above should be substantially resolved with a full rollout of the IBTM. The Mental Health Expert will monitor VYCF's IBTM implementation progress.

16. Incentive program is doing well at the BTP. The female unit is starting to develop a re-enforcement system, which is near completion. However, other than the daily incentive of additional hours of program time in the evening, there appears to be little other formalized incentives at the other units.

Conclusion

Based on the above findings and observations, the Safety and Welfare Expert concludes that VYCF is continuing to make steady progress toward compliance with provisions of the Safety and Welfare Remedial Plan. The facility has achieved an overall rating of substantial compliance of 84% in the fifth round and 90% in the sixth round of audits as measured by the Standards and Criteria of the Safety and Welfare Remedial Plan. Moreover, the Safety and Welfare Expert found the quality of OACC audits continues to be exemplary as he did not identify any need to change the OACC's ratings except for the aforementioned issues. Most of the changes were made through the Safety and Welfare Expert's qualitative judgment. The Safety and Welfare Expert believes it is no longer necessary for him to perform further onsite monitoring of VYCF unless he is specifically requested by Defendant, Plaintiff, or the Special Master to review certain issues.

Although further on-site monitoring at VYCF is no longer necessary, the Safety and Welfare believes certain issues still need to be resolved in order for the facility to fully meet the purpose and intent of the Safety and Welfare Remedial Plan. The issues are highlighted below:

- Review by the FRC is too limited with little focus on prevention – Defendant will provide further mentoring and coaching to the VYCF FRC members. The Safety and Welfare Expert and OSM will continue to monitor the quality of review through participation in DFRC.

- Lack of quality assurance in the reentry program that resulted in gaps and inconsistencies – Defendant will identify means to coordinate the activities of the facility's ReEntry Coordinator, Parole Agents, and Casework Specialists and devise appropriate quality assurance measures.

- Grievance System – Defendant should further review this issue at VYCF.

- Contrabands and drugs – Defendant is well aware of this problem and is taking action to address it. Defendant will develop a plan to address this issue, including action steps to reduce the flow of drugs into the facility and proactive intervention by the living unit staff when evidence suggest youth are using drugs (i.e., marijuana odor). The OSM will monitor Defendant's implementation progress and outcome measures.

- WDP Program – Defendant recently merged the functions of the Disability Coordinator and the Grievance Coordinator into one position. In light of the above-noted observation about the grievance system and questions about the extent of involvement of the Disability Coordinator and staff assistant in case conferences and hearings, Defendant should reassess the functions and duties of these two positions and staff them accordingly.

- High Core Unit (Miramar) – Conditions at this unit have improved and the unit is no longer on limited program status at the time of the Safety and Welfare Expert's site visit. However, much more needs to be done and the unit is at the beginning phase of implementing IBTM. The Mental Health Expert should monitor this issue through his IBTM audits. As the Mental Health Expert's audit of VYCF's IBTM implementation effort is not expected until January 2014, the OSM will in the meantime conduct periodic reviews to assess the conditions of the living unit.

- BTP – Youth at the unit uniformly complained about the lack of exit criteria. Staff also expressed frustration that they have not been able to transition youth out of BTP due to administrative reasons. OSM will conduct a review of the BTPs at all facilities and, in consultation with the Mental Health Expert, make recommendations.

- Incentive Program – The Mental Health Expert will assume monitoring of this issue. The BTP has a well-defined re-enforcement system. However, despite months of efforts, the staff are unable to produce a level system. The female program is at the beginning phase of implementing such a program. This issue needs to be addressed at the departmental level.

As it continues to pursue implementation of IBTM, Defendant should periodically reassess its processes and documentation requirements to identify, streamline, and eliminate any unnecessary work that was created solely for the purpose of demonstrating compliance and that provided little added-value. The resource savings should be redirected to providing more treatment and services to youth. As the Safety and Welfare Remedial Plan Standards and Criteria were developed in 2006, it would be appropriate to examine the documents to explore less cumbersome means for measuring performance and assessing compliance to minimize the workload on the facility staff. The Safety and Welfare Expert is available to provide advice and support in this endeavor.

DJJ GANG/RACE INTEGRATION STRATEGY IMPLEMENTATION PLAN - As of 9/16/13

Task #	Task	Assigned Staff	Status	Projected Completion Date	Actual Completion Date	Proof of Practice/Completion
Administrative Tasks:						
1	Form a Workgroup.	Doug Ugarkovich	Completed	NA	8/17/2012	8/17/12 memo from Director Minor. First Workgroup meeting held on 8/28/12 at STC.
2	Provide Response to Gang Expert's Report.	Chuck Supple	Completed	NA	11/9/2012	11/9/12 email from Doug Ugarkovich with the Workgroup's recommendations sent to the S&W Expert and the OSM.
3	Develop implementation plan.	Doug Ugarkovich	Completed	NA	4/19/2013	Implementation plan submitted to T. McGuire and A. Lucero for approval on 4/19/13
Workgroup's Recommendations:						
A	> Renew Project IMPACT's contract.	Larry Miranda	In-progress	11/1/2013		The contract is currently out to bid.
E	> The Juvenile Parole Board should focus on a youth's behavior, not gang affiliation when determining parole readiness.	DJJ Executive	Completed	N/A	5/31/2013	Eleanor Silva sent an email out to all the Juvenile Parole Board members reinforcing the idea that the Parole Board should focus on a youth's behavior and not a perceived idea of a youth's gang affiliation or degree of involvement when assessing parole release.
F	> The Reinforcement System training should be slightly tweaked to emphasize reinforcement of positive behaviors by gang related youth.	STC	In-progress	10/1/2013		The Reinforcement Training is currently being revised and it will contain examples of youth who have difficulties interacting with other youth from different peer groups.
G	> The Conflict Resolution training should be tweaked to better emphasize that conflict resolution is a shared responsibility among all staff, especially YCCs (not just CRTs).	STC	In-progress	10/1/2013		The Conflict Resolution training is provided by an outside vendor and therefore DJJ does not have the ability to alter the training materials. The training does identify that conflict resolution is a shared responsibility among all staff and therefore DJJ believes the current training is sufficient as is. However, in order to further emphasize this idea, a memo will be developed for Director Minor's signature that will reinforce the idea that conflict resolution is a shared responsibility among all staff.
H	> Develop a monthly calendar for structured activities in the dayroom.	Facility Superintendents	In-progress	11/1/2013		Each DJJ facility will create a Facility Recreation Committee that will be responsible to create a monthly activities calendar for each month of the year and for each living unit within that facility. The calendar will identify structured activities that will take place within the dayroom when youth are participating in "open program." Youth are free to choose whether or not they wish to participate in these activities.
I	> Provide Conflict Resolution and Gang Awareness training to education staff.	STC	In-progress	6/30/2014 (FY 13/14)		Teachers will be required to complete the Crisis Prevention & Management/Use of Force Refresher Training (4 hours) and Core Correctional Practices (8 hours) per the 2013/2014 Block Training schedule. In regards to the Gang Awareness Training recommendation, DJJ does not believe this is necessary as a youth's behavior and not their perceived gang allegiance, should be at the center of any staff interaction and interventions and ultimately the key element in assessing a youth's progress in treatment.

Task #	Task	Assigned Staff	Status	Projected Completion Date	Actual Completion Date	Proof of Practice/Completion
Workgroup's Response to S&W Expert's concerns:						
4	Rename GIC position.	DJJ Executive	Completed	9/1/2013	3/8/2013	An email was sent out from Doug Ugarkovich on 3/8/13 to outside stakeholders identifying the new name as the "Behavior Intervention Coordinator (BIC)." Although this task has been completed, it cannot be implemented in the field until a new duty statement has been created and approved by the various stakeholders.
4a	Re-write GIC/BIC duty statement.	Larry Miranda	In-progress	12/1/2013		A revised draft duty statement has been crafted and is currently being reviewed by DJJ Headquarters.
Workgroup's Recommendations that were not adopted by DJJ:						
B	> Efforts should be made to have Project IMPACT validated.	N/A	N/A	*While this recommendation would be helpful to DJJ, DJJ has no authority to ensure this happens, instead this would be the responsibility of the Project IMPACT administrators as they are a contracted vendor.*		
C	> Better align and integrate Project IMPACT with IBTM principles.	N/A	N/A	*While this recommendation would be helpful to DJJ, DJJ has no authority to ensure this happens, instead this would be the responsibility of the Project IMPACT administrators as they are a contracted vendor.*		
D	> GIC will now score certain sections of the CA-YASI.	N/A	N/A	*The Workgroup has reconsidered this recommendation and no longer endorses this recommendation until which time the CA-YASI is validated. At that time this recommendation may be revisited.*		