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SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. JAMES TILTON, Defendant.	Case No.: RGO3079344 SIXTH REPORT OF SPECIAL MASTER

SIXTH REPORT OF THE SPECIAL MASTER

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I. INTRODUCTION

Since the last report of the Office of the Special Master ("OSM") filed in late October 2007, the mental health experts have completed their report covering those requirements of the mental health and the safety and welfare plans that have deadlines through at least September 2007. The OSM also has monitored issues under the mental health and safety and welfare plans with deadlines through the same period. This report is based on this monitoring by the mental health experts and by OSM. The special master's fourth and fifth reports covered the other areas of the case; the experts in those areas are in the middle of rounds of monitoring and they did not submit information to the OSM for this report. The OSM did not do any independent monitoring in those areas.

At the request of DJJ's counsel, the special master extended DJJ's time to make available to the special master the staff and the documents that the special master has requested related to the systems issues that the special master reviewed in her fourth and fifth reports. The special master plans to cover these issues in her next report, which will be filed in mid-March 2008.

II. MENTAL HEALTH SERVICES

Since their last report in May 2007, the mental health experts conducted a site visit at the Heman G. Stark facility in July, and met with DJJ's central office staff in August and December 2007. Their report, which is attached as Appendix A, also draws on information from their full round of site visits conducted in late 2006 and early 2007.

A. A New Progressive Policy For Management of Potentially Self-Harming Youth

In December 2007, DJJ finalized its policy for the management of youth who are thought to be at risk of self-injurious behavior. Over the past six months, DJJ substantially revised its last draft and now has produced a policy, signed by DJJ's Chief Deputy Director, that fully meets

contemporary standards for the management issues it covers.[1] It is a progressive policy, replacing isolation and restriction with supervision, and the mental health experts strongly support its responsible implementation. It is relatively clearly written – in contrast to prior versions -- and that should facilitate staff training and implementation. The policy includes provisions for staff training and quality improvement, as well as the forms necessary for its implementation.[2]

The special master's reports have detailed DJJ's previous failures to develop and implement a policy to manage youth who appear to be at risk of self-injurious behavior. The success of the current effort resulting in a sound and easily understood policy might be the firm footing that DJJ has needed in order to move forward with the necessary change in attitudes and practices.[3] The experts and special master will monitor the next steps closely. These steps include labor negotiations before the policy can be promulgated to the facilities for implementation, development of training materials, the actual training of non-clinical and clinical staff and, finally, the implementation of the new policy.

The experts have cautioned DJJ to plan the implementation of the new policy carefully, because the changes it requires are so substantial and the safety issues surrounding the management and treatment of self-harming youth are unique. Clinical and non-clinical staff will face new challenges as they take on new roles in the management of these youth. DJJ's

[1] This policy does not address the treatment to be provided by clinicians and non-clinicians working with them and under their clinical direction. The mental health experts repeatedly have urged that DJJ provide clinical training to enhance the skills of clinicians in the treatment of self-harming youth, as a first necessary step towards introducing evidence-based treatments. See, Fourth Report of the Special Master, p. 18. Successful implementation of the new management policy will depend upon both skillful and effective clinical treatment and the adequate direction of non-clinical staff.
[2] *See,* Appendix A (Lee/Trupin report), Attachment 1, #24.
[3] *See*, Fourth Report of the Special Master, pp. 15-17.

leadership and management, within and outside of mental health services, are cognizant of the challenges inherent in implementing this major policy shift and report that they are eager to meet them.[4]

B. Other Mental Health Policies

In addition to the new policy for the management of youth thought to be at risk of self-injurious behavior, discussed above, DJJ has had one other significant accomplishment in the area of mental health policy development: It has completed a reasonably comprehensive table of contents for mental health policies, which can serve as an outline of what specific policies need to be developed and implemented.[5] On the other hand, DJJ has yet to provide a timetable for the development of these policies even though such a timetable was due by March 1, 2007. And even the most elemental polices required by the mental health plan such as one that defines its mental health programs and "levels of care" have yet to be promulgated.[6] In short, because of the role of policies in an institutional system – *e.g.*, managers cannot require staff to deviate from existing policy -- there is a pressing need for the expeditious development of key mental health care policies.[7] DJJ should provide a timetable forthwith that prioritizes key policies and provides for their rapid development.[8]

C. Mental Health Infrastructure And Interdepartmental Integration

Although DJJ recently lost its chief psychiatrist Dr. Ed Morales to reserve military service for a year, it had the depth of psychiatric/management talent such that Dr. Juan Carlos

[4] Statements of DJJ Chief Psychiatrist (Acting) Juan Carlos Arguello and DJJ, Director, Division of Juvenile Facilities, Sandra Youngen, and others, December 2007.
[5] *See*, Appendix A (Lee/Trupin report), Attachment 1, #18.
[6] *See*, Appendix A (Lee/Trupin report), Attachment 1, # 5. DJJ is overdue to have completed several policies by now. *Id.*, ## 2, 4, 5, 6, 7, 10, 11,19, 20; Attachment 2, # 1.
[7] *See*, Appendix A (Lee/Trupin report), p. 5.
[8] Key medical policies were written over a six-month period, *See*, Third Report of the Special Master, p. 12-13.

Arguello could step up to be acting chief psychiatrist. It also succeeded in recruiting Dr. Stephen Connor to fill in for Dr. Arguello as acting senior supervising psychiatrist. It has a cohesive, motivated and productive mental health services management team.[9] Seven senior mental health clinicians are working at least some of the time with the DJJ central office work groups that are leading the effort to plan and implement the reform charted by the remedial plans.[10]

Like the safety and welfare plan, the mental health plan requires that DJJ acquire and deploy "staff resources over and above those needed for day-to-day management of the reformed mental health system . . . for at least three years" for the purpose of implementing the plan.[11] DJJ has put some of the required resources in place by the assignment of senior clinicians to the classification and assessment, program and re-entry work groups in its central office.[12] But, without explanation and in violation of the mental health plan, it has not assigned a "senior administrator with experience in implementing of mental health programs to oversee and direct implementation of [the mental health remedial plan] and its coordination with other remedial plans."[13] Also, despite another specific requirement of the plan, DJJ has not established a dedicated mental health training team consisting of at least three licensed clinicians, an instructional designer and an office technician.[14] By their emphasis on the importance of clinician training in the treatment of potentially self-harming youth and the new policy for their management and by their recommendation that these positions be filled, the mental health

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[9] Statements of mental health experts after December 3, 3007 meeting with mental health staff.
[10] *See*, Appendix A (Lee/Trupin report), Attachment 1, #12.
[11] *See*, Mental Health Remedial Plan, p. 75.
[12] The special master does not have enough information to be sure how the assignment of seven senior clinicians to provide some time or service to the work groups compares with the plan provision requiring the equivalent of four full-time senior clinicians or administrators. The seven include DJJ's chief psychiatrist and two DJJ regional psychologists. The seven also include clinicians that appear to be assigned to one or more of the work groups full-time.
[13] *See*, Mental Health Remedial Plan, p. 75-76.
[14] *See*, Appendix A (Lee/Trupin report), Attachment 2, #12.

experts highlight the need for these management and training resources.[15] DJJ should fill these positions forthwith.

The mental health experts note improved interdepartmental and interdisciplinary integration and communication at the central office level.[16] This improvement demonstrates the promise of DJJ's new interdepartmental and interdisciplinary work groups.[17] In early December 2007, along with the education and sexual behavior treatment experts, the mental health experts met with DJJ management and key central office staff including many members of the new work groups. All five experts and the special master were impressed by the integration and collaboration exemplified in the program work group's thoughtful and comprehensive presentation of program service day alternatives. The work group is planning on presenting these program service day alternatives to DJJ's executive management committee in the very near future. The integration and collaboration reflected in the group's work breaks down the functional, professional and departmental "silos" of the past and creates the basis for necessary institutional reform.

DJJ has not propounded a complete central office organizational chart nor has it instituted a protocol for the protection of clinical autonomy in the event of conflicting interests and needs.[18] The central office organizational chart that DJJ filed in October 2007, pursuant to court order, is far from complete. It, for example, does not include the mental health and sexual behavior treatment staff and, therefore, fails to show their relationship to each other and to other staff units.[19] Nor does the central office organizational chart, even in conjunction with the

[15] *See*, Appendix A (Lee/Trupin report), p. 5.
[16] *See*, Appendix A (Lee/Trupin report), p. 1.
[17] *See*, Beltz, Report of Findings December 2007, attached hereto as Appendix B, p. 3.
[18] *See*, Appendix A (Lee/Trupin report), Attachment 1, #1
[19] Other experts have noted omissions in the organizational chart.

facility charts that DJJ also provided, show how the relationships between central office and facility staff will function so as to ensure clinical and professional autonomy consistent with the mental health, health services and safety and welfare remedial plans.

D. Licensed Bed Care

The licensed bed care issue has a long history and involves a separate lawsuit, the *Wilber* case. The *Wilber* plaintiff agreed to delay the proceedings in that case and to participate in the development of the mental health remedial plan provisions in this case that concern licensed care.[20] Pursuant to those provisions, the mental health experts evaluated DJJ's licensed bed resources and needs and, in May 2007, reported that DJJ should increase or reconfigure its licensed bed resources to better serve the needs of both youth in northern California and female youth.[21] Specifically, the experts reported that DJJ (1) cannot continue to rely, in the long term, on transporting northern California youth to southern California facilities but must rather provide licensed bed services in northern California; (2) may provide licensed care beds by contracts with private hospitals, but only if the contracts ensure that all DJJ patients requiring licensed bed care are admitted and treated adequately[22] and (3) should carefully consider developing the capacity to serve DJJ youth of both genders and in both regions in its own licensed CTCs (correctional treatment facilities) and/or ICFs (Intermediate Care Facilities) facilities.[23]

In November 2007, DJJ responded to the experts' findings and recommendations, stating that it (1) had increased its licensed bed services to female youth by opening the Stark CTC to

[20] See, Mental Health Remedial Plan, p. 40.
[21] Female youth are all in one unit in southern California (Ventura).
[22] DJJ staff reported that difficulties in arranging for treatment for patients who were perceived to be potentially difficult to control or violent. See Appendix B to the Fourth Report of the Special Master, the Lee/Trupin licensed bed report, p. 5.
[23] See Appendix B to the Fourth Report of the Special Master, the Lee/Trupin licensed bed report.

females; (2) was meeting the needs of northern California youth in its southern California CTC and its DMH-operated southern California ICF; (3) is attempting to renegotiate its contract with Metropolitan State Hospital so that the ICF will serve females and youth who previously have been rejected for Axis 2 diagnoses and acting out behavior; and (4) had plans to meet with representatives of two northern California hospitals in December 2007 about the possibility of contract licensed bed services.[24]

To some extent, DJJ's response shows that it is moving forward in the provision of licensed bed mental health care to youth. For example, to the extent that the private hospital serving female youth would not accept some youth needing licensed bed care, opening the Stark CTC to female youth is an advance. It is troubling, however, that DJJ's response to the experts' licensed bed report does not acknowledge that DJJ had ceased to use its contract with Aurora Vista hospital due to a conflict between the hospital's requirements and DJJ's collective bargaining agreement with the CCPOA.[25] DJJ's response to the mental health experts' report should have included an analysis of whether and how well DJJ is able to treat female youth at its CTC and what if anything has been lost by the disruption of the relationship with Aurora Vista.

Further, DJJ's response to the experts' licensed bed report disregards the experts' recommendation that it license its own CTC and/or ICF beds in northern California if practicable (or explain why such a proposal is not practicable.)[26] It is incumbent on DJJ to consider seriously the costs and benefits of both of the obvious possible strategies for meeting the licensed bed needs of northern California youth. Serious consideration would involve, for example, analysis of the costs of the existing CTC and ICF beds and a determination of whether those

[24] *See* the DJJ response, attached as Appendix C.
[25] *See*, Appendix A (Lee/Trupin report), Attachment 1, #1.
[26] *See* Appendix B to the Fourth Report of the Special Master, the Lee/Trupin licensed bed report, p. 7.

costs are likely to increase or decrease, analysis of the costs of providing care under the existing contract with Sierra Vista and whether those costs are likely to increase or decrease, and analysis of need and utilization information including whether the lower rate of utilization licensed bed care by northern California youth is due to a lesser need for such beds or to the difficulties involved in transporting a youth to southern California.

Finally, DJJ's failure until December 2007 to meet with northern California hospitals is not consistent with an intention to solve the licensed bed needs of northern California youth by contracting with a private hospital.[27] DJJ ceased using its contract with Sierra Vista hospital in northern California in July 2006, based on Chief Psychiatrist Ed Morales's apparently sincere and reasonable belief that certain incidents evidenced issues and problems that needed to be addressed before DJJ could responsibly continue to send youth to Sierra Vista.

DJJ has not yet filed the "appropriate written plan" to "address deficiencies" in licensed bed capacity, including a "reasonable implementation schedule," as the mental health plan requires.[28] It should do so forthwith. The written plan should be based on -- or it should provide for – a comprehensive analysis of the alternatives for providing licensed bed care to female youth and youth in northern California.

E. Mental Health Tracking System

[27] *See*, Fourth Report of the Special Master, Appendix B (Trupin/Lee report), p. 1. Dr. Morales discussed his decision with the experts and special master at the time. They encouraged him to meet with Sierra Vista representatives to consider whether or not to continue the contractual relationship. They also encouraged him to arrange for collaboration between DJJ and Sierra Vista representatives to identify and address issues, if DJJ continued the relationship.

[28] The standards and criteria for the Mental Health Plan, filed on or about December 15, 2006, provide that DJJ is required to develop a plan to address the deficiencies in licensed bed care. MH 5.21.g. DJJ's "response" to the mental health expert's licensed bed report expresses its intention to meet youth's licensed bed needs, and it indicates how it intends to do so. But it is too general to be a plan or a meaningful commitment. See Appendix A (Lee/Trupin report), pp. 1-2, and Attachment 1, #13.

DJJ has been delayed in the development of a system to track data and information showing utilization of and need for mental health residential and licensed beds.[29] Staff working on the developing a system and tracking the data have lacked necessary technical expertise, and there have not always been staff available for data entry. Finally, in October and November 2007, DJJ committed to tracking the data and information that its mental health management team, in consultation with the mental health experts, determined should be tracked. It began tracking much of the data and information beginning October 1, 2007. This is a positive development assuming that the tracking continues on a contemporaneous basis and that DJJ is able to track the rest of the information it has committed to track. This will bear close monitoring.

III. SAFETY AND WELFARE

Monitor Cathleen Beltz has continued to monitor the items assigned to the OSM for monitoring by the standards and criteria for the safety and welfare plan. Her report reflecting the compliance status on a number of discrete items is attached as Appendix B. Some of her observations and findings relate to the systemic issues that will be the subject of the special master's next report and some relate to issues that will be the subject of the next report of the safety and welfare expert.

IV. CONCLUSION

This report shows progress in some areas and a lack of progress in others. Further and more specific judicial relief will be justified if DJJ does not take effective action quickly to provide a timetable for the development of mental health policies, develop key mental health

[29] *See*, Appendix A (Lee/Trupin report), Attachment 1, ##12 and 14. The special master was involved in numerous conference calls and meetings with the experts and DJJ staff concerning development of the tracking system and so has first hand knowledge of the progress and the delays.

policies, retain/assign an experienced senior administrator to oversee and direct implementation of the mental health plan, retain/assign three clinician trainers and an instructional designer, develop adequate central and facility organizational charts and provide an appropriate written plan to address deficiencies in licensed bed capacity.

The special master respectfully submits this report.

Dated: January 9, 2008

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Donna Brorby
Special Master

Mental Health Expert Report December 2007

Terry Lee and Eric Trupin

This report provides the findings of our last nine months of monitoring of the California Department of Corrections and Rehabilitation (CDCR), Division of Juvenile Justice (DJJ) mental health remedial plan and programs. It is based on site visits, policy and data review, and communication various individuals and parties. This report is comprised of four sections; (1) Findings in key areas that the mental health experts feel are critical for achieving compliance with the Mental Health Remedial Plan, (2) compliance with specific items and time deadlines in the Mental Remedial Plan, which is included in Attachments 1 and 2, (3) review of selected DJJ mental health tracking data, and (4) recommendations to DJJ administrative and mental health leadership.

Key Area Findings

Filled Positions

DJJ reports that more mental health and health care positions have been filled, a necessary but not sufficient step in developing mental health treatment capacity. Decreased vacancies are attributed in part to DJJ's recent ability to offer competitive compensation packages (see also Attachment 1, #27). The new hires are also reported to more likely to have higher credentials, such as board-certification. This is based on verbal report by and impressions of DJJ personnel. The number and percentage of mental health care positions filled and vacant have been requested from headquarters, but this information has not been received. During site visits, individual facilities are able to describe the number of budgeted and filled positions.

DJJ has not filled positions provided by the mental health plan for implementation, including an experienced senior administrator and at least three clinician trainers. It has appointed the required senior mental health clinicians and/or administrators to central office work groups charged with developing strategies and mechanisms for implementing the remedial plans. See Attachment 2, #12.

Integration and Communication

DJJ mental health management staff report that they have begun regular telephone conferences with Department of Mental Health (DMH) personnel to improve collaboration between the two agencies, and increase access to DMH (see also Attachment 2, #6). We learned during our December 3 central office site visit that DJJ has formed three multidisciplinary work groups: intake and assessment, programs and reentry/transition. The work groups are responsible for integrating the requirements of all six Farrell remedial plans as they plan and direct and take steps towards meeting those requirements. A mental health management team has also been formed. Early on, these latter two initiatives appear to be part of a developing infrastructure for communication. Mental health team members appear more aware and informed of mental health and non-mental health initiatives and plans.

Licensed Mental Health Beds

In the mental health expert 2007 licensed mental health bed report, DJJ was advised of the need to develop mental health licensed bed resources for youth in northern California and females. DJJ is meeting the acute licensed mental health bed needs of females by using the Stark

Correctional Treatment Center (CTC). DJJ reported they are negotiating with the Department of Mental Health (DMH)-run Intermediate Care Facility (ICF) to meet the longer-term licensed mental health bed need for females.

During the December 3, 2007 mental health expert headquarters site visit, DJJ mental health leadership and counsel were informed that DJJ's November 2007 "formal response" to the licensed mental health bed report is inadequate as a plan to meet the mental health needs of youth in northern California and females. If DJJ can meet the needs of female youth at the CTC and ICF in southern California, the need for a plan for females will be mooted. But DJJ needs to develop a northern California resource for licensed mental health beds. Long term, the *status quo* of relying on the southern California CTC and ICF is not acceptable and DJJ needs a real plan to meet the need in northern California.

According to DJJ data, the number of CTC admissions appeared to increase in the second half of 2007. Implementation of the new Suicide Prevention Assessment and Response (SPAR) policy may also be associated with an increase in referrals to acute licensed mental health beds. The maximum census for the CTC this past year appears to have been 11.

More particulars are available in Attachment 1, #13.

Residential Mental Health Beds

Under the Mental Health Remedial Plan, the mental health experts are to report on the current residential mental health program bed need and resource, including whether the number and array of beds are appropriate, with a summary of the mental health experts' opinions and recommendations, by 9/1/07. However, DJJ has not submitted criteria for their proposed levels of mental health care, including admission and discharge criteria distinguishing the different levels or programs. DJJ has not submitted program service day schedules for the residential mental health programs. As a result, the mental health experts have been unable to complete a report on residential mental health beds.

The mental health experts have visited all but one of DJJ's residential mental health programs, and reviewed the DJJ-provided residential mental health bed tracking and waiting list data. In general, the mental health data tracking system is still being developed, and some inaccuracies and inconsistencies are noted. DJJ clinicians and headquarters report some limited waiting periods for youth to access assigned residential mental health beds, but there is no systematic data to analyze this. Because of legislation passed in August 2007, DJJ anticipates a 40% reduction of its population from July 1, 2007 to July 1, 2009. Given the changing nature of the DJJ population, core treatment program treatment capacity development, and improving identification of mental health needs, quantifying the exact number and array of residential mental health beds needed is of limited benefit. DJJ appears to have the approximate capacity required, though is a little short given sporadic waiting lists, and should be able to meet the needs of youth if the DJJ population decreases in absolute numbers.

The utility of having both Intensive Treatment Program (ITP) and Specialized Counseling Program (SCP) levels of care have been discussed with DJJ since the development of the Mental Health Treatment Remedial Plan. The Intensive Behavior Treatment Program level of care will

be left out of this discussion of distinguishing levels of care, but could also be included depending on how levels are defined. At the 12/3 site visit, some mental health management team members inquired about some of advantages of combining ITP and SCP into one level of care, so they will be enumerated here.

1. Simplicity—it may be difficult to operationally define the difference in the levels of care and programming between the two programs, and/or measure the differences in youth clinical need to determine which unit an individual youth should be assigned to; and it is not clear it is worth the time and effort.
2. Economy—collapsing ITP and SCP into one level of care will decrease the number of type of residential mental health programs DJJ needs to maintain (though the absolute number of beds does not change), decrease the number of transfers, and save on all the associated administrative and clinical costs associated with having the 2 levels.
3. Flexibility—with one level of care defined appropriately, DJJ is still free to use ITP's in different ways; for instance, one proffered differentiation between the two levels is that SCP is for more vulnerable youth, while ITP is for more aggressive youth; if the single combined ITP/SCP level is defined with some flexibility, a facility or region can still use one of the hybrid ITP/SCP units for more vulnerable youth and the other hybrid ITP/SCP for more aggressive youth, and would be better situated to respond if the percentage of one group, for instance aggressive youth, increase temporarily. Of course of the staffing of such a hybrid unit would need to be worked out.
4. The desired amount of clinical heterogeneity in a treatment program is a careful calculation. For example, segregating aggressive youth into one program is often appreciated by youth and staff in other programs; but for the youth and staff in a program with a high concentration of aggressive youth, programming is often disrupted, role models may be in short supply, and prosocial norms in such a program may be lacking. A more heterogeneous group will have youth in various stages of skill-development, and more role models.

The mental health experts do not oppose continuation of the ITP, SCP and IBTP residential program nomenclature, provided there are defined differences in the programs and admission and discharge criteria.

More particulars are available in Attachment 1, ##5, 6,7,8,9,10,12,14, and 15.

Effective Mental Health Treatment

The mental health experts continue to observe an absence of integrated, empirically-based mental health treatment throughout DJJ, including on its residential mental health programs. During the July 2007 Stark visit, a Behavior Treatment Program (BTP) staff member shared an aggression treatment model developed by the BTP and facility. With the assistance of a psychologist, the Sex Behavior Treatment Program sexual offending cycle treatment model was adapted for aggression. The adapted model is intended to be used facility-wide, so when youth transition off the BTP, they will continue to learn the same treatment model. The initiative and vision of the involved BTP and Stark staff members are to be commended. At the same time, it is unfortunate that there was not more central support for practice improvement. A contractor has been hired to develop the California Integrated Behavior Treatment Model. DJJ currently does not have a timetable for deliverables from the contractor.

DJJ has begun treatment training programs primarily directed at non-clinical staff, in the areas of aggression replacement therapy, safe crisis management and responding to youth who are mentally ill or who may be at risk for self-injury. This is the beginning of developing the capacity for evidence-based treatment and management of youth and should result in an improvement in the way that staff and youth treat each other in DJJ facilities. This is a step forward. The task ahead is to create a unified, integrated approach, and to provide clinical training for all staff, clinical and non-clinical.

More particulars are available in Attachment 1, #3.

Selected Mental Health Tracking Data

CTC Referrals and Discharge Notices

The CTC referrals and discharge notices from October 2007 only were sent by DJJ for mental health monitoring. According to the electronic records sent, there were 11 admissions to and 11 discharges from the CTC. (It should be noted that the mental health tracking data reported 13 admissions, while the paper summaries mailed to the mental health experts contained 9 admissions.) One referral to CTC was rejected due to lack of acuity. Of the 11 admissions, 1 was from a northern facility and 1 was a female. Of the 11 discharges, 4 were to northern facilities and 2 were females.

The mental health experts are aware that the information contained in the notices may be inaccurate or incomplete, or there may be good explanations for the described actions. However, review of the qualitative information revealed some potentially concerning mental health practices in DJJ that require individual and possibly more systemic follow-up. Youth #86549 has a history of psychosis, and was referred to the CTC after becoming increasingly paranoid. He was being treated with antipsychotic and antidepressant medications until approximately 2 months prior to CTC referral, when his antipsychotic medication was discontinued. According to the referral summary, "It is not clear from the UHR when a psychiatrist last saw him. (A psychiatrist) attempted to see him in September but the ward refused and his Zoloft (the antidepressant medication) was continued. There did not seem to be any follow up with this young man when the Seroquel (the antipsychotic medication) was discontinued."

Youth #A was referred to CTC after attempting to hang himself. Per the referral summary: "(#A) is usually compliant with his medication. His UHR indicates that he last saw a psychiatrist on June 14. (#A)'s medication ran out about 4 – 6 weeks ago, and it was not restarted until 1 – 2 weeks ago; he has been taking it since then, and this had seemed to help somewhat, until the DDMS incident."

The mental health experts are interested in learning more about the clinical reasoning behind youth #B's psychiatric medication regimen of risperidone M-tab 3 mg po qhs, lorazepam 2 mg po qohs and clonazepam 2 mg po qohs on alternating evenings with lorazepam. Specific questions include the reasons for using benzodiazepines in general; the use of 2 different benzodiazepines; and use of a long-acting and shorter-acting benzodiazepine on alternating evenings.

As noted above, DJJ mental health management reports the addition of board-certified or board-eligible psychiatrists. It is hoped that this results in improved care.

Medication Records

The medication logs received are of limited use as they contain only the medication name and the milligram pill size youth are prescribed on two different dates. The total daily dose of medication or whether the medication is ordered to be taken regularly cannot be determined. The information is not organized in any manner beyond alphabetical by facility (more or less), and is approximately one inch thick when printed. The mental health experts have asked for some organization and analysis such as percentage of youth in DJJ and core treatment units on psychiatric medications and on certain medication classes, and flagging and analyzing the number and percentage of youth over specific medication dose thresholds and on four or more concomitant psychiatric medications. This type of information is also needed by DJJ to evaluate and, as indicated, shape psychiatric prescribing practices.

Recommendations

1. DJJ must develop a resource for licensed mental health beds for youth from northern California.
2. DJJ must immediately proceed with an organized development and training of empirically-based mental health treatments. Training on general principles and application of behavioral analysis will be consistent with empirically-based treatments.
3. DJJ must develop a resource for licensed mental health beds for females requiring an intermediate length of stay.
4. DJJ needs to continue negotiating with DMH/ICF administration to assure that the ICF beds meet DJJ's needs as discussed in the mental health experts' May 2007 report on licensed bed care.
5. The mental health experts would like to meet with the contracted developers of the California Integrated Behavior Treatment Model before making additional recommendations related to the development and implementation of treatment programming and the implementation of transition programs for youth paroled to the community.
6. DJJ needs to complete its organizational chart and dispute resolution reserving clinical autonomy.
7. DJJ is making some progress in the area of mental health policy writing, but the progress needs to continue. Key policies and procedures must be prioritized and completed, including policy defining levels of care and setting forth the program service day for residential mental health units. Principles of clinical autonomy must be respected in all aspects of policy development, *e.g.* clinical leadership should control content as it affects clinical practice and supervision.
8. DJJ needs to be attentive to the keeping of mental health management data. Accuracy of data needs to improve.
9. It appears that the senior administrator with experience in implementing mental health programs and the three clinician trainers and instructional designer required by the mental health plan are necessary for the implementation of the mental health remedial plan.

Attachment 1
Mental Health Expert Report December 2007

Terry Lee and Eric Trupin

1. MH 3.1, 3.2 and 3.3 Organizational Charts and Dispute Resolution Preserving Clinical Autonomy: *MH experts to review central office and facility organization charts for whether they are consistent with the MH and S&W remedial plans. The due date for DJJ and facility organization charts is September 2006. (See the plans for details of requirements re purview of Medical Director and mental health leadership).* ***MH 3.1 and 3.2****. By July 1, 2007, DJJ is to have instituted at each facility and for the division, a dispute resolution protocol (for custody/clinical disputes) that is consistent with the S&W, Health Services and MH plans.* ***MH 3.3****.*

We will review this issue when we have more complete information. We agree with the other experts that the organization charts produced are incomplete. DJJ does not yet have a dispute resolution protocol for clinical/custody disputes. The undated, unsigned partial page on plain white paper we were given as a protocol does not appear to have any formal status within DJJ. It is insufficient as a matter of substance as well; it does not cover all areas of clinical and professional autonomy and it lacks details that will be necessary for implementation. It was apparent during our meetings with mental health managers and supervisors in August and December that they are concerned about clinical autonomy, and that they are aware of some of the issues but that there is not a functioning protocol for resolution of perceived conflicts between clinical and other staff over professional and clinical matters. The special master reported to us that they exhibited this awareness and concern during her follow-up telephone conference with them on December 4. Clinical autonomy and resolution of disputes between clinicians and non-clinicians will require the kind of interdisciplinary, interdepartmental collaboration that was exemplified in the "program service day" presentation during our meeting at DJJ central office on December 3.

During our meeting with mental health managers and supervisors on December 3, they described a situation at Ventura that raised medical autonomy and dispute resolution issues. As they described it, Ventura ceased using Aurora Vista Del Mar for licensed bed care because it would not permit DJJ escort officers to enter the hospital with their weapons belt. DJJ reported that "Bargaining Unit 6" took the position that its members would be at risk if they removed the belt. It did not appear that there was any process to consider needs and options for clinical judgments.

Rating: Partial compliance as to 3.1 (central office organization chart) and 3.2 (facility organizational chart). Noncompliance as to 3.3 (dispute resolution protocol).

2. MH 4.1: *DJJ is to develop a tracking system for mental health information pertaining to individual youth requested and received over the course of the youth's confinement in DJJ, re health services/needs, family contacts, attempted family contacts, screenings and assessments by November 1, 2007.*

In its October 2007 quarterly report (106th page/MH Matrix p. 10), DJJ reports "no progress." The special master confirmed this information during a December 4 telephone conference with mental health management staff.

Rating: Noncompliance.

3. MH 5.2. *DJJ is to develop the DJJ Integrated Behavior Treatment Model treatment hierarchy by August 1, 2007.*

As to all items concerning the DJJ Integrated Behavior Treatment Model, DJJ reports it is working with its contractor Orbis Partners Inc. to develop the program. DJJ has informed us that it entered into the contract with Orbis at the end of June 2007, about six months later than was contemplated by the Safety and Welfare Remedial Plan. We have requested to meet with DJJ and Orbis Partners. In the November 14, 2007 mental health issues status update (sent by Doug Ugarkovich by email on November 14), DJJ says that Orbis is still working on a timetable for "deliverables" and that we should meet with Orbis after the timetable has been developed. We think it is a high priority to meet soon with DJJ and Orbis because so much depends on their collaboration.

Rating: Noncompliance.

4. MH 5.3. *DJJ to develop and implement policy re forensic evaluation that is consistent with the mental health plan by June 1, 2007.*

Since September, Dr. Schwartz and we have reviewed at least two drafts of a Welfare and Institutions Code Section 1800 and 1800.5 policy. Through the special master's office, our and Dr. Schwartz's views have been shared with DJJ. We are preparing further comments on the latest draft.

Rating: Partial compliance.

5. MH 5.6a and b, 5.9: *DJJ is to adopt formal criteria for levels of care by 1/31/07, and conduct appropriate staff training on the criteria by 6/30/07. MH 5.6. DJJ is to develop and implement policies and procedures for movement between levels of care by 7/31/07. MH 5.9.*

By its October 2007 quarterly report and during our meeting with DJJ mental health staff on December 3, DJJ reports that it still is developing formal criteria for levels of care and the policies and procedures for movement. It is clear from our discussions with responsible staff that they are seriously engaged in and making progress with the project. There is a relationship between levels of care and the program service day for mental health residential programs, and mental health staff working on levels of care

criteria are dependent on other groups of staff for developing the program service day. The levels of care will include the residential mental health programs.

Rating: Partial compliance.

6. MH 5.8: *DJJ to develop a policy and procedure for developing a treatment plan for each youth within three working days of admission to a residential mental health unit, for weekly treatment team meetings, and for monthly treatment team reviews to evaluate the need for continued stay in the program, refinement of the treatment plan, or recommendation for placement in an alternative treatment program. DJJ to consult MH experts as develop the policy and procedure. This policy and procedure will be implemented by June 30, 2007.*

During the August 30 site visit, DJJ mental health staff said that they had begun drafting a policy but were told to stop and leave that to another group. The November 14 status says that the program workgroup is developing an "umbrella policy" on treatment plans and that mental health services will be involved in developing treatment plan policies after the umbrella policy is completed. During our meeting with the DJJ mental health services management team on December 3, they provided us with a draft form of a treatment plan and explained that Orbis Partners would be involved in the design of treatment planning.

Rating: noncompliance.

7. MH 5.10: *Assess protocol for participation outside clinician in monthly treatment team reviews for youth in IBTP or SCP for more than 4 months or ITP for more than 2 months, and for headquarters monitoring of this. These were due by June 1, 2007.*

The DJJ November 14 status update says "See 5.8 above."

Rating: noncompliance.

8. MH 5.12.a, b and c: *DJJ was to open 5 ITPs, 7 SCPs, and 1 IBTP by July 1, 2007.*

In its October 2007 quarterly report (MH matrix p. 8), DJJ reports that it has 5 not 7 SCPs, and that it has 5 ITPs and 1 IBTP. DJJ is not adding any SCPs at this time because it anticipates a 40% population reduction from July 1, 2007 to June 30, 2009.

Rating: Partial compliance. We need more information about wait lists.

9. MH 5.17 and 11.3: *By July 1, 2007, DJJ is to determine size of mental health residential treatment units in new facilities (MH 5.17). Also by July 1, principles of MH Plan are to be integrated into DJJ design of mental health space in new facilities (MH 11.3). (Consultation with experts required for size MH units. As of 7/1/2007, the MH experts are due to monitor whether the principles of the MH Plan are integrated into the*

design for new facilities.). This is separate from limits for existing residential programs, noted in another item.

In its November 14, 2007 status update, DJJ reports that it will make future projections for mental health program size after it evaluates the impact of the reductions to 30/20 and 24/16 (ITP and SCP /IBTP). It reports that it is not now planning a new facility for MH youth, but only a "prototypic core facility." The special master has told us that the prototype was designed for 250 youth. In a system that is projected to house approximately 1500 youth, with inadequate space for mental health program units, it concerns us that DJJ plans its first prototype without mental health program units.

Rating: Noncompliance.

10. MH 5.18. *After June 30, 2007, verify that DJJ has a centrally approved and adequate program service day is followed on residential mental health program units.* ***(NB,*** *Central Office was supposed to adopt standards for Program Service Day, due October 1, 2006.* ***S&W 6.2.a****. Program service day was due to be in place as of* ***11****/1/2006 at Chad, and as of 12/1/2006 at Stark.* ***S&W 6.2.b and c****.)*

We were pleased to see the progress on the program service day project that is exemplified in the program service day draft that DJJ shared on December 3, 2007. DJJ's program work group prepared that draft, for core program youth on schooldays, which also is responsible for the rest of the program service days. DJJ has not yet provided anything on the program service day for mental health program units. The leadership present on December 3, 2007 gave no timetable for the steps between where DJJ is today and completion of the program service day.

Rating: Partial compliance.

11. MH 5.19: *Assess policy and procedure for youth requiring long term care in a licensed facility (if DJJ continues to house such youth). This policy was due by 12/31/06.*

By email December 7, 2007, following up your December 3 meeting, DJJ's mental health leadership said that this policy will be part of the group of policies on treatment requirements in licensed and unlicensed facilities.

In its October 2007 Quarterly report, the 98th page (pages are not numbered), DJJ reports that it was going to finish development of this policy and procedure by November 2007 until the law changed in a way that requires policy revisions. The revised estimated policy development completion date is January 31, 2008. No draft was provided. But we were not provided with a copy of the draft.

Rating: Noncompliance.

12. MH 5.21(a), (b) and (d): *DJJ is to develop a system to track data relevant to projecting needs for residential and licensed beds. By January 1, 2007, DJJ is to track select data including waiting lists in Excel. By January 31, 2007, in consultation with MH experts, DJJ is to identify additional data to track. By September 30, 2007, DJJ is to modify its manual system to track the additional elements, and produce consolidated and archivable reports.*

We thought that DJJ was tracking select data as of January 1, based on data DJJ provided to us in late 2006 and early 2007, but it did not track the data on a contemporaneous basis in 2007 before October. We hope contemporaneous data collection is continuing. The data provided for October plus the additional items listed for future tracking in the draft list provided by DJJ counsel in mid-November would seem to meet the mental health plan requirements for bed needs/utilization data to be tracked. Policy changes may result in adjustments to the data collected, as illustrated by the new SPAR policy. Experience in tracking the data may show a need to make adjustments.

Rating: Partial compliance. Substantial compliance with 5.21(a) and (b). Partial compliance (low) with 5.21(d).

13. MH 5.21.g: *Plan to address deficiencies in inpatient capacity, by March 31, 2007 (date based on mental health experts' report being filed 1/31/2007; it was filed at the end of May 2007).*

DJJ's formal "response" to our report concerning DJJ's licensed bed needs for mental health care is not an "appropriate written plan" to "address deficiencies" in licensed bed capacity, including a "reasonable implementation schedule" as required by the mental health plan.

In May 2007 we reported that DJJ then had insufficient licensed bed capacity for young women and for northern California youth. DJJ was serving young women at Aurora Vista Del Mar but the contract and relationship between DJJ and Aurora Vista was not strong enough to assure that patients deemed potentially aggressive or violent would be served. DJJ was serving northern California male youth at the southern California CTC and ICF due to dissatisfactions with its contract relationship in northern California. This is not adequate on a long-term basis because the logistics inhibit referrals, and because of the detriment to some of the youth of being separated from family, community and other familiar supports. We believe that it would be best for DJJ if it had CTC and/or ICF beds to serve both populations, in the region of California where the youth are served. Though DJJ has indicated there may be cost issues, we have not been given any documentation or information to show that there has been a serious cost/benefit analysis. It would be acceptable for DJJ to provide the necessary care by contract, if the contracts and the facilities providing contract care are sufficient and assure access for DJJ youth and if youth have access to licensed care in reasonable proximity to their facilities. In the past, the contracts have not been sufficient. The response to our licensed bed reports indicates an intention to attempt to achieve adequate contracts and

relationships. But DJJ has been indicating this intention for some time. It has not made much progress since late 2006. Though it has made its CTC accessible to female youth, it has ceased using its Aurora Vista del Mar contract. It will take further investigation to evaluate that. It has made no progress at providing care in northern California for northern California male youth.

Rating: Partial compliance.

14. Item (MH 5.21i.): *MH expert report on their assessment of current residential program bed need and resource, including whether appropriate array of beds (SCP/ITP distinction and the number of each) by 9/1/07. This is relates to levels of care issue, below (which will have criteria for admission to ITP and SCP beds or alternative beds).*

We anticipated having good utilization and need data and policies defining levels of care and transfers between them as a basis for an evaluation of DJJ's residential bed need and resource. If DJJ had been able to provide that information, we would not be able to reach any firm conclusions for the same reasons that we could not reach firm conclusions about the number of licensed beds DJJ needs for mentally ill youth and because since we wrote that report California has passed legislation that is anticipated to reduce DJJ's population by 40% by June 30, 2009. DJJ is not able to provide the information we need for an evaluation of their residential program bed capacity and their types of residential programs. It did not keep all of the data we understood it was to be tracking as of January 1, 2007, and it has not completed the development of criteria for levels of care and the mental health program service day for the residential programs. As we have said many times, we believe that there would be advantages to combining the ITP and SCP levels of care, and possibly even the IBTP level; we do not oppose DJJ's current configuration as long as there are articulated differences between the programs and between the criteria for being put in them.

15. MH 5.25a and b: *DJJ is to define screening and assessment criteria to clarify the distinction between licensed and residential program bed patients, in consultation with DHS, by June 30, 2007.*

DJJ provided notes of a telephone conference with an official from the California Department of Public Health in October 2007, but there is nothing in the notes about the distinction between licensed and residential program bed patients. DJJ says that it has the classification and assessment work group working on this issue as well. We will need to learn more about this work group and its progress on this issue. We were impressed by the quality of the work of the program workgroup on the program service day that we learned about during a meeting at DJJ's central office on December 3, so we are hopeful that DJJ's new "work group" organization will enable it to move forward on this and other issues. We have not yet seen any work product from the workgroup on this issue.

Rating: noncompliance.

16. MH 6.2, 6.4 and 6.6: *After May 15, 2007, DJJ is required to have documentation that it conducted a feasibility review of (a) Family Engagement Model or other evidence-based model of family engagement and (b) parent partners program.* ***MH 6.2 and 6.4****. After May 30, 2007, DJJ is required to have piloted Family Integrated Transitions and Family Justice Model.* ***MH6.6. S&W 8.2 and 8.3:*** *By July 7, 2007, DJJ is required to document adequate strategies for improving family involvement at commitment.* ***S&W 8.2(2).*** *By December 1, 2006, DJJ is required to have materials for the education of families, probation and court personnel concerning DJJ services/programs, expectations and family involvement.* ***S&W 8.2(3).*** *By July 1, 2008, pending funding (which DJJ must request), DJJ will provide orientation at county detention facilities.* ***S&W 8.2(4).*** *By July 1, 2007, DJJ is required to begin conducting Community Assessment Reports for each youth at intake, which will include contacts with parents and close relatives and knowledgeable community service providers; the reports will include measures to assess family background, strengths and functioning.* ***S&W 8.3(1).*** *By November 1, 2006, DJJ is required to facilitate family phone contact within 24 hours of youth arrival.* ***S&W 8.3(2a).*** *By December 2006, DJJ is required to facilitate ongoing family phone contact.* ***S&W 8.3(2b).*** *By March 1, 2007, DJJ is required to have organized family visiting days.* ***S&W 8.3(3).***

DJJ reported in its October 2007 quarterly report that the Family Justice Model (La Bodega) was about to be piloted at OH Close. This program is for youth in "core treatment" units. DJJ reported that there was no progress on Family Integrated Transition (for youth in residential mental health units). It reported in the November 14 Mental Health Status Update that the Family Justice Model (La Bodega) being piloted at OH Close, and was arranged by an NCB (non-competitive bid) contract. The Re-Entry workgroup will be responsible for follow-up/continuation.

Monitor Beltz's report on DJJ's work with Family Justice Inc. indicates that DJJ is seriously pursuing strategies for family engagement. She reports also family events at facilities, which we have encouraged. It appears from her report that DJJ generally facilitates family calls for youth within 24 hours of commitment, but that youth are not able to have regular telephone contact with families. Evidence shows that family engagement is critical and we will focus on this issue in our next report.

Rating: Partial compliance.

17. MH 6.11a: *DJJ is to consult experts about options for mental health monitoring systems, by 8/1/07, as a step in its process of deciding what acquired or developed monitoring system to use.*

Consistent with what DJJ's mental health management team reported to you on August 30, the November 14 status update reports that:

> "MH Services is including Quality Improvement Indicators to monitor compliance with written policy and Tracking System information used for

management purposes in each policy developed by MH Services. Current MH draft policies for Suicide Assessment and Response and for Forensic Services: 1800/1800.5 include both Quality Improvement Indicators and a Tracking System. ORBIS is not currently involved in this process."

DJJ has consistently reported plans to include QI processes when developing new policies and programs, and some psychiatry QI indicators have been shared with the mental health experts. Otherwise, we have not been consulted about options for mental health monitoring, though we would like to be helpful in this area.

Rating: Partial compliance.

18. MH 8.1.a.1–4: *Verify that DJJ has developed table of contents and a schedule for MH policies by March 1, 2007. DJJ is required on an ongoing basis to update policies on a schedule, use TDOs for policy as needed, and train staff on new policies.*

By November 14, 2007, DJJ provided us with a table of contents that the DJJ mental health leadership confirms reflects its views and needs. According to the October 2007 quarterly report, this table was completed in October 2007 and was then under DJJ management review. The mental health leadership explained that the table might be improved as DJJ progresses in the development of policy and program. From March 2007 through November 2007, there was conflict among DJJ management staff concerning the table of contents. For a time, DJJ would only provide the list of policies from pages 62-63 of the mental health plan. We are pleased to see that the conflict was resolved appropriately, with respect for principles of clinical autonomy and deference to mental health services management on clinical matters.

According to the DJJ November 14 status update: "Schedule will be developed after the Master Table of Contents has been accepted, policies have been developed and implementation has occurred."

Recommendation: Partial Compliance.

19. MH 8.2a: *DJJ is to develop use of force policy accommodations for mentally ill youth in consultation with MH experts, by January 31, 2007. MH experts also share the responsibility for monitoring training on new use of force policy with the S&W expert. S&W 3.2.*

At the meeting with central office mental health staff on August 30, 2007, they told us that they were not involved in the development of use of force policy accommodations. In the November 14, 2007 status update, DJJ reports that the current Use of Force policy does not sufficiently address mental health issues and that a revised policy that addresses mental health issues is currently in the final stages of development.

Rating: Noncompliance.

20. MH 8.2b; S&W 8.6.1.a and b: *DJJ is to develop disciplinary process policy accommodations for mentally ill youth, in consultation with the mental health experts, by June 30, 2007. MH 8.2.b. See also, S&W 8.6.1.a, and S&W 8.6.1.b, DJJ to provide for mental health review by other-than-treating-clinician for relationship between disciplinary offense conduct and mental illness and determination of appropriate disciplinary action (modification of youth's treatment plan results from positive determination) and DJJ was supposed to work with MH experts to develop policy and procedures by September 1, 2006.*

At the meeting with central office mental health staff on August 30, 2007, they told us that they were not involved in the development of DDMS policy accommodations. In the October 2007 quarterly report and the November 14, 2007 status update, DJJ reports that the current DDMS policy has been completed and approved for purposes of S&W plan, but that it does not meet the requirements of MH Plan.

Rating: Noncompliance.

21. S&W 4.2, 4.3, 5.1 and 5.2: *MH and S&W experts monitor S&W 4.2, 4.3, 5.1 and 5.2. These require DJJ to consult expert consultants (not necessarily the Farrell experts, but simply consultants) regarding treatment program design by May 30, 2007.* ***S&W 5.1****. They require DJJ to consult expert consultants about development of the Integrated Behavior Treatment Model by July 1, 2007.* ***S&W 4.2****. They require DJJ to have a writing describing its treatment model by August 1, 2007.* ***S&W 5.2****. (The written description and manual is due by November 15, 2008.* ***S&W 4.3.****)*

As to all items concerning the DJJ Integrated Behavior Treatment Model, DJJ says that it is working with its contractor Orbis Partners Inc. to assist with the development of the IBTM, including the risk/needs assessment, a classification and placement process, interventions, training for staff and trainers, and a quality assurance process. DJJ has informed us that it entered into the contract with Orbis at the end of June 2007, about 6 months later than was contemplated by the Safety and Welfare Remedial Plan. We have requested to meet with DJJ and Orbis Partners. In the November 14, 2007 mental health issues status update (sent by Doug Ugarkovich by email on November 14), DJJ says that it **Orbis** is still working on a timetable for "deliverables" and that we should meet with Orbis after the timetable has been developed. We think it is a high priority to meet soon with DJJ and Orbis.

Rating: Partial compliance.

22. S&W 6.1.a-c: *Chaderjian was due for conversion to a treatment facility as of April 2007 and Stark was due to begin conversion to rehabilitative model January 1, 2007 and to complete the conversion by July 1, 2007. In February, at the big meeting, DJJ indicated that it would be providing the MH and S&W experts with facility action plans. (OSM and experts are assigned to monitor this.)*

As of our August 30 central office site visit, DJJ mental health and CDCR counsel with them had no information. In the November 14 update, DJJ reports that "At this time, awaiting a decision by CDCR Executive Management." Staff repeatedly have referred to actions and decisions that have to be deferred until a decision is made about which DJJ facilities will close to accommodate the anticipation of a reduced population. On December 16, we received a draft of Monitor Cathleen Beltz's report to the effect that the conversion at Chaderjian will begin early next year.

Rating: Noncompliance.

23. S&W 6.2 a, b and c. *DJJ to develop Central Office Standards for Program Service Day by October 1, 2006, Chaderjian Program Service Day by November 1, 2006, Stark Program Service Day by December 1, 2006 and Preston Program Service Day by July 1, 2007.*

On December 3, 2007, we and the education and sexual behavior treatment experts met with DJJ's leadership and key central office staff to discuss the apparent competition between DJJ staff for youths' time for education and treatment activities and behavior management. Tami McKee-Sani, one of the leaders of the new program workgroup, led the discussion of the draft program day for core youth on school days. She explained that this draft was farther along than drafts of any other of the program days, but that work was in progress on others also.

Rating: Partial compliance.

24. Consent Decree: SPAR policy (suicide watch procedures).

DJJ developed a new version of its Suicide Prevention Assessment and Response Program since our last assessment reported to the special master. DJJ reports that the policy will be signed the week of December 17, 2007, and we strongly support that. The version that is about to be signed is a great step forward from the last version and is progressive in important respects.

The new SPAR policy replaces camera surveillance with one-on-one direct supervision. It greatly limits the use of isolation and restrictions. It requires direct observation instead of isolation and restrictions to reduce the risk of self-injurious behavior. The required response/evaluation times, and management oversight imposed by the policy, should limit restrictions to those necessary for youth safety. Youth will be able to engage in their normal activities during most of the time that they spend in a suicide risk reduction status.

With a companion policy that will address youth safety/protection needs, the new version separates youth with mental health issues from youth with administrative or placement/safety issues. The mental health policy appropriately focuses on meeting the

needs of first group of youth. Youth in a suicide risk reduction status will include only youth whose needs are appropriately addressed by mental health staff and policies and procedures. Under the companion policy, youth will have an alternate mechanism for raising their safety concerns.

DJJ has taken account of many of our prior suggestions concerning the policy. We have made further suggestions as recently as December 14, but none of our suggestions at this time are so important that they should delay finalization and implementation of the current version of the policy.

Because this policy represents a significant departure from current policy and practice and affects treatment of youth who may be at risk of serious self-harm or suicide, our greatest concern at this time is that DJJ take all necessary steps to implement the changes safely. We have requested DJJ to provide us with training materials and information about implementation planning and capacity before implementation.

It became clear during our December 14 telephone conference that the language appearing to require that youth in Suicide Precaution status stay there for at least 72 hours was not intended to have that meaning. We do not think that it is wise to mandate a 72 hour stay in SP status, so we support clarifying the policy to remove the appearance of a 72 hour rule.

We continue to suggest simplification of the policy by combining what are now two scales of suicidality (suicide risk levels and suicide risk reduction statuses) to become one scale. We continue to suggest that the scales be labeled in a way that is intuitive, to limit mistakes and confusion (e.g. 1, 2, 3, 4, 5, 6 rather than SI, SW, SP and FS, etc.)

MEMORANDUM

TO: Eric Trupin and Terry Lee, Farrell Mental Health/Treatment Program Experts
FROM: Donna Brorby, Special Master
RE: Office of the Special Master Monitoring and Findings
DATE: December 16, 2007

* *

The Mental Health Remedial Plan Standards and Criteria assign certain items to the Office of the Special Master for monitoring. You also have asked us to pull together factual information for you on some other items. This memorandum states our factual findings and the basis for them.

1. MH 4.2.a, 4.2.b and 4.3: *OSM to monitor whether DJJ has consulted with local governmental agencies by March 31, 2007, as a first step in a process to establish a policy and process to receive and share behavioral and assessment information about youth committed to DJJ. MH 4.2.a. By June 1, 2007, DJJ is to have adopted the policy/process. MH 4.2.b. By December 1, 2007, it is to have implemented it. MH 4.3. If and when the OSM can get a draft or final policy, it will provide it to the experts for evaluation. MH experts to assess policy and process for receiving and sharing (btw counties and state) behavioral and assessment information about youth committed to DJJ.*

In its October 2007 quarterly report (MH matrix p. 5) and by Proof of Practice documents #68 and 69, DJJ reports that counties are supposed to provide information to DJJ on a particular form and that DJJ is legally required to report some information to committing courts. The form and legal requirement date to 2003, long before the MH remedial plan was drafted and filed.

During a telephone conference on December 4, DJJ staff (Dr. Arguello, Dr. Connor and Dr. Freeland) reported that they are working on ensuring that youth coming in arrive with the form that summarizes the health care they received at the county and that youth arrive during regular business hours. All youth with known serious mental health issues are reviewed by the Chief Psychiatrist prior to their admission to DJJ, and DJJ is working on a system to ensure that the information developed in the course of that review be transmitted to the receiving institution by the time the youth is received. DJJ also is working on developing a discharge summary of care for DJJ to provide to counties with every youth transferred from DJJ to counties (so that DJJ provides information to counties similar to what it wants counties to provide to it).

Rating (item 4.2a): Noncompliance. The interim efforts of DJJ's mental health management to be sure to receive necessary mental health information with youth as they are received, and to receive youth during normal business hours, are good.

Rating (item 4.2b): Noncompliance. DJJ has not provided documentation of a policy or process.

2. MH 4.4 – 4.7: *MH experts delegated to OSM monitoring use of MAYSI-2 and DJJ SRSQ on all youth at initial intake by 9/1/2006, and V-DISC at least for under 18 year olds (V-DISC or alternative validated instrument for over 18 year olds) by July 1, 2007. MH 4.2-4.6. DJJ to develop and implement structured clinical assessment for psychosis by February 15, 2007. MH 4.7.*

As you know, I tracked the process of DJJ's contracting with Columbia's Wasserman group for V-DISC, and implementation. Both sides to the contract informed me that V-DISC was implemented in DJJ's reception centers by July 1, 2007. See also, DJJ's 10/07 Quarterly Report p. 104 (MH matrix p. 8). I checked with DJJ and Columbia (Gail Wasserman) about the status of V-Disc in December 2007 and will send you copies of the email. According to DJJ, there were some technical issues that have been resolved. According to Dr. Wasserman, DJJ has not yet provided Columbia with any usable data. DJJ's response indicates that the technical difficulties have been resolved and that Columbia is about to be given or has been given the data.

Rating (4.6): Substantial compliance.

DJJ has reported (10/07 Quarterly Report, MH matrix p. 9) and Cathleen Beltz of my office has verified in her report attached to the Fifth Report of the Special Master that DJJ is using the SRSQ screening instrument in the reception centers.

Rating (4.5): Substantial compliance.

DJJ has continued to use MAYSI (not MAYSI 2) at reception centers. It previously has said that it was using MAYSI-2 because the difference between MAYSI and MAYSI 2 is merely scoring, but it reported in October that "IT program issues for the scoring of MAYSI-2 are currently being identified and discussed." DJJ 10/07 Quarterly Report p. 105 (matrix p. 9).

Rating (4.4): Partial compliance (high).

DJJ has not yet implemented use of a psychosis assessment tool at reception. During our telephone conference on December 4, Dr. Arguello said that the classification and assessment work group is evaluating tools at this time. This is consistent with DJJ's representations in its 10/07 Quarterly Report MH (MH matrix p. 4).

Rating (4.7): Noncompliance.

3. MH 5.5: *OSM to monitor whether DJJ appoints MH administrator at each facility with residential MH program, by July 1, 2007.*

DJJ provided us with a list of mental health program administrators for five of the six facilities that have residential mental health programs. They are Randy Aguirre at Preston, Rick Flynn at Chaderjian, Liam Cowan at SYCRCC, Elverta Mock at Stark and Cynthia Brown at Ventura. Paso has an SCP but no mental health program administrator. As you visit facilities, you might talk to the program administrators and determine that they are filling the function you expect them to fill.

Rating: Substantial compliance. DJJ announced in the first week of January that it would be discontinuing the use of El Paso de Robles effective over the course of eight months.

4. MH 5.11: *OSM to monitor outpatient MH staffing against the plan as of July 1, 2007.*

DJJ has not provided the requested staffing information.

Rating: Insufficient information. By the draft report, the OSM again requested the pertinent information from DJJ but the information was not provided.

5. MH 5.14. a and b: *OSM to monitor population reduction in residential MH units, 30 for ITP and SCP units, 20 for IBTP (exclusive of youth mentors). These limits apply by June 30, 2007. (By 6/30/08, 24 for ITPs and SCPs, and IBTP to 16. By 2010 consider further reductions. 5.15 and 5.16.)*

DJJ reports that it met the 30/20 limits by June 30, 2007, with 7 of 11 residential mental health units meeting next years 24/16 standard. DJJ October 2007 Quarterly Report p. 103 (MH matrix p. 7). End of month census figures are consistent.

Rating: Substantial compliance.

6. MH 5.20. *OSM to monitor whether DJJ has collaborated with DMH to expedite transfers and facilitate transitions, by November 30, 2006.*

Cathleen Beltz reported this fall, Appendix B to the Fifth Report of the Special Master:

> "The safety and welfare plan requires that DJJ begin meeting periodically with the Department of Mental Health ("DMH") to "strengthen communication, expedite transfers to DMH of youth who are appropriately referred for inpatient mental health services, and facilitate transition of youth no longer in need of such care back to DJJ facilities."[1] The implementation deadline for this requirement was November 30, 2006. The OSM previously reported that DJJ provided documentation that its staff met with DMH staff in October 2006 and January 2007 and created a "DJJ Coordinated Clinical Assessment Team

[1] *See,* Mental Health Remedial Plan, p. 45.

('CCAT') Process" to resolve issues with DMH referrals.[2] In July, DJJ reported that it held a third meeting in May 2007.[3] DJJ is in partial compliance with mental health audit item 5.20."

DJJ reports in its October 2007 Quarterly Report, Mental Health Matrix p. 2, that it had a quarterly meeting with DMH in August 2007 and that one was scheduled for November 2007. DJJ reports that the meetings have improved communication and that admissions and discharges are being handled efficiently.

In its formal response to your recommendations concerning licensed bed care emailed to us on November 15, 2007, DJJ reports: (1) Executive managers of DJJ and DMH are required by law to meet annually and a meeting is to be scheduled for April 2008 (no representation was made about the annual meetings actually occurring in the past and we do not believe any have occurred yet); (2) DJJ Health Care Services staff have been meeting quarterly with DMH representatives of the Long Term Programs since November 2006 to address the relationship under which DMH provides treatment to DJJ youth in DMH facilities and at the DJJ/Metro ICF; and (3) DJJ is renegotiating the contract with Metro State Hospital to expand the patients that the ICF treats to include youth with significant Axis II disorders and females.

The audit standard requires that DJJ meet periodically with DMH regarding transfers to DMH facilities and transitions back to DJJ, and that DJJ have written protocols describing DJJ's actions to expedite transfers and facilitate transitions as appropriate. As with item 5.19 above, this protocol would fit under the mental health policy table of contents items on licensed bed treatment. When there is a sufficient writing, DJJ will achieve substantial compliance.

Rating: partial compliance (high).

7. MH 5.21.c: *OSM to monitor whether DJJ has developed timetable for tracking elements from 5.21 not currently tracked, by March 31, 2007 (date based on 1/31/07 completion of list, but list was substantially completed in May 2007).*

DJJ's position is that it will supply a timetable sometime after the list is finalized. I have cautioned DJJ that we expect them to be moving ahead with developing the capacity to track the information they agreed to track by mid-May 2007 and that we will be critical of delays based on the delays in finalizing that list since May.

Rating: Deferred for future monitoring.

8. MH 6.10. *OSM to monitor whether DJJ is funding ongoing attendance by key staff at appropriate national and regional conferences, by Sept. 1, 2006.*

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[2] Emails, agenda and meeting minutes, Katie Riley.
[3] DJJ Quarterly Report, July 2007 Mental Health Plan Matrix, p. 2.

DJJ reported in its October 2007 quarterly report that this item was "completed" and "funding is available." It provided a list of events and clinicians representing funded attendance at events as Proof of Practice #27. You have reviewed the list and advised me that the list and the information you have from staff interviews causes you to conclude that DJJ is funding ongoing attendance by key staff at appropriate national and regional conferences.

Rating: Substantial compliance.

9. MH 7.1, 7.2, 7.3. *OSM is to monitor pay parity with CDCR, DJJ work with Office of Workforce Planning re participation in job fairs and recruitment, and participation in job fairs and recruitment events.*

As Monitor Cathleen Beltz previously has reported, DJJ achieved pay parity with CDCR in April or May 2007. As she also has reported, as of this past summer, DJJ and Office of Workforce Planning were not engaged in effective recruitment activities. I interviewed Gregory O'Brien in September 2007. He is a central office staff member who is responsible for many personnel related issues. He appeared to be highly competent and motivated and to be getting a grip on the personnel issues, including recruitment. He reported steps he was taking to making recruiting more effective, including by job fairs and recruitment events. He reported that DJJ would hold recruitment fairs at each facility, targeted on vacancies at the facility. It is likely however, that these plans have been disrupted by the uncertainty as to which institutions are closing which was not resolved until the first week of January 2008.

Rating: Substantial compliance as to 7.1 (pay parity), partial compliance with 7.2 and 7.3.

10. MH 8.1.a.5. *OSM to monitor whether youth informed of MH policy changes as appropriate, on an ongoing basis.*

Central office staff have informed Cathleen Beltz that they believe that more work has to be done to ensure youth notification of policy changes generally (S&W 2.1.4a). We shared her write up of that information with you and it will be filed contemporaneously with your report. We are not aware of any recent implementation of new mental health policies.

Rating: Deferred for future monitoring.

11. MH 11.1. *OSM is in the process of monitoring whether DJJ developed an implementation plan for creating offices and mental health treatment rooms using renovations and modulars. The plan should identify locations and schedules. The plan is to be created by January 31, 2007.*

As of October 2007, Cathleen Beltz reported:

G. Implementation Plan For Offices And Mental Health Treatment Rooms (MH 11.1)

The mental health plan requires that DJJ create a plan for renovating existing structures and using modular buildings to create additional office and mental health treatment space.[4] Specifically, the plan requires that mental health clinicians be given sufficient office space that is appropriate for treatment, provides a therapeutic milieu and areas for confidential conversation.[5] Additionally, the space must be sufficient so that no regular mental health programs must be cancelled due to lack of space.[6] The implementation deadline for this requirement was January 31, 2007.[7]

DJJ provided email communication dated April 25 and 26, 2007 reflecting the monitor's request for the implementation plan and a responsible staff member's brief response.[8] The monitor was not able to interview the responsible staff person. DJJ has commenced some projects to add mental health office and treatment space, and some facility administrators interviewed report that they were told they would receive additional space.[9] Two facilities showed the monitor copies of plans for additional space.[10] Some projects have been temporarily halted due to regulatory issues.[11] Most staff and clinicians interviewed report that clinicians do not have sufficient treatment space.[12] The Farrell Sexual Behavior Treatment Expert, Dr. Barbara Schwartz, observed that one sexual behavior treatment group met regularly held in a busy corridor.[13] DJJ has not yet provided a coherent plan for the necessary renovations or anticipated completion dates for this requirement.

Rating: Noncompliance.

12. MH 12.1, 2 and 3: *OSM monitors whether DJJ has added or appointed Sr. Administrator for Plan implementation by Feb 28, 2007 (MH 12.1), 4 clinicians/MH administrators to reform team by Oct 31, 3006 (MH 12.2), and MH training team (3 clinicians, an instructional designer and an office technician) by January 31, 2007 (MH 12.3).*

As of June 2007, Cathleen Beltz reported:

F. Implementation of the Mental Health Plan (MH 12.1, 12.2 and 12.3)

[4] See, Mental Health Remedial Plan pp. 72-73.
[5] *Ibid.* and MH 11.1 audit criteria.
[6] MH 11.1 audit criteria.
[7] MH 11.1
[8] Email, Keith Beland, April 26, 2007.
[9] Staff interviews, 2007 site visits.
[10] *Ibid. and* document review, 2007 site visits.
[11] Staff interviews, 2007 site visits.
[12] *Ibid.*
[13] SBTP site visit, May 2007.

The mental health plan requires DJJ to appoint a "senior administrator with experience in implementing mental health programs to oversee and direct implementation of [the mental health] remedial plan and its coordination with other remedial plans."[14] The implementation deadline for this requirement was February 29, 2007. As of May 31, 2007, no appointment had been made.[15]

The mental health plan requires DJJ to appoint four senior clinicians and/or senior administrators, "with expertise in mental health services" to the program development and implementation team.[16] The implementation deadline for this requirement was October 31, 2006. As of May 31, 2007, two of the four senior clinicians/administrators with mental health expertise had been appointed.[17]

Finally, the mental health plan requires DJJ to create a "dedicated mental health training team consisting of at least three licensed clinicians plus an instructional designer and office technician."[18] The implementation deadline for this requirement was January 31, 2007. As of May 31, 2007, the office technician position was filled with a staff support analyst. DJJ has not identified any other team members.[19]

DJJ has informed Ms. Beltz that DJJ has seven senior clinicians assigned to the work groups at central office. This includes Dr. Arguello who of course cannot really be counted as meeting the requirement for four senior clinicians or administrators on an implementation team, but it also includes some clinicians who were brought into central office to implement the reform required by the remedial plans (as opposed to deliver services or supervise the delivery of services), such as a Dr. White, Ph.D. It includes Drs. Telander, Wall and Freeland with whom you have had significant contact, two of whom (Wall and Freeland) have operational responsibility as supervisors.

DJJ reported in its October 2007 quarterly report (MH matrix p. 13 and 15, 109th and 111th pages of the report) that it was not authorized to fill the "previously funded position[s]" of Senior Administrator and clinical trainers.

At our meeting with DJJ's mental health management team on December 3, 2007, they had no information about the senior administrator except that they were not authorized to fill the position. They said that they were not ready to do clinical training because they did not yet have policies to train staff on. They said that there was a logistics work group that Amy Seidlitz and Barry Gold managed and/or staffed that was planning and managing training. They said that mental health and safety and welfare or "reform" were being integrated in the work groups (referring to the three main work groups of classification and assessment, program and re-entry). You (Eric) observed that training needs to be continuous/repetitive/reinforced (adults do not learn by one-time

[14] *See,* Mental Health Remedial Plan, pp.75-76.
[15] Statements of DJJ staff, central office meeting, May 2007.
[16] *See,* Mental Health Remedial Plan, pp.75-76.
[17] *See,* Attachment 1.
[18] *See,* Mental Health Remedial Plan, pp.75-76.
[19] Statements of DJJ staff, central office meeting, May 2007.

trainings) and that mental health clinicians were the behavioral experts and needed to play an active role in training. You repeatedly have urged training of clinicians in the treatment of youth who present as at risk of self-injury.

At the December 3 meeting, clinicians reported some of the training that currently is in progress at DJJ, all of it directed primarily at correctional counselors rather than clinicians, specifically ART, Safe Crisis Management (JKM), Motivational Interviewing and a training about youth with mental illness and self-harming youth (Boesky).

You have observed that training for clinicians will be critical to successful implementation of the new policy for management of youth who present as at risk for self-harm (the "SPAR" policy). The three clinician trainers and instructional designer would have been helpful for designing and implementing clinician training and perhaps still could be.

Rating: Noncompliance 12.1 (experienced senior administrator), substantial compliance 12.2 (senior clinicians on implementation team), noncompliance 12.3 (mental health trainers and instructional designer).

13. S&W 5.5 a, b and c: *OSM to monitor whether job descriptions consistent with MH and S&W plans for treatment team leaders, case managers and other team members due 2/8/07.*

At your August 30, 2007 meeting with DJJ's mental health management, mental health staff reported that mental health had turned in a proposal "a long time ago." In the November 14 status update DJJ reports: "These job descriptions cannot be developed until the IBTM is developed. DJJ has contracted with Orbis to help assist with this program development."

Rating: Noncompliance.

14. S&W 6.1a. *OSM and experts to monitor conversion of Chaderjian to a special treatment facility as of April 1, 2007.*

DJJ staff report that, in January 2008, DJJ will provide notice of the conversion details to the peace officer's labor union. It will then begin labor negotiations, which staff report will take 30 days. Staff report that DJJ will then begin the conversion, including realignment of positions, new schedules, and staff training. [20]

[20] Statements of DJJ staff to Monitor Cathleen Beltz, December 2007.