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November 17, 2009

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RE: Margaret Farrell v. Matthew Cate  
Superior Court of California, County of Alameda, Case No. RG 03079344

Dear Drs. Trupin and Lee:

Thank you for providing the California Department of Corrections and Rehabilitation's Division of Juvenile Justice (DJJ) with the opportunity to comment upon the 2008-2009 Site Visit Summary for the first round of audits. The Mental Health staff at each of the five facilities, in addition to DJJ Headquarters staff, appreciate your efforts, comments, and professionalism. DJJ submits the following comments for your consideration. Additionally, the matrix response is attached for your review, which includes administrative comments as well as mental health comments. DJJ requests, and looks forward to, your response to these comments and recommendations.

Recognizing that its response is overdue, DJJ wishes to explain the reason for the delay. In addition to the usual clinical audit response, in which DJJ objects on a substantive basis to an audit rating, this report's audit responses were confusing and required a significant period of analysis and interpretation before DJJ could begin its clinical response. Significant DJJ staff resources were required to decipher which ratings were repeated, as well as what the experts' intended rating for a particular audit item actually was. Consequently, given the substantial confusion surrounding the majority of the experts' ratings and comments, this report was not as helpful to DJJ as DJJ would prefer it to be.

1. **Suicidal Behavior.**

(b) and (c): It is not the case that youth in DJJ are denied effective treatment for suicidal and self-harming behavior. Although Dialectical Behavioral Treatment (DBT) has not yet been trained on (see below), DJJ developed a new Suicide Prevention and Response (SPAR) Policy, presently implemented statewide, to address the management and treatment of self-harming youth. As part of the new DJJ SPAR Policy, youth who are placed on suicide risk reduction are 1) placed into the appropriate level of safety precaution; and 2) evaluated by a mental health clinician, at which time an Individualized Focal Treatment Plan (IFTP) is initiated. An IFTP is a goal-oriented, strength-based, individualized treatment plan developed by a mental health clinician with input from the treatment team when the youth is initially placed on Suicide Watch, Suicide Precaution or Follow-up Status. This Plan provides clinical and non-clinical staff with specific guidelines to address youth who have recently engaged in self-injurious behavior.

The IFTP includes a review of the following elements:

- Precipitant or stressors that may have contributed to the youth's fragile psychological state;
- A differential diagnosis;
- The treatment team's immediate goals for the youth;
- The youth's areas of strength;
- The individual, family, school, and system factors that may have influenced the youth's behavior, and contributed to his or her fragile emotional state; and
- Custody, school, clinical and system interventions recommended for the youth.

The possible clinical interventions include referral to medical; referral to psychiatry; laboratories; individual therapy; group therapy; behavioral interventions; behavioral groups; safety management plan; psychoeducation; anger management; psychological testing; behavior/reward plan; relaxation techniques; feeling sheets; general list of coping skills; sleep chart; journal and others. The FTP also indicates if the youth is part of the Wards with Disabilities Program, and specifies what the youth needs to have successfully completed to be placed in a lower level of care. The FTP is shared and discussed with the youth.

DJJ clinicians use their professional expertise to decide what interventions will be used while the youth undergoes suicide risk reduction. The clinicians use an array of treatment modalities to include Cognitive Behavioral Treatment (CBT), Psychodynamic Psychotherapy, Supportive Individual Psychotherapy, and Family Systems based Therapy. DBT is also used by a few of DJJ's clinicians, and N.A. Chaderjian currently has DBT group therapy, Behavioral Analysis and Behavioral Modification, Cognitive Restructuring, Crisis Intervention, Trauma Focused Interventions, and Systems Focus Treatment.

(c) and (f): Contrary to the information contained in the Summary, it is not true that suicidal and self-harming youth are treated in isolated confinement. The new DJJ SPAR Policy was

developed to ensure that suicidal youth are placed in a safe environment where they can receive the appropriate services during their emotional, fragile state. The intent of the new SPAR Policy is to ensure safety and to engage the youth through interventions without isolating them from peers and support groups

(d): The DBT pilot programs are scheduled for March 2010 at Ventura and N.A. Chaderjian YCFs. DJJ has a contract with Behavior Affiliates, Inc. to implement the pilot programs and train staff.

(f): The SPAR Policy is very clear that youth on suicide risk reduction, if clinically indicated, will be provided services in the less restrictive environment. With the implementation of the new policy, DJJ no longer uses clocked video observation rooms or mock gear. The SPAR Policy mandates that the youth receive services during suicide risk reduction in their living units, and are allowed to participate as much as possible in regular programming.

### 3. Licensed Mental Health Beds.

DJJ disagrees with your assertion that Northern California males "do not have adequate access to acute licensed mental health beds." Males from Northern California are placed in contracted beds at Sierra Vista Hospital, which has Correctional Treatment Center (CTC) level of care. DJJ's contract with Sierra Vista Hospital is working well; DJJ renewed its contract with Sierra Vista Hospital and continues to utilize it for Northern California youth. DJJ also transports some Northern California youth to the CTC at Heman G. Stark YCF.

Females who need a higher level of care are placed in the CTC at Stark. They may stay longer than males at the CTC, since DJJ presently does not have an Intermediate Care Facility (ICF) Level of Care for females 17 years old or younger. The travel time from Ventura to Ontario is not extensive. DJJ has entered into discussions with DMH regarding services for females in the ICF at Metropolitan State Hospital. However, DMH does not take any person under the age of 18. The only current placement option for DJJ's female youth under age 18 continues to be the CTC at Heman G. Stark YCF. However, DJJ is currently discussing alternatives for the provision of licensed psychiatric care of youth in Northern and Southern California. DJJ is actively contacting community psychiatric hospitals in Southern California to attempt to develop new contracts for acute and intermediate care.

### 4. Peer Review.

A mental health peer review process has not been implemented. A small pilot was conducted using a new Peer Review Form to examine the form's effectiveness and ease of use. The new MH Peer Policy is presently awaiting final legal review and signature. The new policy ensures that every quarter, several clinical notes are reviewed for appropriate care. In addition, the new MH Peer Review Policy creates a centralized peer review committee that keeps track of all peer reviews and corrective action plans for those clinicians showing deficiencies in the way they

provide care to the youth. In the near future, DJJ expects that the mental health and health care services peer review policies will be merged into one policy.

**5. Definition of Mental Health Youth.**

DJJ now has a uniform definition for Mental Health Youth:

A Mental Health Youth is a youth who has a mental health condition that impairs his or her psychological and social functioning, and/or has been diagnosed with a DSM-IV-TR Axis I diagnosis, except if the youth has only one of the following:

- Sole diagnosis of **any** Conduct Disorder;
- Sole diagnosis of **any** Sexual Disorder;
- Sole diagnosis of **any** Substance Disorder; or
- A youth receiving psychotropic medication and/or a youth that has had suicidal or homicidal ideation in the last six months.

**7. DDMS.**

DDMS policy is implemented throughout all five DJJ facilities even though a grievance was filed. Reviews are occurring and a process for modifying the disposition or DDMS is in place. The Chief Psychiatrist is reviewing the Level 3's and is modifying or approving them based upon his thorough review.

The policy was implemented in April 2009, and we have an 85% reduction in the number of time adds for mental health youth.

**8. Family Participation.**

DJJ facilities do have family therapy available, and have family events on a quarterly basis. Proofs of practice have been sent out to this effect. The charter for Family Engagement has started meeting, which includes a Mental Health Clinician as a member. All sites have begun family engagement activities and initial training has been completed.

**9. Training in New Programs.**

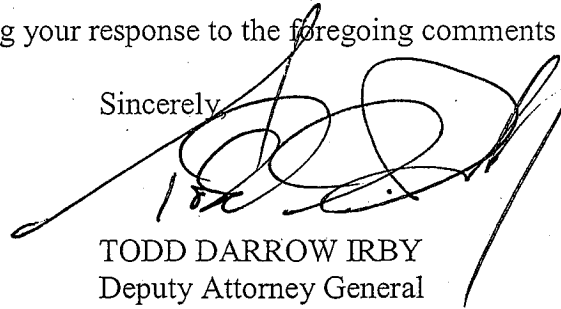
DJJ disagrees with the experts' comment that "suicide training was a generic educational training" and "inappropriate" for non-clinicians. Since the role of the MH clinicians in core units is to provide education, clinical support and coaching to non-clinicians, DJJ felt that the

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clinicians needed to participate in the training so that they knew the information that was provided to non-clinical staff so that they would be able to provide better coaching and support.

DJJ looks forward to receiving your response to the foregoing comments and recommendations.

Sincerely,



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Deputy Attorney General

For EDMUND G. BROWN JR.  
Attorney General

Attachment: Referenced above.

cc: Michael K. Brady  
Rachel Stern  
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