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SUPERIOR COURT OF CALIFORNIA  
CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL,  
  
Plaintiff,  
  
vs.  
  
MATTHEW CATE,  
  
Defendant.

Case No.: RGO3079344

FOURTEENTH REPORT OF SPECIAL  
MASTER

Pursuant to paragraph 28 of the November 2004 Consent Decree, the special master submits for filing the attached report. The special master's report and its appendices were circulated to the parties in draft form. This final version reflects consideration of the parties' comments.

Dated: February 12, 2010

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Donna Brorby  
Special Master

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FOURTEENTH REPORT OF SPECIAL MASTER

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## I. INTRODUCTION

This report reviews the 2009 report of the *Farrell* mental health experts and summarizes the status of compliance with key components of the Mental Health Remedial Plan. The office of the special master (OSM) and the experts submit these final reports after consideration of the parties' comments. The OSM filed its own monitoring report on mental health remedial plan requirements as Appendix H to the Eleventh Report of the Special Master in November 2009.

## II. MENTAL HEALTH SERVICES

The mental health experts provided the special master with their prior formal report two years ago, in December 2007.<sup>1</sup> From December 2007 through August 2009, the experts conducted the following site visits: Preston, July 18-19, 2008; Close, October 16, 2008; Chaderjian, October 17, 2008; Ventura, December 1-2, 2008; DJJ Central Office, January 8-9, 2009; SYCRCC, April 16-17, 2009 (Dr. Lee only), and Stark, October 2-3, 2008 and May 7-8, 2009. They submitted their comprehensive report to the parties for comment and review in August 2009. DJJ did not provide comments on the report until November 17, 2009. The experts delivered their final report to the special master on January 10, 2010, and it is attached as Appendix A.<sup>2</sup> The experts also provided informal site visit reports to the OSM and the parties.

### A. Organizational Structure and Integration of Staff to Provide Treatment

For DJJ to evolve from adult-type prisons to juvenile treatment facilities, as required by the safety and welfare and mental health plans, the staff responsible for the

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<sup>1</sup> See Sixth Report of the Special Master (January 2008), Appendix A (Lee and Trupin Report) [hereinafter Lee and Trupin, 2007 Formal Report].

<sup>2</sup> See Appendix A, Terry Lee and Eric Trupin, Farrell Mental Health Experts' 2008-2009 Site Visit Summary, January 9, 2010 [hereinafter Lee and Trupin, 2009 Formal Report].

care and treatment of youth must collaborate across professional and disciplinary lines to share and achieve treatment goals. This will require obliterating the “silos” dividing “custody” or “facility” staff and clinical staff.<sup>3</sup>

The need for better collaboration among clinical and facility staff is evidenced in many ways. Across the state, core SBTP therapy groups are comprised according to youth correctional counselor caseload, rather than according to clinical judgments about group composition.<sup>4</sup> In a similar vein, according to DJJ’s compliance unit, clinical staff at Chaderjian believe that clinical needs are discounted by facility staff responsible for scheduling and staff assignments.<sup>5</sup> At Ventura, facility staff were administratively overriding clinical decisions about appropriate residential placement for particular youth.<sup>6</sup> It also appears that DJJ stopped using a local private hospital for mental health treatment

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<sup>3</sup> “Silos” exist when some staff work in isolation according to a rigid division of roles and institutional purposes, with insufficient regard to the relationship of their work to the work of others and the achievement of what should be the shared goal of delivering appropriate services to youth. Silos impede collaborative exchanges that depend upon respect and deference to others’ expertise where appropriate. They have affected all areas of DJJ’s operations. For example, the disabilities expert has been concerned that the wards with disabilities program (WDP) has been relegated to the province of WDP staff, and that many facility and clinical staff members are not aware of their responsibilities under the disabilities remedial plan. *See* Tenth Report of the Special Master (September 2009), p 26; Fifth Report of the Special Master (October 2007), pp. 32-33. The medical experts found divisions among staff in 2006-2007, though they made no reference to divisions in their 2007-2008 monitoring round. *See* Fifth Report of the Special Master (October 2007), p.24, n. 93; Tenth Report of the Special Master (September 2009), Appendix G (LaMarre and Goldenson Report). They and the mental health and sexual behavior treatment experts have raised the issue in relation to conflicts between clinical and non-clinical staff and DJJ’s protocol for the resolution of such disputes. *See, e.g.*, Lee and Trupin, 2007 Formal Report, p. 1 (need for interdepartmental, interdisciplinary collaboration focused on clinical autonomy and resolution of disputes between clinical and nonclinical staff); Lee and Trupin, 2009 Formal Report, pp. 5, 9; e-mail of special master to Doug McKeever, et al., September 8, 2009 (summarizing several experts’ consensus regarding resolution of disputes between clinical and non-clinical staff); e-mail of special master to Doug McKeever, et al., December 9, 2009 (same). This is discussed in more detail below.

<sup>4</sup> Observations of monitor Aubra Fletcher during SBTP audit case note reviews, January 2009 to May 2009; statements of staff to OSM during site visit, October 2008. The SBTP expert has informed DJJ that YCC caseload assignments should not determine the composition of clinical groups. *See* e-mail of Barbara Schwartz to Erin Peel, et al., June 12, 2009 (attaching comments on draft revised remedial plan).

<sup>5</sup> DJJ, Fact Finding on *Farrell* SBTP Audit at N.A. Chaderjian Youth Correctional Facility, undated (provided as PoP #525, October 5, 2009), pp. 3-4.

<sup>6</sup> *See, e.g.*, statements of staff during Ventura site visit, December 1-2, 2009. In July 2008, Ventura staff reported that most youth who completed the drug treatment program could not be moved from the residential treatment unit, because the housing unit needed to maintain a certain population level. Terry Lee and Eric Trupin, Informal Report: Ventura, January 7, 2009, p. 13.

for young women, without consideration of clinical needs, because the hospital would not permit DJJ officers to enter the hospital with certain security equipment.<sup>7</sup> Facility staff regularly give youth on the mental health caseload time adds as punishment for disciplinary violations<sup>8</sup> which are reversed on review by the chief psychiatrist.<sup>9</sup> There also have been troubling allegations of personal conflict across the clinical-custody divide among individuals; these will not be elaborated upon or cited in this public report.

DJJ's protocol for resolving disputes between clinical and non-clinical staff<sup>10</sup> reflects the difficulty that that DJJ has approaching the divide between the disciplines. In January 2008, the mental health experts reported that there was "not a functioning protocol for resolution of perceived conflicts between clinical and other staff over professional and clinical matters."<sup>11</sup> By March 2008, DJJ distributed a proposed protocol, and the mental health, medical, and SBTP experts provided DJJ with their critique.<sup>12</sup> DJJ adopted the protocol without making any of the experts' recommended changes,<sup>13</sup> and the experts reiterated their critique a few times without response.<sup>14</sup> In the

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<sup>7</sup> This issue is discussed in greater detail below.

<sup>8</sup> DJJ reports that youth on the mental health caseload received 48% of time adds given from November 2008 – July 2009. Memorandum of Randy Aguirre to Sandra Youngen, et al., September 3, 2009 (PoP #500, September 14, 2009). At the time, according to CompStat data, approximately 14% of DJJ's population was designated as "MH youth," though there was no uniform definition of "MH youth" at that time. Lee and Trupin, 2009 Formal Report [August 19, 2009 draft], p. 6; Lee and Trupin, 2009 Formal Report [December 16, 2009 draft], p. 7; e-mail of OSM to mental health experts, September 11, 2009; e-mail of Terry Lee to special master, September 11, 2009.

<sup>9</sup> See Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 4. Mr. Irby's representations are consistent with information that the special master has received directly from DJJ's Chief Psychiatrist Dr. Morales. This reflects the positive effect of the new disciplinary policy's implementation and also illustrates the divide between custody and mental health staff with respect to the utility and appropriateness of time adds.

<sup>10</sup> See Mental Health Remedial Plan Standards and Criteria, item 3.3 (requiring protocol).

<sup>11</sup> See Lee and Trupin, 2007 Formal Report, Attachment 1, p. 1.

<sup>12</sup> See e-mail of special master to Katie Riley, et al., March 26, 2008 (summarizing experts' consensus critique).

<sup>13</sup> See memorandum of Sandra Youngen and Robert Morris to superintendents, et al., December 14, 2007 (PoP #130, May 21, 2008).

<sup>14</sup> See e-mail of special master to Robert Morris, et al., November 7, 2008 (summarizing experts' concerns); e-mail of special master to Doug McKeever, et al., September 8, 2009 (same); e-mail of special master to

experts' view, the protocol does not adequately specify the kinds of disputes that may arise or the basis for facility staff to dispute a clinical decision. The experts consider the protocol almost counter-productive, as it indicates that facility staff may evaluate the judgments and directions of clinical staff. The protocol fails to clarify that facility staff should follow the direction of clinical and other professional treatment staff about the content and manner of treatment. Further, the protocol does not specify whose judgment governs pending resolution of the dispute and does not set an expectation that staff will collaborate and cooperate to ensure maximum treatment and constructive activity in a safe environment. Almost two years after the first iteration of the protocol, in response to a draft version of this report, DJJ informed the special master that the protocol is "in the process of being updated."<sup>15</sup>

The mental health and sexual behavior treatment experts explain that DJJ needs an organizational and supervisory structure that provides administrative and clinical supervision of treatment for all staff who are part of the treatment team, including custody staff.<sup>16</sup> Organization charts for central office and all facilities do not depict a clinical supervision relationship between mental health and administrative/custody personnel.<sup>17</sup> CDCR's own internal auditors attribute this to a "[l]ack of collaboration/communication between administrative staff, Health Care Services staff,

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Doug McKeever, et al., December 9, 2009 (same). Unless otherwise indicated, the remainder of this paragraph and the following paragraph are based on these sources.

<sup>15</sup> E-mail of Van Kamberian to special master, November 17, 2009 (attaching comments).

<sup>16</sup> See Lee and Trupin, 2009 Formal Report, pp. 5, 9. As the sexual behavior treatment expert has described, there is no supervisor responsible for the treatment program, whether at the system or the living unit level; neither the SBTP coordinator nor any living unit manager have the authority to direct both clinical and non-clinical SBTP staff. Twelfth Report of the Special Master (December 2009), p. 6; Eighth Report of the Special Master (February 2009), p. 17.

<sup>17</sup> CDCR Office of Audits and Compliance, Compliance Review, March 2009, pp. 5, 8, 14, 17, 20, 23.

MH staff, and the Court appointed [sic] experts” and between central office and facilities.<sup>18</sup>

The development and strategic implementation of the IBTM must address the supervision of and working relationships among DJJ personnel.<sup>19</sup> As a part of its implementation, DJJ must redesign policies governing interactions among staff and between staff and youth, use of force, and youth behavior management.<sup>20</sup> In the meantime, DJJ should identify and take reasonable steps to improve interdisciplinary and inter-departmental cooperation and collaboration directed at treatment goals.

#### B. Policy and Training for Management and Treatment of Potentially Self-Harming Youth

The transformation of DJJ’s suicide and self-harm prevention practices has been at issue since the entry of the consent decree. DJJ is required to implement an administrative policy for the treatment and management of intentionally self-harming youth.<sup>21</sup> DJJ is also required to train its clinicians to treat potentially self-harming youth.<sup>22</sup> Last year, the mental health experts again urged DJJ to prioritize the implementation of the administrative policy and the provision of appropriate clinician training.<sup>23</sup> DJJ’s compliance with each requirement is discussed in turn below.

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<sup>18</sup> *See id.*

<sup>19</sup> *See id.*; Mental Health Remedial Plan, pp. 6-8; Henry Schmidt and Angela Wolf, The Integrated Behavior Treatment Model Report, November 29, 2009, pp. 47-48.

<sup>20</sup> *See, e.g.*, Lee and Trupin, 2009 Formal Report, pp. 7-8.

<sup>21</sup> Consent Decree, ¶ 7.c. Specifically, the Consent Decree required defendant to “develop policies and procedures to immediately provide for the treatment and management of wards on suicide watch and those with acute psychiatric needs.” *See id.* For purposes of this report, the phrase “self harm” encompasses suicide attempts, suicidal gestures, and non-suicidal self-injurious behaviors.

<sup>22</sup> *See* Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan; Order, December 13, 2005, ¶ 13. The special master has referred to this stipulation and order as the November 30, 2005 stipulation in past reports, resulting from a November 30, 2005 deadline that was extended by the stipulation and the effort to file the stipulation on November 30, 2005. The pleading on file was filed by the parties on December 1, and was entered as an order on December 13, 2005.

<sup>23</sup> *See* Ninth Report of the Special Master (June 2009), Appendix C (Experts’ Priorities for Fiscal Year 2008-2009), p. 2 (“Improve management and treatment of self-harming youth: (a) Train staff on

## 1. Suicide Prevention, Assessment, and Response (SPAR) Policy

The Consent Decree requires DJJ to develop and implement administrative measures for managing and treating potentially self-harming youth. These measures must be in the form of “criteria that institutions must meet for these wards, including number of hours of clinical intervention per week and maximum number of in-room hours per day.”<sup>24</sup> Since the special master last reported on this issue, DJJ directed facilities to implement a new SPAR policy aimed at minimizing isolation of potentially self-harming youth and allowing them to engage in supervised ordinary activities when appropriate.<sup>25</sup>

DJJ modified the SPAR policy in consultation with the mental health experts, and the experts first approved the policy as an interim measure in late 2004.<sup>26</sup> Under the policies and procedures, clinicians were to order one-on-one supervision where appropriate to enable youth participation in normal activities instead of isolating youth beyond the time necessary for clinical assessment and resolution of acute suicidality.<sup>27</sup> In April 2005, DJJ filed its Mental Health and Rehabilitation Interim Plan, which extended

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empirically-based treatment(s) on an expedited basis. (b) Implement the SPAR [Suicide Prevention and Response] policy system-wide (and continue evaluation and improvement of the policy as necessary).”); Eleventh Report of the Special Master (November 2009), Appendix I (Experts’ Priorities for Fiscal Year 2009-2010), pp. 2-3 (“[I]mprove management and treatment of self-harming youth. Over this next year, train all staff and implement [dialectical behavior therapy] on two mental health units for pilot. Train additional MH clinicians in preparation for system-wide dissemination. Evaluate Suicide Prevention, Assessment, and Response policy; modify and streamline policy and procedures as indicated.”).

<sup>24</sup> Consent Decree, ¶ 7.c.

<sup>25</sup> The experts approved this policy as “an improvement over its predecessor” but recommend simplifying it the next time it is revised. *See* Lee and Trupin, 2009 Formal Report, p. 4. By 2007, they described an earlier version of the SPAR policy as “a great step forward” and “progressive in important respects.” *See* Lee and Trupin, 2007 Formal Report, Attachment 1, #24.

<sup>26</sup> First Report of the Special Master (April 2006), p. 32.

<sup>27</sup> *Id.*, p. 33. For a detailed summary of the SPAR policy, see the Third Report of the Special Master (December 2006), pp. 8-9. Youth confined to rooms on suicide watch or suicide precaution were housed in “camera rooms,” and posted staff were responsible to keep watch of the surveillance screens.

the December 2004 deadline for implementation of the SPAR policy to July 1, 2005.<sup>28</sup> DJJ issued Temporary Departmental Orders in early November 2005<sup>29</sup> and trained mental health staff in November and December 2005.<sup>30</sup> Yet, as of December 2005, none of the staff interviewed by the special master knew of any instance involving application of the one-on-one provision.<sup>31</sup> DJJ continued to confine self-harming youth and to isolate them in punitive conditions.<sup>32</sup>

The situation changed little over the next year. The November 2005 temporary policy remained in effect.<sup>33</sup> As of September 2006:

Almost all youth on suicide or crisis watch status for more than a day receive a maximum of two to three hours out of room time for showers and unstructured day room time (often alone in the dayroom). Some have an hour or less out of their rooms in shower/holding areas. For the rest of the day and night, the youth generally are alone in observation/watch rooms, limited to suicide resistant clothing and bedding a perhaps a book . . . . Some administrative and clinical staff seemed unaware that current policy requires that youth on observation/watch status spend as much time out of their rooms as clinicians determine is clinically appropriate . . . . Others were aware of the requirements of policy but felt that their facility did not have enough staff to provide one-on-one supervision for youth for whom more normal activity would have been appropriate.<sup>34</sup>

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<sup>28</sup> See Mental Health and Rehabilitation Interim Plan, April 8, 2005, ¶ 16.

<sup>29</sup> See First Report of the Special Master (April 2006), pp. 32-33, Appendix Z (DJJ Suicide Watch Policy). This was a time when DJJ was not promulgating new policies expeditiously. See Fourth Report of the Special Master (July 2007), p. 16.

<sup>30</sup> First Report of the Special Master (April 2006), p. 33.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> The November 2005 order was retained in effect upon its expiration by new temporary departmental orders issued in April 2006. See Third Report of the Special Master (December 2006), Appendices B (Temporary Departmental Order #06-38), C (Temporary Departmental Order #06-39). The April 2006 temporary departmental orders are identical to the November 2005 TDOs but for the new expiration date, extending them to April 2007.

<sup>34</sup> Third Report of the Special Master (December 2006), pp. 10-11.

Thus, nine months after training staff on the interim policy DJJ had not succeeded in implementing it.<sup>35</sup>

The mental health experts recommended that DJJ improve the interim SPAR policy and procedures that it had not implemented.<sup>36</sup> DJJ completed a policy revision fifteen months later, in December 2007.<sup>37</sup> The mental health experts supported the revised policy because it (1) hastened clinical evaluation and treatment of youth deemed to be at risk of self-harm, (2) increased mental health management oversight of the management and treatment of those youth, and (3) replaced camera surveillance with direct one-on-one supervision and limited the use of isolation and restrictions even more than prior policies had.<sup>38</sup> In 2008, DJJ piloted the policy at N.A. Chaderjian and further revised it.<sup>39</sup> At DJJ's request, the Court extended the official deadline for implementation to February 23, 2009.<sup>40</sup> DJJ reports that it implemented the policy on March 19, 2009.<sup>41</sup>

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<sup>35</sup> Fourth Report of the Special Master (July 2007), p. 16.

<sup>36</sup> *Id.*

<sup>37</sup> See Lee and Trupin, 2007 Formal Report, Attachment 1, #24.

<sup>38</sup> *Id.*; see also DJJ, Policy Revision Packet – 42, Revision # 81, Institutions and Camps Manual, Section 6263-6272, December 19, 2007 [hereinafter DJJ, December 2007 SPAR policy]. The December 2007 policy required facility staff to bring youth deemed at risk of self-harm to the facility medical clinic for prompt evaluation by health care professional staff and mental health clinicians. DJJ, December 2007 SPAR policy, p. 17. The time frames for the mental health clinicians to see the youth differed depending whether mental health clinicians were on-site. See *id.* The SPAR policies in effect before December 2007 required only that a mental health clinician see a potentially self-harming youth within 24 hours of placement on a suicide risk reduction status. Third Report of the Special Master (December 2006), p. 8 and Appendix B (Temporary Departmental Order #06-38).

<sup>39</sup> See Appendix C, DJJ, Suicide Prevention, Assessment, and Response [policy], Institutions and Camps Manual, Section 6263, January 9, 2009; DJJ Project Charter: Suicide Prevention, Assessment, and Response, November 13, 2008.

<sup>40</sup> See Order, February 20, 2009, p. 2; see also, DJJ Project Charter: Suicide Prevention, Assessment, and Response, November 13, 2008 (scheduling statewide SPAR implementation for February 2009).

<sup>41</sup> See, e.g., e-mail of Robert Rollins to DJJ facility staff, et al., March 19, 2009 (officially disseminating the SPAR policy to all institutions). The experts and OSM reviewed draft SPAR training materials in January 2009 and submitted joint comments to DJJ. The experts and OSM recommended that the materials be revised to 1) advise staff as to how to manage or reduce self harming behaviors in youth and 2) explain more clearly when the different “suicide risk reduction” statuses are appropriate. See e-mail of Zack

DJJ reports that it has improved the treatment and management of youth at risk for self-harm as its administrative SPAR policy has evolved.<sup>42</sup> The new policy does require prompt clinical attention for potentially self-harming youth and more oversight by DJJ's mental health leadership.<sup>43</sup> The experts have not yet assessed the effects of the policy's implementation, however.<sup>44</sup> OSM has asked the experts to evaluate the new policy's implementation in their current audit round.<sup>45</sup>

## 2. Empirically-Based Treatment for Self-Injurious Behavior

DJJ's SPAR policy is a set of administrative procedures intended to prevent suicides in an institutional setting, but it does not address the specific clinical treatment to be provided to self-harming youth.<sup>46</sup> Since 2005, the mental health experts have repeatedly urged DJJ to provide training to clinical staff in the effective treatment and clinical management of self-injuring and suicidal youth.<sup>47</sup>

The parties stipulated in November 2005 that Dr. Trupin would develop a plan to enhance DJJ clinicians' ability to treat self-destructive youth, in consultation with DJJ

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Schwartz to Doug Ugarkovich, January 6, 2009. As of this writing, OSM has received no substantive response to this feedback.

<sup>42</sup> See Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 2.

<sup>43</sup> See *supra* n.40.

<sup>44</sup> Because DJJ directed the facilities to implement the policy near the end of the mental health audit round, the experts had the opportunity to observe its implementation only at Stark and SYCRCC. They did not do so in any systematic way. See Terry Lee and Eric Trupin, Informal Report: Stark, undated (provided January 7, 2009), p. 10 (reporting on policy training and content only); Terry Lee and Eric Trupin, Informal Report: SYCRCC, undated (provided September 25, 2009), p. 12 (describing the experience of one youth); Lee and Trupin, 2009 Formal Report, p. 4 (limiting findings on SPAR implementation to reporting what has been reported to the experts by DJJ).

<sup>45</sup> See Consent Decree, ¶37 ("The Special Master may direct any expert to tour any CYA facility or facilities to evaluate implementation and compliance with the remedial plan."); memorandum of Aubra Fletcher and special master to mental health experts, November 6, 2009 (fact-gathering memorandum for experts' upcoming Preston audit); e-mail of special master to mental health experts, October 22, 2009.

<sup>46</sup> See Sixth Report of the Special Master (January 2008), p. 2 n.1.

<sup>47</sup> See, e.g., *id.*; statements of Eric Trupin to DJJ director of programs during Chaderjian site visit, October 17, 2008; e-mail of Eric Trupin to Michael Brady, et al., January 6, 2009.

and taking account of DJJ's legal constraints.<sup>48</sup> The stipulation required DJJ to implement Dr. Trupin's plan absent compelling reasons not to do so.<sup>49</sup> In March 2006, Dr. Trupin introduced DJJ to Dr. Henry Schmidt, who proposed a contract to provide training and supervision to DJJ clinicians.<sup>50</sup> DJJ objected that the plan did not take account of a legislative restriction prohibiting it from funding new training until the completion of a training needs assessment; DJJ was also reluctant to enter into such a contract without first establishing an integrated plan for clinician training pursuant to the mental health remedial plan then being drafted.<sup>51</sup> At the time, the special master found DJJ's position to be reasonable.<sup>52</sup> DJJ did not refuse to implement Dr. Trupin's plan or negotiate alternatives with Dr. Trupin; instead, DJJ committed to providing similar training in the future.<sup>53</sup>

In October 2006, DJJ filed the Mental Health Remedial Plan, which mandates staff training in an evidence-based intervention targeting suicidal behavior.<sup>54</sup> The plan requires DJJ to train selected individuals in the treatment and clinical management of self-injurious and suicidal behaviors in "the first phase" of training on the IBTM and certain specialized treatment interventions.<sup>55</sup> If DJJ had met the timetable of the remedial plan, it would have had an IBTM description, manual and training materials by

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<sup>48</sup> See Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan, November 2005; Order, ¶ 13, filed December 13, 2005.

<sup>49</sup> See Stipulation Regarding Safety and Welfare Remedial Plan and Mental Health Remedial Plan, November 2005; Order, ¶ 13, filed December 13, 2005.

<sup>50</sup> Second Report of the Special Master (August 2006), p. 11; e-mail of Eric Trupin to Paul Woodward, et al., March 12, 2006 (explaining that Dr. Schmidt would make a proposal to DJJ at a March 20, 2006 meeting, pursuant to the December 2005 stipulation and order).

<sup>51</sup> Second Report of the Special Master (August 2006), p. 12. Drs. Trupin and Schmidt then proposed that DJJ contract with Dr. Schmidt to lead a DJJ work-group that would write a description of DJJ's IBTM. See e-mail of Henry Schmidt to Eric Trupin, Elizabeth Siggins, and Amy Seidlitz, May 12, 2006. This did not occur.

<sup>52</sup> *Id.*

<sup>53</sup> See, e.g., e-mail of special master to Michael Brady, et al., December 17, 2008.

<sup>54</sup> See Mental Health Remedial Plan, pp. 47-48, 63.

<sup>55</sup> *Id.*, pp. 47-48.

November 15, 2008.<sup>56</sup> Further, it would have trained or hired IBTM trainers by April 2009 and it would have trained direct care staff in the IBTM by August 15, 2009.<sup>57</sup> DJJ was far behind remedial plan timetables by 2008, and the training in the treatment and clinical management of self-harming and suicidal youth remains overdue.

In early 2008, a central office manager stated that DJJ hoped to contract with Dr. Schmidt for the provision of clinician training.<sup>58</sup> Later, DJJ introduced a training directed at non-clinical staff in “understanding and preventing suicide” instead.<sup>59</sup> This training may have been educational for non-clinical staff, but it did not help develop appropriate treatment and clinical management of self-injuring and suicidal youth.<sup>60</sup> At the end of 2008, the mental health experts raised the clinician training issue as an urgent matter with then-new Chief of Compliance Michael Brady. The experts and the special master informed Mr. Brady that DJJ was required to train clinicians in dialectical behavior therapy (DBT) training as Dr. Trupin originally recommended, or else propose an alternative evidence-based approach.<sup>61</sup> Mr. Brady promptly brought this demand to the directors and Chief Deputy Secretary.<sup>62</sup> The experts met with DJJ’s clinical and administrative managers on January 13, 2009 and were told that DJJ would proceed with DBT training.<sup>63</sup> As of mid-March 2009, DJJ’s mental health leadership could not obtain

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<sup>56</sup> See Safety and Welfare Remedial Plan Standards and Criteria, items 4.3 and 5.3.a.

<sup>57</sup> See Safety and Welfare Remedial Plan Standards and Criteria, item 5.4a; Mental Health Remedial Plan Standards and Criteria, item 5.1.

<sup>58</sup> See statements of Amy Seidlitz to the special master, January 2008.

<sup>59</sup> See “Farrell Related Training Data – Training Attendance Report – Understanding and Preventing Suicide,” June 20, 2008 (PoP #171, July 1, 2008).

<sup>60</sup> Statements of mental health experts during central office site visit, January 8-9, 2009.

<sup>61</sup> See e-mail of special master to Michael Brady, et al., December 17, 2008. DBT is a core of Washington JRA’s integrated treatment model and is similar to the training that Dr. Schmidt would have provided in 2006 had DJJ contracted with him then. See e-mail of Eric Trupin to Paul Woodward, et al., March 12, 2006 (forwarding chapter by Schmidt on treatment and management of self-harming youth).

<sup>62</sup> See e-mail of Michael Brady to special master, et al., December 17, 2008.

<sup>63</sup> See, e.g., e-mail of Juan Carlos Arguello to Drs. Trupin and Lee, et al., January 13, 2009. The mental health experts and DJJ’s mental health leadership long have agreed that DBT is an appropriate evidence-

administrative approval to go forward.<sup>64</sup> The mental health experts were severely critical of the continuing delays.<sup>65</sup> In June 2009, DJJ contracted Dr. Schmidt to train select DJJ clinicians in DBT and provide a program development plan to pilot DBT in a mental health unit.<sup>66</sup> DJJ plans to pilot the DBT training at Ventura's female intensive treatment program unit and at Chaderjian's intensive behavior treatment program in March 2010.<sup>67</sup>

DJJ's failure, until recently, to take effective steps to train staff in the effective treatment of intentionally self-harming youth is an example of DJJ's failure to prioritize and to take decisive, effective action in important areas. When experts believe that there is at least one treatment intervention that reduces serious self-harming behavior, and when a significant minority of DJJ youth engage in self-injurious and suicidal acts,<sup>68</sup> training select staff in the intervention should become one of DJJ's highest priorities.

DJJ acknowledges that DBT "once implemented, will provide trained clinical and non-clinical staff additional alternatives to use of force to de-escalate youth engaged in

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based clinical intervention for most of the intentionally self-harming behavior in DJJ. *See, e.g.*, statements of Drs. Trupin and Lee during central office site visit, January 8, 2009; statements of Dr. Ed Morales during central office site visit, January 8, 2009.

<sup>64</sup> *See* statements of Ed Morales to Aubra Fletcher and Dr. Barbara Schwartz, January 30, 2009; statements of Juan Carlos Arguello to Aubra Fletcher, February 18, 2009; e-mail of Juan Carlos Arguello to the special master, March 18, 2009. In January, DJJ's administrative leadership instructed Dr. Arguello to prepare a "charter" for the project which would have to be approved. It did not approve his first attempt.

<sup>65</sup> *See* e-mail of Eric Trupin to Bernard Warner, March 19, 2009.

<sup>66</sup> Statements of Michael Brady during Court Compliance Task Force meetings, May 14, 2009 and June 4, 2009; *see also* Standard Agreement between CDCR and contractor Henry Schmidt II, Ph.D., June 12, 2009 (PoP #472, August 3, 2009). The contract was signed on June 12, 2009 and will expire September 30, 2010.

<sup>67</sup> Statements of Juan Carlos Arguello during Court Compliance Task Force meeting, September 10, 2009; memo of Van Kamberian to special master, November 17, 2009 (attaching comments on draft version of this report).

<sup>68</sup> *See* OSM Master Log of Sentinel Event Serious Incident Reports for incidents through November 2009. For the period August 2008 – November 2009, DJJ provided the OSM with "serious incident reports" documenting 29 "suicide attempts" at Stark, 25 at Chaderjian, 15 at Ventura, and one at Preston. As discussed below, DJJ is not yet able to provide data on the number of incidents of self-injurious behavior, and DJJ's serious incident reports do not appear to capture most of them.

self-injurious behavior.”<sup>69</sup> The use of force against self-harming youth accounts at least in part for the priority that the mental health experts have placed on this training.<sup>70</sup> In October 2008, a youth at Chaderjian told OSM that “when [staff] see” a youth attempting or engaging in self harm, “they spray you.”<sup>71</sup> He cited an instance in which he had been maced by staff in the recent past.<sup>72</sup> OSM later obtained documentation regarding the use of force against “mental health youth” at Chaderjian between August 1, 2008 and October 17, 2008 and compiled it for the experts.<sup>73</sup> Of 45 recorded incidents of potentially self-injurious behavior, 14 resulted in the use of force against the youth, and six of these instances involved the use of chemical force.<sup>74</sup> In at least four of these six instances,<sup>75</sup> staff utilized the Z505 Cap Stun Crowd Control, which the manufacturer recommends for “crowd control, prisons, correctional facilities, rescue operations and saturation of an indoor barricaded area where innocent individuals might be exposed to injury or death if traditional ordinance is used.”<sup>76</sup> One written justification for the use of the Z505 reads: “Ward . . . maced for self-injurious behavior, attempting to bite

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<sup>69</sup> See letter of Van Kamberian to the special master, November 17, 2009, p. 8 (providing comments on a draft version of this report).

<sup>70</sup> See Lee and Trupin, 2009 Formal Report, p. 7.

<sup>71</sup> See memorandum of Aubra Fletcher to Barry Krisberg, Eric Trupin, and Terry Lee, November 10, 2008, pp. 3-4.

<sup>72</sup> See *id.* Documentation confirmed that the interviewed youth was maced for self-harm behavior twice on August 4, 2008 and once on September 3, 2008. *Id.* This youth was taking psychotropic medications at the time of these and other instances of chemical force; the mental health experts have repeatedly recommended that DJJ cease the use of chemical force on youth taking psychotropics. The revised use of force policy prohibits some uses of chemical agents on youth taking psychotropics, but allows staff to use chemical agents when any youth poses an imminent threat to self, others, or the security of the facility. See DJJ, Crisis Prevention and Management Policy, February 6, 2009 (PoP #338, April 20, 2009).

<sup>73</sup> See e-mail of Aubra Fletcher to Eric Trupin, Terry Lee, and Barry Krisberg, November 10, 2008 and summary of incidents attached thereto. A redacted version of the summary is attached as Appendix D.

<sup>74</sup> *Id.*

<sup>75</sup> The type of chemical force used in one of the six instances was unspecified. *Id.*

<sup>76</sup> “Cap-Stun Weapon Systems: Z505 Crowd Control,” available at <http://www.zarc.com/english/cap-stun/PDFs/Z-505%20Crowd%20Control.pdf> (last visited September 24, 2009). The particular youth interviewed by OSM monitors stated that staff spray the “big cans” of mace into youth cells.

himself.”<sup>77</sup> The safety and welfare expert advises that the use of the Z505 under these circumstances “is completely inappropriate and should be stopped immediately.”<sup>78</sup>

DJJ documented 65 incidents of “suicide attempts” for purposes of serious incident reporting, from August 2008 through November 2009.<sup>79</sup> According to the serious incident reports provided, there were no incidents at O.H. Close and SYCRCC, one at Preston, 15 at Ventura, 24 at Stark and 25 at Chaderjian.<sup>80</sup> Of those incidents, only two resulted in uses of force. These incidents represent only some of the incidents of self-injurious behavior in DJJ; the Chaderjian incident reports document three incidents of self-harm in August through October 2008, compared to the many more incidents documented for that period in other records as discussed above.

DJJ directed facilities to implement a new use of force policy in mid-April 2009.<sup>81</sup> Multiple specific incidents of use of force on mentally ill youth have come to the attention of the experts, plaintiff’s counsel, and OSM since that time.<sup>82</sup> Plaintiff’s counsel has asked the mental health, safety and welfare, and disabilities experts to review the use of force against DJJ’s youth with mental illness and disabilities.<sup>83</sup> OSM has

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<sup>77</sup> See e-mail of Aubra Fletcher to Eric Trupin, Terry Lee, and Barry Krisberg, November 10, 2008 (attaching OSM’s use of force data compilation). OSM brought the chemical force problem to the attention of DJJ’s director of facilities following the completion of Chaderjian’s SPAR pilots. See e-mail of Zack Schwartz to Sandra Youngen, December 16, 2008.

<sup>78</sup> See e-mail of Barry Krisberg to the special master, September 27, 2009.

<sup>79</sup> At OSM’s request, DJJ provides all serious incident reports documenting certain “sentinel events,” i.e., deaths, self-harm behavior, and group fights/disturbances. These reports are the source for the remainder of this paragraph and the next note.

<sup>80</sup> Of the 65 incidents, 34 resulted in the youth being taken to a licensed medical facility, the Stark CTC or a hospital. Of the 34 medical care cases, 20 were evaluated only and not retained for treatment in a licensed care facility. Fourteen were retained in the CTC or a hospital, with seven of those being Stark youth treated at the Stark CTC.

<sup>81</sup> Eleventh Report of the Special Master (November 2009), Appendix B (Fletcher Report), p. 4.

<sup>82</sup> See, e.g., e-mail of Doug Ugarkovich to special master, et al., June 29, 2009; e-mail of Sara Norman to Eric Trupin, et al., August 4, 2009.

<sup>83</sup> See letter of Sara Norman to special master and mental health, safety and welfare, and disabilities experts, July 24, 2009.

assisted the experts in obtaining documentation and organizing their joint effort and will provide the results of their review once available.<sup>84</sup>

Inappropriate physical force is only one of the negative consequences of assigning staff without appropriate training to manage emotionally dysregulated, self-injurious youth. Out of concern for the amount of self-injurious behavior among youth on the residential mental health units at Stark, DJJ's chief psychiatrist interviewed many youth there in April 2009.<sup>85</sup> Of the 24 youth for whom interview notes were provided, seven shared positive or neutral comments about living unit staff.<sup>86</sup> The remaining 17 youth variously reported that staff play favorites, "push youths' buttons," curse at youth, threaten to plant shanks in their rooms, overuse chemical force, disclose embarrassing facts about youth, and speak disparagingly about youth and their families.<sup>87</sup> One had seen staff make comments to other youth such as "I saw you crying like a bitch when you were suicidal."<sup>88</sup> Another young man recounted an incident in which he "started getting agitated" after a bad phone call; staff handcuffed him, placed him on the floor and then pepper sprayed him in the face with a large "Crowd Control" canister.<sup>89</sup>

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<sup>84</sup> During a conference call of the OSM and experts, the experts committed to complete their reviews of incidents by the third week of January. Dr. Krisberg committed to draft a report based on the reviews. The disabilities expert provided a written review of 20 incident reports on January 8, 2010, and Dr. Krisberg provided his notes on January 20, 2010.

<sup>85</sup> Memorandum of Dr. Ed Morales to Eric Trupin, et al., May 18, 2009 (PoP #412, May 28, 2009), p. 1.

<sup>86</sup> "HGSYCF Clinical Report 4/22/09 – 4/24/09" (PoP #412, May 28, 2009).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*, p. 1.

<sup>89</sup> *Id.*, p. 3. Note also that one of the youth who spoke positively about staff in April was maced on March 12, 2009 and May 23, 2009, each time after breaking living unit windows. This youth is diagnosed as bipolar and has a recent history of both self harm and aggression toward others. See memorandum of Laura Poncin to Elverta Mock, June 4, 2009 (attached to e-mail of Doug Ugarkovich to Drs. Krisberg, Trupin, and Lee, et al., June 19, 2009). The March and May incidents are now under the scrutiny of the L.A. County Public Defender's Office. See memorandum of Sandra Youngen and Doug McKeever to Shelan Joseph, June 17, 2009 (attached to above-referenced e-mail). DJJ administrators have determined that staff actions "were reasonable and necessary given the specifics of each incident." *Id.* DJJ's chief of security has stated that "if physical force instead [of] chemical spray had been used, it would have placed [the youth] and staff at high risk for injury due to glass [s]hards on the floor in the immediate incident area." Memorandum of Jeff Plunkett to Sandra Youngen, June 12, 2009. Dr. Trupin notes that this administrative

The special master interviewed youth and staff at two of Stark's residential mental health units in April as well. Her observations and her interviews were consistent with those of the chief psychiatrist. Three apparently high-functioning youth told the special master that about half of the facility staff were good staff and tried to help youth and about half were not.<sup>90</sup> Some of the latter group, they said, would disregard youth needs or deliberately disturb youth, which they identified as the main cause of self-injurious behavior on the unit. From the time she spent on the housing units and interviews of clinical staff, the special master also observed that clinical staff and facility staff operated separately from each other for the most part. Clinical staff generally were not present on the residential units but rather saw patients in their offices, and facility staff did not seek their help or take direction from them.

### C. Mental Health Data and Tracking System

DJJ lacks a single, reliable source of comprehensive data regarding self-harm incidents among DJJ youth.<sup>91</sup> The new SPAR policy requires staff to maintain an automated tracking log,<sup>92</sup> and DJJ is refining a standardized system to track self-harm incidents.<sup>93</sup> DJJ consulted the OSM and mental health experts on the data elements,<sup>94</sup>

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response defending the use of chemical agents does not reflect awareness of alternative approaches to address the youth's self harming and aggressive behavior. *See* e-mail of Eric Trupin to Doug Ugarkovich, et al., June 25, 2009.

<sup>90</sup> *See* statements of ITP and IBTP youth during Stark site visit, April 29-30, 2009. The following sentence is also based on this source.

<sup>91</sup> *See, e.g.*, memorandum of Dr. Ed Morales to Eric Trupin, et al., May 18, 2009 (PoP #412, May 28, 2009), p. 1.

<sup>92</sup> Appendix C, DJJ, Suicide Prevention, Assessment, and Response [policy], Institutions and Camps Manual, Section 6263, January 9, 2009, p. 24.

<sup>93</sup> Statements of Bob Eden and Ken Sandoval during central office site visit, June 22, 2009; statements of Juan Carlos Arguello during central office site visit, September 23, 2009; memorandum of Van Kamberian to the special master, November 17, 2009 (attaching comments on draft of this report); e-mail of Juan Carlos Arguello to Aubra Fletcher, et al., December 2, 2009; statements of Rick Flynn during DJJ Court Compliance Task Force meeting, February 4, 2010.

<sup>94</sup> E-mail correspondence between the special master and Dr. Juan Carlos Arguello, December 7 and 8, 2009 and January 8 and 19, 2010.

and the system should capture all self-injurious behavior and document other aspects of the management of the behavior.

The remedial plan also requires DJJ to develop a system to track data showing the need for and utilization of beds at each level of care.<sup>95</sup> DJJ began manually tracking this information in October 2007.<sup>96</sup> Staff maintain lists of mental health placements, uses of clinical restraints, psychotropic medication prescriptions, WIC-1800 extensions, and intake evaluations.<sup>97</sup> In addition, staff produce tables indicating the number of DJJ youth in licensed beds each day.<sup>98</sup> DJJ has also developed a system to track and prioritize youth on waiting lists for residential mental health programs, though waiting lists are unusual.<sup>99</sup> DJJ produced its first quarterly report comparing resources to need in June 2009.<sup>100</sup>

Some of the data are not usable in their current form.<sup>101</sup> For example, prescribing practices are tracked through a list that notes each prescription for each youth.<sup>102</sup> Although such a list is useful as raw material, it is nearly impossible to take in as a whole. It is hoped that the transition to an automated tracking system will enable DJJ managers to extract summaries of this and other data. The remedial plan mandates DJJ's

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<sup>95</sup> See Mental Health Remedial Plan Standards and Criteria item, 5.21a; Mental Health Remedial Plan, p. 45.

<sup>96</sup> Lee and Trupin, 2007 Formal Report, Attachment 1, #12.

<sup>97</sup> July to August 2008 Mental Health Tracking Data (PoP #275, November 6, 2008); October 2007 Mental Health Tracking Data (PoP #79, December 6, 2007); statements of Paul Woodward to the special master during central office site visit, September 23, 2009.

<sup>98</sup> Statements of Paul Woodward to the special master during central office site visit, September 23, 2009.

<sup>99</sup> See Mental Health Remedial Plan Standards and Criteria, item 5.27; Mental Health Remedial Plan, p. 46; Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 10; Lee and Trupin, 2009 Formal Report, p. 14 (adequate numbers of residential mental health beds).

<sup>100</sup> See DJJ, Quarterly Report Comparing Existing and Planned Mental Health Resources to Need (PoP #450, June 29, 2009).

<sup>101</sup> See Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 28; statements of Juan Carlos Arguello and Louise Allen during central office site visit, September 23, 2009.

<sup>102</sup> See DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).

conversion to an automated tracking system,<sup>103</sup> and the Court recently reset this deadline from September 30, 2009 to December 31, 2010.<sup>104</sup> The Court also extended the deadline for DJJ to generate monthly reports on collected data.<sup>105</sup>

DJJ has not acquired or developed a monitoring system to analyze treatment intervention efficacy and needs, as the plan required it to do by December 31, 2007.<sup>106</sup>

The primary barrier to compliance with these requirements appears to be the lack of technical resources. DJJ's mental health leadership stated in March 2009 that insufficient information technology (IT) staff were assigned to mental health for these purposes.<sup>107</sup> Currently, only one IT staff member is assigned to mental health.<sup>108</sup>

#### D. Licensed Bed Care

As previously reported, the mental health experts evaluated DJJ's licensed mental health care facility resources and needs in May 2007 and found that many DJJ youth had sufficient access to licensed beds but that female and northern California males lacked adequate access.<sup>109</sup> The private hospital DJJ contracted for women requiring licensed care, Aurora Vista Del Mar, rejected patients deemed to pose a risk of aggression.

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<sup>103</sup> See Mental Health Remedial Plan Standards and Criteria, item 5.21e.

<sup>104</sup> See Order, March 27, 2009, p. 2.

<sup>105</sup> See *id.* DJJ was also to develop tracking systems to document certain testing information, family contact attempts, and screenings and assessments by November 1, 2007. See Mental Health Remedial Plan, p. 19; Mental Health Remedial Plan Standards and Criteria, item 4.1. The Court also extended this deadline to December 31, 2010. See Order, March 27, 2009, p. 2.

<sup>106</sup> See Mental Health Remedial Plan, p. 55; Mental Health Remedial Plan Standards and Criteria, items 6.11a-b, d-h; Terry Lee and Eric Trupin, Informal Report: Central Office, March 2009, p. 43; Lee and Trupin, 2009 Formal Report, p. 17.

<sup>107</sup> See statements of Juan Carlos Arguello and Louise Allen during central office site visit, March 18, 2009; Terry Lee and Eric Trupin, Farrell Mental Health Experts' Headquarters Site Visit, January 8-9, 2009, p. 4 ("On July 1, 2008, Mental Health Services submitted requests for Information Technology support to the DJJ Executive Staff for budget consideration and is awaiting a response. A request for reprioritization of Information Technology support needed for mental health tracking purposes and documentation was submitted in August 2008.").

<sup>108</sup> Statements of Juan Carlos Arguello and Louise Allen during central office site visit, September 23, 2009; statements of Ken Sandoval during central office site visit, June 22, 2009.

<sup>109</sup> See Fourth Report of the Special Master (July 2007), pp. 14-15. This is also the source for the next two sentences.

Almost all of the licensed beds were in southern California, creating a disincentive for clinicians in the north to refer youth requiring licensed bed care.

In response to the experts' May 2007 recommendations, DJJ opened Stark's Correctional Treatment Center (CTC) to females in 2007, making licensed beds available for female patients who were or would be rejected by Aurora Vista as too aggressive.<sup>110</sup> Soon thereafter, however, the correctional officers' union objected to Aurora Vista's restriction on equipment permitted in the hospital, and DJJ ceased using its contract with it.<sup>111</sup> Although the CTC remained open to females, the decision to stop using Aurora eliminated licensed beds for young women in a facility that could provide group activities for female patients.<sup>112</sup> Also in 2007, DJJ reported that it was attempting to renegotiate its contract with Metropolitan State Hospital to open SYCRCC's intermediate care facility (ICF) to females and to certain youth who had been previously rejected as posing too much risk of aggression.<sup>113</sup>

Although it continued to send northern California males to its southern California CTC and DMH-operated ICF,<sup>114</sup> DJJ also described its plans to meet with representatives of two private northern California hospitals in December 2007 about the possibility of contracting for licensed bed services.<sup>115</sup> DJJ had ceased using a contract with one of these hospitals, Sierra Vista, in July 2006, based on the chief psychiatrist's concerns about the management and treatment of youth there.<sup>116</sup> Based on these facts, at

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<sup>110</sup> See Lee and Trupin, 2007 Formal Report, Attachment 1, #13.

<sup>111</sup> See *id.*, Attachment 1, #1.

<sup>112</sup> The experts find the CTC less adequate for female than for male patients because there are rarely if ever enough females there at a time for group activity; usually a female patient will be the only female patient, and male and female patients are not permitted to mix. See Lee and Trupin, 2009 Formal Report, p. 6.

<sup>113</sup> See *id.*; Lee and Trupin, 2007 Formal Report, pp. 6-7.

<sup>114</sup> See Sixth Report of the Special Master (January 2008), pp. 6-7.

<sup>115</sup> See *id.*

<sup>116</sup> See *id.*, p. 8.

the end of 2007, the mental health experts found DJJ's access to licensed bed care inadequate for northern California youth and for women requiring intermediate licensed bed care.<sup>117</sup>

Since 2007, DJJ has resumed sending some northern California youth to Sierra Vista hospital in Sacramento.<sup>118</sup> Thirteen of sixty (22%) northern California youth who were admitted to licensed bed facilities in fiscal year 2008-2009 were admitted to Sierra Vista hospital.<sup>119</sup> Proving its limits as a resource for DJJ, Sierra Vista rejected almost 50% of DJJ's referrals in the same period.<sup>120</sup>

The mental health experts believe that DJJ's negotiations with DMH have resulted in some improvement of access to DMH-operated SYCRCC ICF beds for male youth.<sup>121</sup> However, CTC clinicians reported to the mental health experts that they refrain from referring some of the more aggressive youth to the ICF because they believe that the ICF will refuse them admission.<sup>122</sup>

The CTC at Stark remains the only facility providing access to acute licensed bed care for DJJ's young women.<sup>123</sup> In fiscal year 2008-2009, of 14 women admitted to

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<sup>117</sup> See Lee and Trupin, 2007 Formal Report, pp. 1-2, 5.

<sup>118</sup> Appendix E, memorandum of Zack Schwartz to Donna Brorby, October 22, 2009, p. 4 [hereinafter Licensed Bed Usage Data].

<sup>119</sup> *Id.*, p. 8.

<sup>120</sup> *Id.*, p. 9.

<sup>121</sup> See Lee and Trupin, 2009 Formal Report, p. 6.; e-mail of Sara Norman to Barry Krisberg, August 4, 2009 (drawing attention to use of force on one of the youth later admitted to the ICF); e-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report). DJJ data show that three youth who had been rejected for licensed bed admission later were admitted to the ICF, including a youth that the OSM knows to have a history of acting out behavior. Licensed Bed Usage Data, pp. 14-15.

<sup>122</sup> E-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report); Terry Lee and Eric Trupin, Informal Report: Stark, September 2009, p. 20. During fiscal year 2008-2009, 8 of 117 youth remained at the CTC longer than one month. One youth remained at the CTC for 117 days and another, for 49 days. The median length of stay at the CTC during fiscal year 2008-2009 was 10 days, and 75% of CTC admits remained there fewer than 18 days. DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).

<sup>123</sup> Licensed Bed Usage Data, p. 11.

licensed bed care, 13 were to the CTC.<sup>124</sup> DMH is an option for intermediate (longer-term) care for women over eighteen years of age<sup>125</sup> who are not prone to aggressive behaviors. The fourteenth licensed bed admission for a female youth was at Metro State Hospital.<sup>126</sup> DJJ's contract with Aurora Vista Del Mar hospital in Ventura expired and was not renewed.<sup>127</sup> The ICF at SYCRCC still does not admit female youth; DJJ says that it is negotiating with DMH for it to admit females,<sup>128</sup> as it did in 2007.<sup>129</sup>

The mental health experts conclude that during the last fiscal year, northern California male youth lacked adequate access to licensed acute and intermediate beds, female youth lacked adequate access to licensed acute care beds, and male and female youth with aggression all lacked adequate access to licensed intermediate care beds.<sup>130</sup> DJJ disagrees with the experts with respect to northern California youth;<sup>131</sup> the disagreement appears to concern whether it is acceptable for most northern California male youth to be transferred to southern California for treatment at facilities that the experts find to be acceptable for southern California youth.<sup>132</sup> The experts accept the transfers in the short-term, recognizing that appropriate facility location is an issue that

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<sup>124</sup> *Id.*

<sup>125</sup> The DMH-operated ICF at SYCRCC does admit youth under the age of 18. See DJJ, "Trackable Mental Health List, January 2008 – June 2009" (PoP #534, October 13, 2009).

<sup>126</sup> Licensed Bed Usage Data, p. 11.

<sup>127</sup> E-mail of Juan Carlos Arguello to the special master, September 24, 2009.

<sup>128</sup> See e-mail of Van Kamberian to special master, November 17, 2009, pp. 8-9 (attachment commenting on a draft of this report).

<sup>129</sup> See Lee and Trupin, 2007 Formal Report, p. 2.

<sup>130</sup> See Lee and Trupin, 2009 Formal Report, p. 6; statements of Terry Lee to special master during teleconference, February 10, 2010.

<sup>131</sup> Appendix B, letter of Todd Irby to mental health experts, November 17, 2009, p. 3.

<sup>132</sup> The experts have not actually systematically evaluated the quality of care at the CTC; they find it acceptable for the treatment of southern California youth in the sense that it is licensed and its geographical location is suitable for southern California youth.

extends beyond the mental health remedial plan.<sup>133</sup> They believe that DJJ needs appropriately located facilities in the long-term, so that youth are not separated from their families and communities.

For the present, DJJ must meet the licensed bed care needs of its youth within the current array of options, the Stark CTC, the SYCRCC ICF, DMH hospital beds, and contracts with private hospitals. In the long-term, CDCR's repurposing of Heman G. Stark from a youth to an adult facility changes will require relocation of the licensed beds that accounted for 68% of DJJ's licensed bed admissions.<sup>134</sup> When CDCR announced its decision in August 2009, the mental health and medical experts immediately informed DJJ that maintaining a juvenile CTC at an adult facility is not likely feasible over the long term.<sup>135</sup> In response, DJJ promised an assessment of options by "CDCR facilities management," which DJJ expected to provide by December 2009 and has not yet provided.<sup>136</sup> The long-term options DJJ is assessing include providing five CTC beds in each of the northern and southern parts of the state and converting the Ventura medical wing to a licensed bed facility.<sup>137</sup>

The mental health plan requires DJJ to provide an "appropriate written plan" to "address deficiencies" in licensed bed capacity, including a "reasonable implementation

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<sup>133</sup> For example, there is only one facility for female youth, and northern California female youth reside at Ventura in southern California. Statements of Terry Lee during teleconference with special master, February 10, 2010. This is the source for the next sentence as well.

<sup>134</sup> Licensed Bed Usage Data, p. 4 (of 171 admissions, 117 were to the CTC).

<sup>135</sup> E-mail of special master to parties, September 4, 2009 (reporting experts' consensus regarding Stark closure and CTC).

<sup>136</sup> See e-mail of Doug McKeever to special master, et al., November 29, 2009 (assessment expected by the week of December 21, 2009), December 21, 2009 (not yet complete), January 7, 2010 (assessment expected by week of January 18), January 22, 2010 (assessment not yet complete), and February 5, 2010 (facilities management determined the Ventura medical wing could be converted to a CTC within a reasonable time and at the cost of \$124,000 but it has not determined how to replace Ventura's medical wing).

<sup>137</sup> Statements of Doug McKeever during teleconference of parties, experts, and OSM, September 16 and November 24, 2009. Any "long term" option is years away. *Id.*

schedule.”<sup>138</sup> An adequate written plan would be based on and reflect a comprehensive analysis of the alternatives for providing licensed bed care to female youth and youth in northern California. In 2007 and 2008, the special master found that DJJ had not provided an adequate written plan, and, in 2008, she recommended that the court order DJJ to do so.<sup>139</sup> It is incumbent on DJJ to file an adequate written plan for licensed bed mental health care after CDCR management completes its assessment of the options available at this time.

#### E. Other Issues

The experts have found that DJJ is substantially compliant with requirements concerning mental health staffing,<sup>140</sup> the number and size of residential mental health treatment units,<sup>141</sup> and most elements of diagnostic screening.<sup>142</sup> Their primary concern is that DJJ implement “integrated, empirically-based mental health treatment throughout DJJ,”<sup>143</sup> including family engagement and participation in their youths’ treatment,<sup>144</sup> and effective behavior management in place of overreliance on the use of force and a punitive

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<sup>138</sup> See Mental Health Remedial Plan Standards and Criteria, item 5.21g. DJJ’s November 2007 “formal response” to the mental health experts’ licensed bed report expressed its intention to meet youths’ licensed bed needs, but it was not an “appropriate written plan” to “address deficiencies” and included no implementation schedule. See Sixth Report of the Special Master (January 2008), pp. 7-8; Lee and Trupin, 2007 Formal Report, pp. 1-2, Attachment 1, #13.

<sup>139</sup> Consent Decree ¶28(n). See Seventh Report of the Special Master (April 2008), pp. 39-40.

<sup>140</sup> They have not systematically reviewed the professional services provided by DJJ’s mental health staff. They do not believe that such a systematic review, which they intend to undertake at a later time, would be of sufficient value given DJJ’s lack of an integrated, empirically-based mental health treatment program. See e-mail of Terry Lee to Aubra Fletcher, et al., February 9, 2010 (attaching comments on a draft of this report).

<sup>141</sup> Lee and Trupin, 2009 Formal Report, p. 1-2,

<sup>142</sup> Lee and Trupin, 2009 Formal Report, p. 10, items 4.3 – 4.7.

<sup>143</sup> See, e.g., Lee and Trupin, 2007 Formal Report, p. 3; Lee and Trupin, 2009 Formal Report, p. 4 (DJJ lacks an “overarching paradigm,” and “various mental health professionals use different approaches,” making it “inevitable” that “clinical and facility staff will operate independently, resulting [in] inconsistent and uncoordinated care.”).

<sup>144</sup> See, e.g., Lee and Trupin, 2009 Formal Report, p. 8.

disciplinary system.<sup>145</sup> For this reason, they continue to emphasize the importance of an integrated behavior treatment model that will guide the treatment of all DJJ youth.<sup>146</sup> They also urge DJJ to develop and implement peer review and quality management to “assess individual and aggregate clinician practice and progress towards identified desired clinical behaviors.”<sup>147</sup>

### III. CONCLUSION

The special master respectfully submits this report.

Dated: February 12, 2010

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Donna Brorby  
Special Master

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<sup>145</sup> Lee and Trupin, 2009 Formal Report, p. 7.

<sup>146</sup> *See, e.g.*, statements of Terry Lee during teleconference with special master, February 10, 2010.

<sup>147</sup> Lee and Trupin, 2009 Formal Report, pp.6-7.