

SUPERIOR COURT OF CALIFORNIA
CITY AND COUNTY OF ALAMEDA

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

NINTH REPORT OF SPECIAL MASTER

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I. INTRODUCTION

This report attaches the medical experts' second annual report and a report on the safety and welfare issues monitored by the special master's office. It also attaches a summary of priorities designated by the experts in each remedial area and an update on the compliance status of certain standards and criteria items for which the Court reset deadlines this year.

The special master has not yet received the comprehensive reports of the safety and welfare and mental health experts that she expected to file with this report, though she and the parties have received numerous informal site visit reports from these experts. She now expects to file the experts' comprehensive reports with her next report, which will also likely include comprehensive reports in the areas of education and disability.

II. FARRELL EXPERTS' PRIORITIES

Between December 2008 and February 2009, the *Farrell* experts identified priority areas for fiscal year 2008-2009 and provided this information to DJJ leadership.¹ This was done at the request of then-new Chief of Court Compliance Michael Brady. Except in the area of wards with disabilities, where the expert relied on his dashboard submission and his conversation with Mr. Brady about it, these priorities are not identical but are closely related to the items on the "key indicators" portion of the "dashboard."² The office of the special master will focus future reports on DJJ compliance with priority requirements, as experts provide their findings in these areas. The priorities are attached as Appendix A.

¹ E-mail of Zack Schwartz to Michael Brady, February 16, 2009.

² At the request of the Court, the parties crafted a "dashboard" with the help of the experts to depict compliance status in identified priority areas. DJJ provides an update for each Case Management Conference.

III. STATUS UPDATE ON RESET DEADLINES

On February 20, 2009 and March 27, 2009, the Court adopted DJJ's proposed modifications of certain *Farrell* deadlines.³ A number of those deadlines have passed. A status update regarding some of those items is attached as Appendix B.

IV. MEDICAL CARE

The medical experts conducted their second round of site visits from September 2007 to June 2008.⁴ Their comprehensive report was completed in February 2009 and is attached as Appendix C. The experts' executive summary and the recommendation section at the close of the report are brief and summarize the experts' findings and recommendations for the current fiscal year. The medical experts have reviewed and approve our summary of their report.

A. Inclusion of Facility Compliance Scores

This is the first *Farrell* medical report to include compliance scores for each facility.⁵ During the previous round of site visits, the experts were "field-testing" the medical audit instrument.⁶ The compliance scores range from 61% to 81% overall and are a starting point for measuring further progress.⁷ To put these scores in context, 85% is a benchmark for compliance, though the percentage score is not itself necessary or sufficient for compliance.⁸

³ Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2.

⁴ Appendix C (Goldenson/LaMarre second report), p. 3.

⁵ *See ibid.*

⁶ Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 3.

⁷ *Id.*, p. 41, n.1.

⁸ Health Services Remedial Plan Health Care Audit Instrument, p. 3.

Table I: Compliance Scores by Facility and Aspect of Care (%)⁹

	Chaderjian	Close	Preston	Stark	SYCRCC	Ventura
Facility Leadership, etc.	55	67	NR	33	43	63
Medical Reception	42	NA	72	43	63	69
Intrasystem Transfer	56	80	56	54	59	83
Nursing Sick Call	NR	55	51	48	60	62
Medical Care	65	97	83	71	69	81
Chronic Disease Management	60	87	82	53	51	77
Infection Control	38	50	100	71	63	50
Pharmacy Services	100	100	67	93	100	92
Medication Administration: Process	60	92	92	66	75	77
Medication Administration: Records	80	75	87	75	88	84
Urgent/Emergent Care	60	54	88	81	70	75
Outpatient Housing Unit	73	73	NR	NA	63	NR
Health Records	0	25	25	50	100	25
Preventive Services	79	76	96	85	88	88
Consultations	38	80	91	74	98	84
Peer Review	60	60	20	0	67	40
Credentialing	88	88	71	71	67	88
Quality Management	50	50	50	50	63	38
Total (%)	61	81	77	64	72	76

The compliance scores reveal several areas of strength for DJJ health services.

During the monitoring period, DJJ hired a statewide Pharmacy Services Manager, who implemented standardized pharmacy practices at the facilities.¹⁰ Under this leadership, pharmacy services received the highest scores of any aspect of care during this round.¹¹

Preventive services, which had not been implemented at any facility as of the previous report, are at or near compliance at all facilities.¹² The medication administration process

⁹ “NR” indicates that the item was not rated, and “NA” denotes “not applicable.”

¹⁰ Appendix C (Goldenson/LaMarre second report), p. 16.

¹¹ All facilities but Preston had pharmacy services scores above 90%. *See* Table I, above.

¹² *See* Table I, above; Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 31. Preventive services include lifestyle changes (e.g., assistance in weight loss), screening for disease (e.g., annual TB skin test) and mental health conditions, immunizations, and health education or counseling. Health Care Services Remedial Plan, pp. 34-36. In the area of preventive care, the medical experts continue to recommend that DJJ develop a statewide program to address obesity in the DJJ population.

also improved, drawing high scores at several facilities that had received poor qualitative evaluations in the previous report.¹³

Table II: Average Compliance Scores

Aspect of Care	Score (%)
Pharmacy Services	92
Preventive Services	85
Medication Administration: Records	82
Credentialing	79
Medical Care	78
Consultations	78
Medication Administration: Process	77
Urgent/Emergent Care	71
Outpatient Housing Unit	70
Chronic Disease Management	68
Intrasystem Transfer	65
Infection Control	62
Medical Reception	58
Facility Leadership, etc.	52
Quality Management	50
Nursing Sick Call	45
Peer Review	41
Health Records	38

B. Achievements Since the Last Report

DJJ has addressed or begun to address most of the recommendations the experts made in their last report.¹⁴ With the completion of the Peer Review, Credentialing and Organizational Structure policies, the division now has a complete set of initial medical policies.¹⁵ Although the Clinical Records Administrator position remains vacant, DJJ has one contractor and one employee working to develop health records and a health records

¹³ See Appendix C (Goldenson/LaMarre second report), p. 4; Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 26.

¹⁴ See Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 34.

¹⁵ Appendix C (Goldenson/LaMarre second report), pp. 12-13. Twenty-nine of the 32 key policies were written as of the previous experts' report. Fifth Report of the Special Master (October 2007), p. 23.

management program.¹⁶ The pharmacy manager has begun to collect data on purchasing practices, which may be used to evaluate its cost-effectiveness.¹⁷ Cooperation among medical and custody staff has improved at all facilities, although some youth still miss medical appointments because staff are not available to escort them.¹⁸

DJJ issued final organization charts which establish a model for health care delivery, supervision, and oversight.¹⁹ There are certain conflicts between the requirements of the remedial plan and the current charts.²⁰ DJJ and the medical experts have agreed to plan modifications that will resolve these conflicts.²¹

Central office has implemented an internal auditing process (“Quality Management Plan”) for medical care.²² A team at each facility will evaluate emergency medical care plus two aspects of care from the remedial plan each quarter and will develop corrective action plans.²³ The former Director of Nurses similarly developed and implemented a Nursing Services Quality Management Plan.²⁴ She independently checked the results of the facility evaluations and instructed Supervising Nurses as to how to improve their audits.²⁵ The general Quality Management Plan does not include external review, does not provide for each aspect of care to be evaluated annually (instead, two aspects of care will be evaluated each quarter), and does not encourage

¹⁶ Seventh Report of the Special Master (March 2008), p. 10; Appendix C (Goldenson/LaMarre second report), pp. 14-15.

¹⁷ Appendix C (Goldenson/LaMarre second report), p. 16.

¹⁸ *Id.*, pp. 4,

¹⁹ *Id.*, pp. 7-8.

²⁰ *Id.*, p. 8.

²¹ *Id.*, p. 7; e-mail of Rachel Stern to special master, et al., April 24, 2009 (proposing modifications to remedial plans); e-mail of Madie LaMarre to Rachel Stern, et al., May 4, 2009 (indicating that experts support proposal to modify plan requirements regarding Medical Director and Public Health Nurse).

²² Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 33; Appendix C (Goldenson/LaMarre second report), pp. 4, 13.

²³ Appendix C (Goldenson/LaMarre second report), p. 13.

²⁴ *Id.*, p. 10.

²⁵ *Ibid.*

facilities to study problems unique to their facility.²⁶ The experts therefore rated the Quality Management Plan as partially compliant, indicating that more work is required in this area.²⁷

A previous report noted that youth in DJJ who require health care services for serious medical problems faced an unacceptable risk of receiving substandard care.²⁸ The medical experts generally did not observe the same problems during this round.²⁹ This was evidenced by relatively high scores on chart reviews of medical care.³⁰ They attribute this change to the drop in population and the fact that new physician hires and attrition have increased the proportion of good doctors in the system.³¹ This proportion will be important for DJJ to maintain as it adjusts its health services staffing levels to its smaller population.³²

C. Areas for Improvement

Medical reception remains weak.³³ At most facilities, the experts noted, clinicians “did not consistently perform and document adequate history and physical examinations, identify medical conditions and develop appropriate treatment plans for each active medical problem. This is particularly disturbing because DJJ adolescents and young adults are by and large a medically healthy population and the failure to adequately address the medical conditions they do have is a serious concern.”³⁴

²⁶ *Id.*, pp. 4, 13.

²⁷ *Id.*, p. 13.

²⁸ Fifth Report of the Special Master (October 2007), pp. 23-24.

²⁹ E-mail of Madie LaMarre to Zack Schwartz, May 1, 2009.

³⁰ See Table I, above.

³¹ E-mail of Madie LaMarre to Zack Schwartz, May 1, 2009.

³² *Ibid.*

³³ See Table II, above; Appendix C (Goldenson/LaMarre second report), p. 4.

³⁴ Appendix C (Goldenson/LaMarre second report), p. 4.

DJJ still has trouble retaining key central office medical staff. Previous reports have noted “poor morale among health care services headquarters staff leading to attrition by transfers and resignations,” as well as a high level of vacancies among this group.³⁵ The Director of Nurses (Cathy Ruebusch, RN) resigned in August 2008, after serving slightly more than a year.³⁶ During this brief time, she showed an ability to identify problems in DJJ’s nursing system and develop solutions. In addition to work on quality management, described above, she developed and implemented physical assessment training for nurses and identified problems in the division of supervisory responsibility for nursing services.³⁷ She ultimately resigned because of a perceived lack of resources and support.³⁸

The medical experts have urged DJJ to adjust facility staffing to appropriate levels.³⁹ DJJ has continued to increase health care staffing even as it loses youth.⁴⁰ As a result, clinician-to-patient ratios are sometimes excessive.⁴¹ Such inefficiency is perpetuated by weaknesses in nursing sick call.⁴² DJJ lacks standardized procedures that would guide nurses’ care of minor issues and establish which conditions and complaints must be referred to a physician.⁴³ Currently, youth see physicians for minor complaints that could be handled by a nurse, such as athlete’s foot, acne, and mild headaches.⁴⁴ The medical experts consider the development of standardized nursing procedures a top

³⁵ See Third Report of the Special Master (September/November 2006), p. 14; Seventh Report of the Special Master (March 2008), p. 9.

³⁶ Appendix C (Goldenson/LaMarre second report), pp. 7, 10-11. Ms. Ruebusch was hired in May 2007. Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 8.

³⁷ Appendix C (Goldenson/LaMarre second report), pp. 10-11.

³⁸ *Id.*, pp. 7, 10-11.

³⁹ E-mail of Madie LaMarre to Michael Brady, January 23, 2009.

⁴⁰ Appendix C (Goldenson/LaMarre second report), p. 4.

⁴¹ *Id.*, p. 35.

⁴² Nursing sick call compliance scores were among the lowest this round. See Table II, above.

⁴³ Health Services Remedial Plan, p. 17; Appendix C (Goldenson/LaMarre second report), pp. 5, 36, 39.

⁴⁴ Appendix C (Goldenson/LaMarre second report), pp. 5, 36.

priority.⁴⁵ They have also urged DJJ to evaluate resource use and staff productivity.⁴⁶

Without data on health care resource needs, which DJJ is currently unable to provide, it will not be able to adjust staff levels effectively.⁴⁷

V. SAFETY AND WELFARE

A. Monitors' Report on Safety and Welfare Standards/Criteria Items

The special master is assigned to monitor certain items of the Safety and Welfare Remedial Plan. Monitors Aubra Fletcher and Zack Schwartz conducted a round of site visits to monitor these items between October 2008 and March 2009. A report of their findings has been provided to the safety and welfare expert and is attached as Appendix D. The safety and welfare expert is completing a round of monitoring and will be providing a comprehensive report on the state of compliance with the safety and welfare remedial plan in the near future. The special master will reserve comment on matters discussed in the reports for her next report.

B. Development Of DJJ's Integrated Behavior Treatment Model

The pivotal issue before the *Farrell* parties at this time is the development of the integrated behavior treatment model (IBTM) that is promised and required by the safety and welfare and mental health plans. The IBTM will serve as the overarching paradigm for the treatment of youth twenty-four hours a day, seven days a week. DJJ has been pursuing a particular vision of a model since at least 2006, when the safety and welfare plan was completed and filed.⁴⁸ The *Farrell* safety and welfare and mental health experts

⁴⁵ E-mail of Madie LaMarre to Michael Brady, January 23, 2009; Appendix C (Goldenson/LaMarre second report), p. 36.

⁴⁶ Appendix C (Goldenson/LaMarre second report), p. 10.

⁴⁷ *Id.*, pp. 10, 16.

⁴⁸ DJJ's risk/needs and IBTM consultant Orbis Partners, Inc. has provided an articulation of that vision. See pp. 16-17, *infra*.

have envisioned something different for just as long. Both (or all) visions are embedded in the plan. The experts felt constrained to reserve judgment and give DJJ time to work with its chosen consultants and develop its chosen model, on the grounds that DJJ was acting within its discretion under the remedial plans. They warned DJJ that they thought DJJ would fail to develop and implement the model it envisioned, and now they feel that subsequent developments have proven them right. Plaintiff has brought these concerns to the Court's attention, and the Court has scheduled a hearing for July 2, 2009.⁴⁹

1. Remedial Plan Requirements

In the January 31, 2005 Stipulation Regarding California Youth Authority Remedial Efforts, the Safety and Welfare Remedial Plan, and the Mental Health Remedial Plan, DJJ committed to reform its system from a punitive to a rehabilitative model.⁵⁰ The plans refer to the new model to be developed as the Integrated Behavior Treatment Model or "IBTM."⁵¹ The IBTM is to "provide[] the central guiding vision uniting screening, assessment, case planning, treatment/rehabilitation, transition, and aftercare."⁵² Its concepts will be "used across all parts of the agency – including the core treatment program, special treatment programs, academic and vocational education, work, recreation, mental health, and parole."⁵³ Because all staff will be trained on and follow the model, the IBTM will "not only structure[] the environment to help promote success in changing behavior, it [will] also create[] a common vocabulary for all parts of the agency and facilitate[] continuity of treatment/rehabilitation when youth move

⁴⁹ Order, June 2009.

⁵⁰ For the remedial plan revisions that relate to that commitment, see Safety and Welfare Remedial Plan, pp. 33-43 and Mental Health Remedial Plan, pp. 3-5, 21-23.

⁵¹ See, e.g., Mental Health Remedial Plan, pp. 21-23.

⁵² Safety and Welfare Remedial Plan, p. 34.

⁵³ *Ibid.*

between facilities and living units.”⁵⁴ The IBTM will encompass most aspects of life in DJJ, including the incentive and disciplinary systems.⁵⁵ It will provide the framework for all staff interactions with youth and their families.⁵⁶ The IBTM’s treatment/rehabilitation philosophy and interventions are to be based on cognitive-behavioral treatment.⁵⁷

The safety and welfare and mental health remedial plans require DJJ to adapt the Washington State Juvenile Rehabilitation Administration’s Integrated Treatment Model (“Washington ITM” or “Washington model”) in crafting its IBTM. The Mental Health Remedial Plan states that DJJ will develop a treatment model “based on” the Washington ITM.⁵⁸ The safety and welfare plan requires DJJ to “consult with experts in cognitive-behavioral treatment for juvenile offenders to adapt the Washington [ITM] to the needs of DJJ with specific emphasis on modifications needed for” older youth, gang-involved youth, youth with racist attitudes and behaviors, and “[a]ny other area DJJ deems necessary.”⁵⁹ It states that DJJ will “modify and tailor” Washington’s ITM training materials, implementation plan, and other documentation to meet DJJ’s needs.⁶⁰ The

⁵⁴ *Ibid.* The mental health plan similarly states: “Using an IBTM throughout DJJ will provide a common language and approach for understanding and changing youth behavior. It will simplify staff training and ease staff movement between units. System-wide adoption of an IBTM will facilitate continuity of care for youth moving between programs and living units.” Mental Health Remedial Plan, p. 21. This language from the two plans invokes a core feature of the Washington ITM. *See* Juvenile Rehabilitation Administration Integrated Treatment Model Design Report, September 2002, pp. 13-53, available at <http://www1.dshs.wa.gov/jra/ITM.shtml> (describing how staff can understand a youth’s problematic behavior, create conditions to change it, and build skills that youth will continue to use in the community) [hereinafter “ITM Design Report”].

⁵⁵ Safety and Welfare Remedial Plan, p. 54 (“Positive incentives and negative sanctions are an integral part of the integrated treatment model . . .”).

⁵⁶ Mental Health Remedial Plan, p. 21 (“The IBTM will also require that all DJJ personnel . . . are therapeutic/rehabilitative in their interactions with youth and families All direct care staff will be trained on the IBTM and able to work with youth on emotional regulation, interpersonal effectiveness, distress tolerance, behavior analysis and, as the need arises, aggression and self-harm behavior.”).

⁵⁷ Safety and Welfare Remedial Plan, p. 34.

⁵⁸ Mental Health Remedial Plan, pp. 22; *see also id.*, pp. 21-23.

⁵⁹ *Id.*, 41; *see also id.*, p. 33 (“This section defines the components of a rehabilitative model and outlines a well documented and successful approach used by one state [Washington] that DJJ will adapt to meet its needs.”).

⁶⁰ *Id.*, p. 34.

plan refers to the Washington ITM not because it is the only successful system in the United States, but because it is “the most fully documented” of several successful state systems.⁶¹

The safety and welfare plan also requires DJJ to develop a treatment/rehabilitation model directed at reducing recidivism by using risk/needs assessment, case management, and research-based rehabilitative programs targeting identified risks and needs.⁶² It requires that DJJ develop a “comprehensive system . . . to accurately assess the risks and needs of the youths and match rehabilitation/treatment services to meet their needs, while building on and developing strengths and protective factors.”⁶³ In context, the risks, needs, strengths, and protective factors referred to are primarily those related to the risk that a particular youth will repeat criminal conduct.⁶⁴ Risk/needs assessment “identifies issues to be prioritized for behavioral analysis and treatment/rehabilitation interventions.”⁶⁵ Periodic reassessment of risks and needs measure a youth’s progress in treatment and the effectiveness of the treatment programs.⁶⁶

The kind of individualized recidivism-focused risk/needs assessment and related case management described by these provisions of the safety and welfare plan is not part

⁶¹ *Ibid.* (“[T]he concepts behind the treatment model in states with successful rehabilitative programs are more or less the same. As the state with the most fully documented model, the [ITM] developed by the Washington State is used to illustrate these concepts.”). In his comments on a draft of this memorandum, Dr. Trupin points out that these successful/effective programs have developed rehabilitation/treatment program content and interventions that are adhered to with fidelity by staff and that effectively improve skills while the youth is incarcerated. These skills are required for youth to function safely and maturely when they return to their communities and families. Washington’s extensive documentation makes it the most clearly and completely articulated and manualized model available.

⁶² Safety and Welfare Remedial Plan, pp. 4-5, 35-38; *see also* Mental Health Remedial Plan, p. 5.

⁶³ Safety and Welfare Remedial Plan, p. 4.

⁶⁴ *See id.*, pp. 4-5.

⁶⁵ *Id.*, p. 35.

⁶⁶ *Id.*

of the Washington ITM.⁶⁷ The safety and welfare plan also requires DJJ to include “normative culture” in its IBTM,⁶⁸ another component not mentioned in the Washington ITM description. The remedial plans do not indicate the extent to which these components are consistent, inconsistent, complementary, or redundant of the Washington ITM or precisely how DJJ should integrate them with an adaption of the Washington model.

The Safety and Welfare Remedial Plan required DJJ to complete a detailed description of its proposed IBTM and an accompanying manual by November 15, 2008.⁶⁹ DJJ was to convert facilities to a rehabilitative model between January 2007 and January 2010, beginning before and finishing after it created the written description and manual of the IBTM.⁷⁰ Three facilities were to complete conversion to the rehabilitative model before the description and manual for the IBTM would be written. DJJ was to issue a request for proposals for a risk needs assessment tool in October 2006, consult with experts to develop its IBTM by July 2007, complete the IBTM description and manual by mid-November 2008, complete training in risk/needs assessment by February 2009, complete training in treatment plan development and the IBTM by August 2009, and complete training in motivational interviewing, normative peer culture, interactive

⁶⁷ See ITM Design Report, *supra* note 54. Washington JRA has not been using risk/needs assessment. *E.g.*, statements of Orbis associate David Robinson during teleconference with DJJ and *Farrell* mental health experts, October 15, 2008. The Washington model does rely heavily on behavior analysis-based assessment, however. See ITM Design Report, *supra* note 54. An emphasis is on all youth mastering skills (*e.g.*, self-regulation, distress tolerance, etc.) that most youth who enter juvenile corrections facilities lack and that experts believe commonly are a cause of criminal behavior is central to the Washington ITM. This is part of what DJJ is to adapt to its population and needs, integrated with normative peer culture and with risk/needs assessment and case management directed at recidivism.

⁶⁸ Safety and Welfare Remedial Plan, p. 42.

⁶⁹ Safety and Welfare Remedial Plan, p. 41; Safety and Welfare Remedial Plan Standards and Criteria, item 4.3. The Court has not modified the deadline for this item. See Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2. The special master anticipates that DJJ will propose a new deadline.

⁷⁰ Safety and Welfare Remedial Plan Standards and Criteria, items 6.b-c.

journaling and other unnamed key components of the IBTM by dates to be set in a training schedule.⁷¹

2. Chronology

DJJ issued its request for proposals for “Integrated Behavior Treatment Model: Risk Needs Assessment, Interventions and Training” in April 2007 and entered into a contract with the winning bidder, Orbis Partners, Inc., two months later.⁷² Since then, it has developed and begun to use risk/needs assessment and case management focused on factors assessed as related to youths’ risk to recidivate.⁷³ DJJ has trained some staff members in risk/needs assessment, treatment planning, the principles of cognitive behavioral treatment, motivational interviewing, as well as conflict resolution and crisis management.⁷⁴ All of this was pursuant to and consistent with several provisions of the safety and welfare remedial plan.⁷⁵

It was not, however, sequenced or undertaken in consultation with the safety and welfare and mental health experts. DJJ did not consult the court experts before it issued the request for proposals that resulted in the contract with Orbis Partners, Inc. (“Orbis”). The experts would have advised separate contracts for risk/needs assessment and for treatment programming, for example, because the best potential treatment program contractors would not bid on a contract requiring development of a risk/needs assessment

⁷¹ Safety and Welfare Remedial Plan Standards and Criteria, items 5.3, 5.4, and 6.7. DJJ has regularly provided schedules for trainings, but this documentation does not indicate when all staff requiring the training will have received it.

⁷² Seventh Report of the Special Master (March 2008), p. 18 n.66.

⁷³ *E.g.*, statements of staff to Barry Krisberg during central office site visit, January 14, 2009; the special master observed an initial case management conference at the Stark facility in April 2009.

⁷⁴ *See* Appendix D (Fletcher and Schwartz, Safety and Welfare Remedial Plan Audit Items: Report of Findings, June 2009), pp. 29-33.

⁷⁵ *See id.*

tool.⁷⁶ In the experts' view, Orbis' particular expertise was in risk/needs assessment and not in treatment model development or treatment programming.⁷⁷ Compounding its error, DJJ resisted the requests of the safety and welfare and mental health experts to consult with DJJ and Orbis as they commenced their work together in 2007.⁷⁸ It did not arrange for the experts and Orbis to meet until April 2008, when it presented the model it was developing with DJJ to the experts and a conference room full of DJJ management staff.⁷⁹ That meeting was not a forum for the experts and the Orbis principals to engage in a high-level discussion of the model.⁸⁰ The approach Orbis presented then – based on risk/needs assessment, case management, and cognitive behavioral treatment programs targeting risks and needs assessed as related to recidivism – is the approach that DJJ has pursued and is proffering now.⁸¹ The experts' seriously questioned whether this approach was appropriate for confined youth, as opposed to youth being treated in a community setting, where it has proven effective.⁸² They pursued their questions and concerns that the approach would not work for DJJ during a series of five lengthy telephone conferences with DJJ and Orbis between August 2008 and February 2009.⁸³

⁷⁶ Statements of Eric Trupin and Barry Krisberg to special master during teleconference, June 2007; *see also* Reporter's Transcript of Proceedings, Order to Show Cause hearing, May 9, 2008, at 749:5-750:15 [hereinafter "RT, May 9, 2008"].

⁷⁷ Statements of Eric Trupin and Barry Krisberg to special master during teleconference, June 2007.

⁷⁸ In November 2007, DJJ advised the special master and experts that Orbis was still working on a timetable for "deliverables" and not available to meet with the experts. *See* Sixth Report of the Special Master (January 2008), Appendix A (Trupin/Lee report), Attachment 1 (Trupin/Lee report on standards and criteria items), p. 2.

⁷⁹ RT, May 9, 2008, at 705:21-706:20, 745:21-747:24.

⁸⁰ RT, May 9, 2008, at 705:21-706:20.

⁸¹ Declaration of Michael K. Brady In Support of Defendant's Brief Concerning the Integrated Treatment Model, ¶ 12 and Appendix B.

⁸² Letter of special master to Monica Anderson, May 6, 2008, admitted as Exhibit E, RT, May 9, 2008, 699:2-28; *see also* RT, May 9, 2008, 705:21-706:20, 745:21-747:24.

⁸³ The special master's office prepared minutes and summaries of teleconferences held on August 22, 2008, September 8, 2008, September 17, 2008, October 15, 2008, and February 5, 2009 and provided them to the parties and experts by e-mails dated September 5, 2008, September 11, 2008, September 21, 2008, November 25, 2008, and February 10, 2009, respectively. Those minutes and summaries contributed to the basis for the special master's summary of the history and the experts' positions sent to the parties and

By October 2008, the safety and welfare and mental health experts and DJJ reached an understanding that the DJJ/Orbis approach was within DJJ's discretion under the remedial plans but was not the approach that the experts favored.⁸⁴ Though some of the experts' concerns had been resolved, they strongly recommended that DJJ closely adapt the Washington model, which the safety and welfare plan required DJJ to adapt without specifying how closely. They reiterated that the Washington model had already been developed and proven effective in an institutional juvenile corrections setting. It would be relatively easy to closely adapt and adopt it because Washington had documented ("manualized") it.⁸⁵ The experts explained that, though a risk/needs and case management approach directed at recidivism might be equally good in theory, it would be much harder for DJJ and Orbis to succeed in the development and implementation of a model that was new and untested in an institutional setting.⁸⁶ That would involve designing and implementing components for the model to change and manage the institutional environment and staff and youth culture and behavior. Given the challenges reflected in the slow pace of reform through October 2008, they strongly advised DJJ to take the easier, and better documented, path.⁸⁷ With the support of its Orbis Partners, Inc. consultants, DJJ promised to meet the challenges identified by the experts and remained firmly committed to the path they had been pursuing for two years.⁸⁸

experts on March 3, 2009. A copy of the text of the March 3, 2009 e-mail is attached hereto as Appendix E. The safety and welfare expert delegated his role in the discussions to the mental health experts for the September 17, 2008 and October 15, 2008 teleconferences.

⁸⁴ Statements of Eric Trupin and Terry Lee during teleconference with DJJ and Orbis, October 15, 2008.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Statements of Bernie Warner, Amy Seidlitz and David Robinson during teleconference with experts, October 15, 2008.

In February 2009, DJJ and the safety and welfare and mental health experts were locked in the same impasse. The experts concluded that DJJ had not progressed in the development of its treatment model to meet the concerns that they had expressed in October.⁸⁹ DJJ did not appear to understand what would be necessary to complete the model on which it was working and to implement it.⁹⁰ The experts informed DJJ that they would bring their concerns to the Court unless DJJ provided them with a written description of an IBTM that they believed met the requirements of the remedial plans.⁹¹

DJJ responded by dedicating staff to write a comprehensive description with the assistance of a consultant recommended by the safety and welfare expert.⁹² The DJJ IBTM team started work in early April, and DJJ projected that a draft written description would be produced within 30 days.⁹³ The mental health experts informed DJJ that they believed that the team would be incomplete if it did not include an expert in the Washington JRA model.⁹⁴ DJJ added a Washington consultant recommended by the mental health experts, and he began work with the IBTM team at the end of April.⁹⁵ DJJ instructed the consultants that DJJ was engaging them to help prepare the best possible written draft of what DJJ envisioned as its model, for purposes of putting DJJ's approach in writing for the safety and welfare and mental health experts' and plaintiff's counsels'

⁸⁹ See, e.g., Appendix E (Donna Brorby, facsimile of e-mail, *IBTM -- experts' high level issues*, March 3, 2008).

⁹⁰ See, *id.*, ¶ 3.

⁹¹ See *id.*

⁹² Statements of DJJ management during meeting with OSM and plaintiff's counsel, March 25, 2009; statements of Michael Brady during telephone conference, week of April 13, 2009. Dr. Angela Wolf, recommended by Dr. Krisberg, began working with DJJ on the IBTM draft in early April 2009. Statements of Dr. Angela Wolf and Michael Brady during court compliance task force meeting, April 2, 2009.

⁹³ Statements of DJJ management during meeting with OSM and plaintiff's counsel, March 25, 2009; statements of Michael Brady during telephone conference, week of April 13, 2009.

⁹⁴ Statements of Michael Brady and Angela Wolf to the special master, May 2009.

⁹⁵ The availability of the consultant, Dr. Henry Schmidt, was limited by his full-time job commitment. Statements of DJJ staff during *Farrell* Task Force meeting April 30, 2009.

review and input.⁹⁶ If the consultants disagreed and could not convince DJJ to modify the draft to something that they would support, then the consultants would so inform the safety and welfare and mental health experts and the parties.

Under the compulsion of the Court's scheduling order that required it to file a draft of the IBTM description by June 1 or an explanation for failing to meet that deadline,⁹⁷ DJJ filed (1) notes reflecting the meetings and work of the dedicated IBTM work group that had been working with the expert-designated consultants to put DJJ's model in writing and (2) a document prepared by DJJ's Orbis consultants to explain the model as DJJ and Orbis Partners, Inc. had conceived it.⁹⁸ The Orbis-prepared document reflects the model that DJJ and Orbis have been working on together for two years.⁹⁹ It does not, however, reflect an understanding of and response to the concerns that the *Farrell* safety and welfare and mental health experts have repeatedly raised.¹⁰⁰ The work group notes reflect that the group was far from being able to outline a model at the

⁹⁶ Statements of Michael Brady to special master, May 2009. The special master supported Mr. Brady's plan for writing the description, based on credible representations by DJJ's mental health leadership that DJJ's IBTM manager had a more complete and better IBTM in mind than had been put on paper, and based on the utility of having a full description for the experts' consideration.

⁹⁷ Order, May 4, 2009.

⁹⁸ Declaration of Michael K. Brady In Support of Defendant's Brief Concerning the Integrated Treatment Model, ¶¶ 11-12 and appendices A and B. What DJJ filed was very different from what DJJ's consultants and most of the DJJ work group had expected to file as of May 17, 2009. One of DJJ's consultants, Dr. Wolf, expected to complete a draft based on a ten-page document created by the work group during the period May 20-25. DJJ's IBTM manager informed the group that she would keep the responsibility to produce the draft, rather than turn it over to Dr. Wolf on May 19. Rather than building upon the 10-page document, the IBTM manager submitted the Orbis description as the draft to the work group on the evening of May 23.

⁹⁹ The special master infers this from Chief Deputy Secretary Bernard Warner's statements during the October 15, 2008 and February 5, 2009 teleconferences of the safety and welfare and mental health experts, special master, and DJJ staff.

¹⁰⁰ Statements of Barry Krisberg, Eric Trupin, Terry Lee, and Barbara Schwartz to the special master, et al. during teleconference, June 5, 2009. The experts will explicate their views during the upcoming hearing. Dr. Krisberg's opinions based on an April 2009 informal report are attached hereto as Appendix F (Excerpt from Barry Krisberg, revised informal report on January 2009 central office site visit (summary), submitted April 10, 2009). Dr. Krisberg provided the draft of this report to the parties in February 2009, and provided the April 10, 2009 version after the period for comments expired. DJJ's June 1, 2009 filing has not changed his views, though he is preparing a revised report that reflects his consideration of the June 1 IBTM documents. Statements of Barry Krisberg to special master during teleconference, June 9, 2009.

end of May, apparently because of the attachment of some within DJJ to the model as they and DJJ's Orbis consultants have conceived it for two years. The parties seem to be at impasse now as they prepare for the hearing set for July 2.

V. CONCLUSION

The special master respectfully submits this report.

Dated: June 12, 2009

Donna Brorby
Special Master