Report of Findings of Mental Health and Substance Abuse Treatment Services to Youth in California Youth Authority Facilities

December 2003

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Structure of the Consultants' Review & Report

This report summarizes the findings of Dr. Eric Trupin and Dr. Raymond Patterson, regarding mental health and substance abuse services to youth under the aegis of the California Youth Authority (CYA). The report also includes our responses to the 22 areas of inquiry put forward by the State of California's Attorney General's Office.

As part of this review, we had the opportunity to meet with Director Jerry Harper, Assistant Deputy Director Kip Lowe, and the Superintendents at each of the facilities (see below). In addition, we interviewed key administrative, medical, mental health, education and custody staff. We had the opportunity to individually interview 65 youth and review 90 medical records and 60 juvenile justice files. At each facility we observed and interviewed youth participating in school programs, unit based group programs, treatment groups, vocational programs as well as being "staffed" for either regular classification reviews or for disciplinary hearings. A component of our site inspection procedure was to have a list provided at each facility of youth identified as having significant mental health needs or on a current suicide level or on psychotropic medications or those who had multiple stays in Special Management Programs or those youth where use of force had been required on multiple occasions. We chose from these lists the youth we subsequently interviewed. On a number of occasions youth or staff suggested we interview a particular staff member or youth.

This report is based both on our own information, gathered through site inspections, and on a review of documents provided by the California Youth Authority (CYA), including assessments of the CYA's mental health system, reports of the Office of the Inspector General, the Stanford Report, the Dvoskin and Kosan Report and documents prepared as a function of a number of pending litigations.

We had the opportunity to tour the following facilities:

1) Northern Youth Correctional Reception Center Clinic
2) Southern Youth Correctional Reception Center Clinic
3) Preston
4) Heman G. Stark
5) Ventura
6) Nelles
7) O.H. Close
8) Dewitt Nelson
9) Chadjerian

The Karl Holton facility (primarily a facility for youth identified as having significant substance use and chemical dependency) was not visited; comments related to substance abuse and chemical dependency treatment are based on program descriptions and the facilities visited.

On our site visits, we were accompanied by either Ms. Anderson or Mr. Acquisto from the Attorney General's Office, as well as by Dr. Lowe from CYA. These three individuals facilitated our access, provided us with contextual and factual information and clarified information from requested documents. In no circumstance did they attempt to influence "who or what" we reviewed, nor did they attempt to bias the findings we are submitting. It was our impression that the attorneys representing the Attorney General's office and Dr. Lowe participated in this review in an open and helpful manner and appeared to find the process instructive and beneficial to their understanding of the continued challenges and strengths of the programs provided to youth managed under the aegis of CYA.

Findings in the following report were based on accepted professional standards (also included in report). These standards have been derived from the clinical, administrative and forensic experience of Drs. Patterson and Trupin as well as other experts recognized for their professional expertise in the field of juvenile justice rehabilitation.

This report acknowledges that progress has been made to improve services for youth with behavioral health disorders (mental health and substance abuse disorders) during the past 6 months and over the course of our review. However, the California Youth Authority continues to fall short of meeting many recognized standards of care for youth with mental health and substance use disorders.

The second half of the report is organized to address the areas of inquiry provided by your office, and follows a question/answer format.

Report of Findings of Mental Health and Substance Abuse Treatment Services To Youth in California Youth Authority Facilities

December 2003

This report summarizes the findings of Dr. Raymond Patterson and Dr. Eric Trupin, in their review of the Mental Health and Substance Abuse Treatment Services to youth incarcerated in facilities of the California Youth Authority (CYA), over many visits throughout 2003. The report begins with accepted standards of service in the field and the related findings in CYA (*in italics*). Following that, the questions posed by the State Attorney General's office are answered.

I. Mental Health Standards for Secure Juvenile Justice Facilities

The following standards are derived from Drs. Patterson and Trupin's clinical and academic experience, from current regulatory guidelines, and from the work and professional recommendations of experts in the fields of mental health and juvenile justice, as discussed and documented in the professional literature and in programs across the country. These are appropriate standards of care for this population.

A. Screening/Initial Assessment

All youth entering secure facilities need to be provided a reliable, valid, and confidential initial **screening,** in a timely manner, to identify emergent suicide risk, psychiatric, medical, substance use, and developmental and learning disorders. Reliable and valid tools developed for juvenile justice populations such as the Massachusetts Adolescent Screening Inventory (MAYSI II) should be a component of the intake screening procedure. The screening information needs to be summarized and communicated to the youth's case manager so that identified needs are addressed in a timely manner. Family or guardian contact is to be initiated in order to provide feedback and elicit information related to the youth's mental health/health status.

CYA partially meets this Standard in providing reliable, valid and confidential initial screening of youth for past and current mental health and substance use problems, including current risk for suicide. However, information is often not communicated to a youth's case manager in a way that would allow the development of a practical intervention plan. In addition, families are rarely contacted either to clarify diagnostic issues or to provide information related to a youth's current status.

B. Specialized Mental Health Assessments

Further assessment must be completed on any youth whose screening/initial assessment indicates problems. Specialized mental health assessments are designed to accurately

diagnose mental illness, substance abuse disorders, developmental disabilities and learning disorders. These assessments consist of structured psychiatric evaluations, mental status examinations and standardized cognitive and psychological assessments. These assessments will allow a clinician to both identify and confirm a diagnosis, identify the degree of functional impairment, and develop a proposed strategy for treatment.

In the past 6 months, specialized assessments have been and continue to be added to the TNA process. On a more consistent basis, structured psychiatric interviews (VDISC), as well as personality tests such as the Millon and the MMPI, are administered. Measures of sociopathic behavior are being implemented. In addition, specialized assessments for substance use and sex offenders are provided.

C. Treatment Planning

Treatment planning is the process of identifying a hypothesis as to the reason a youth needs treatment and a plan to intervene in the youth's symptoms and emotional disorders. Treatment plans require the setting of specific goals of treatment in a coherent manner. Plans must identify targets for intervention, methods to accomplish those goals and ways to measure if the treatment is effective. Specific strategies need to be clearly identified to address, integrate and/or coordinate the approach when common co-existing problems such as substance abuse and learning disabilities are present.

Despite the screening, assessment and specialized assessments being done, treatment planning, as described in this Standard, is not evident in the clinical records of youth in CYA. Treatment planning requires significant improvement. Implementation of the SPAN process will aid in making decisions regarding the type and intensity of program a youth requires, however, specific treatment goals employing evidenced-based interventions must be developed as they are, currently, consistently absent.

D. Case Management

Case management entails the coordination and monitoring of all rehabilitative needs identified in the findings of the court, as well as the treatment and educational needs accessed through screenings and assessments. Insuring that consistent communication is maintained between clinical, educational and custody staff is a key component of case management. Developing transition plans with community providers, community parole/probation officers, family or guardians or other placement facilities is also a core function of case management.

Case Management Standards were found to be inconsistently applied across facilities and in need of significant improvement.

E. Mental Health Counseling

Mental health counseling refers to treatments provided by or under the supervision of qualified/licensed mental health personnel. Use of evidence-based treatments or "best practices" and practice parameters are to be emphasized. Clinical treatment effectiveness

research with juvenile offenders strongly supports the use of Cognitive Behavioral Treatment (CBT) strategies as the most effective interventions for the majority of psychiatric disorders manifested by juvenile justice youth. These treatments are often implemented in conjunction with psychopharmacological interventions, depending on the particular problem a youth manifests, and his/her functional status. Counseling needs to relate to the targets outlined in an initial treatment plan. The ongoing counseling plan needs to specify how the interventions' effectiveness will be measured. Involvement of family members and coordination with educational and custodial staff is encouraged. Transition plans and termination or completion of treatment summaries are required in order to facilitate continuity of care when a youth is being transferred between facilities or returning to the community.

Mental Health Counseling Standards were found to be inadequately and inconsistently adhered to throughout CYA facilities visited

F. Management of Psychotropic Medications

Management of psychotropic medications must be conducted either by a psychiatrist or, under certain defined circumstances, a non-psychiatrist physician or clinical nurse practitioner supervised by a child psychiatrist. Treatment must adhere to practice parameters as they relate to the specific diagnosed disorder a youth manifests. Coordination with other providers and case managers is essential in providing appropriate treatment and consistent monitoring. For each medication used, a specific targeted symptom needs to be identified. Monitoring plans, designed to assess the effectiveness of reducing symptoms, should include case managers, counselors, teachers and, where appropriate, custody staff and family members. Youth participation in treatment must include assent and education related to the purpose of the medication, a specific manner in which a youth can assess the benefits, and potential side effects. Parental or guardian consent must be obtained, depending on the age of consent regulations of a jurisdiction. Specific plans for providing medication on discharge or transfer from a facility needs to be documented.

Inconsistent and substandard practices are evident as it relates to the use of psychotropic medication. In a number of facilities, psychiatric evaluations are cursory and do not meet accepted professional standards. Psychiatric histories are often not comprehensive and do not include developmental or family information. Prior experience with medication and outcomes are often missing. Measurement of the effect of the medication on target symptoms is consistently missing and coordination with other mental health professionals and case managers is lacking. Attention Deficit Hyperactivity Disorder in particular is poorly managed. A number of psychiatrists are reluctant to use stimulant medications (due to their concern over illicit use) thus depriving youth of an effective treatment for this relatively high frequency disorder.

On a positive note, consenting practices are consistently followed, and information related to the benefits and risks of medication is regularly provided to youth.

G. Crisis Management

Crisis management requires that facilities, in a consistent and well monitored manner, address, assess, develop and implement plans to protect and prevent youth from engaging in behaviors which place them or others at risk for harm.

The National Commission on Correctional Health Care (NCCHC) *Standards for Juvenile Detention Facilities* requires that Juvenile detention facilities have a suicide plan that:

6. Identifies youth potentially at risk of suicidal behavior
7. Reviews the risk of imminent harm to others
8. Trains all staff who work with youth to recognize those youth at risk of suicidal behavior
9. Assesses youths deemed potential risks by qualified mental health professionals
10. Monitors youth deemed at risk for suicidal behavior
11. Houses suicidal youths appropriately (in particular, a prohibition against isolating such youths)
12. Refers youth to appropriate mental health providers or facilities
13. Provides for communication between health care staff and youth care workers on current information and status of suicidal youth
14. Documents steps taken to identify, treat, supervise, house, etc. suicidal youths
15. Reviews the risk of previous substance use and the long term consequences of abuse on potential self harming behaviors
16. Reviews the risk of discontinuation of prescribed medication or non- compliance with appropriately administered psychotropic medications
17. Notifies facility administrators, outside officials and family members of potential, attempted, or completed suicides
18. Reviews and addresses procedures if a suicide occurs

In addition, a facility needs to have policies and procedures for the use of physical and chemical restraints, and policies regarding cell restriction and isolation for all youth and particularly those with mental illness and developmental disabilities.

Our evaluation indicated that the CYA facilities varied in their compliance with the Standard related to Crisis Intervention but, in general, consistently adhered to 1-5 ,12 and 13, with more variability in following the Standards outlined in 6-11. However, the over use of chemical restraints continues to be a major concern, particularly when administered to youth who are not presenting a threat to staff or other youth and are being non-compliant. Lack of skill with verbal de-escalation methods and insufficient training of staff in strategies for the management of non-compliant youth contributes to the inappropriate use of punitive strategies, as well as the overuse of SPA's for controlling mentally ill youth who engage in aggressive behaviors.

H. Youth Development/Treatment Programs

Youth Development/Treatment Programs refer to the expectation that juvenile facilities will implement an incentive-based and well-defined behavior management program in all domains in which a youth functions. These programs must provide opportunities for youth to learn and practice effective behaviors that promote positive strategies of self-regulation and pro-social behavior in all aspects of daily living i.e., unit activities, recreation, school, groups, etc. For youth identified as having behavioral health problems, behavior management programs need to be coordinated with a treatment plan and evidence of this communication must be documented.

Simple "level systems" or "point systems" without practice and learning opportunities to develop the skills for attainment of points are not sufficient. Custodial staff needs to implement "point" programs in a consistent and non-punitive manner. In addition, juvenile facilities must provide opportunities for youth with behavioral health disorders to participate in educational and vocational programs and to address family conflict, substance abuse, anger management, gang affiliation, gender and cultural issues.

Access for mentally ill youth to Youth Development Programs and Treatment Programs is often circumscribed and limited because of their frequent stays in Special Management Programs, where the environment is not conducive to youth learning behaviors that would enhance their ability to self regulate their behaviors. Some improvement in access to these programs should occur as youth have greater access to CTCs, along with expanded access to both ITPs and STPs. Specific behavioral skill programs based on Cognitive Behavioral principles need to be consistently implemented, so as to reward youth for incorporating positive skills into their daily behavior in dorms, schools and vocational activities. Level and point systems need to be consistently monitored so staff are applying the incentives consistently across shifts. Inconsistency in applying incentives was noted across facilities. In addition, mental health staff rarely incorporate treatment expectations into the point and level systems administered on Units, e.g. when a mental health clinician is working with a youth on dealing with frustration or anger, custody staff should be made aware of specific targets for change and reward the youth with points or level advancement for displaying the skills being taught.

II. Questions from Attorney Generals' Office and Related Findings

1. On a system-wide level, is the mental health care provided by the CYA adequate and does it conform to community standards?

Response:

- *Overview*: The mental health care provided by the CYA is not adequate and does not conform to community standards or to the professional standards identified in this report. Evidence of clinicians utilizing evidence based treatments (Cognitive Behavioral Therapies) are rare. Family involvement in treatment interventions is very much the exception in all facilities visited. Thus, treatment gains made during a secure placement in a CYA facility are likely to be undermined by the lack of commensurate skill development or education in parents/guardians. This often leads to the youth returning to behaviors which contributed to their offending behavior, once they return to their home situation.

  Substance abuse treatments do not comport with those recommended by the American Society of Addictions Medicine (ASAM) and there is little evidence that youth suffering these problems (85% of the CYA population as measured by the Steiner report), most of whom have a co-occurring mental health disorder, have treatments designed to treat these disorders in a comprehensive manner, except in one program (Dewitt Nelson Therapeutic Community Program). Empirically supported *Motivational Enhancement* strategies are not consistently utilized by clinicians in individual or group activities. Although outcome information was not provided on the benefits of the RSAT programs at the Nelson or Nelles facilities, it would be not be surprising if youth enrolled in these more comprehensive programs have lower levels of recidivism—even though the programs have limited continuity and transition planning and are only partially utilizing best practices.

  During the course of our site visits, we found wide variation in the quality of care and treatment provided to youths receiving mental health services. Much of this variation is a consequence of a history of limited central direction of behavioral health care services. Until recently, clinicians (psychiatrists, psychologists and social workers) worked as if they were in independent practice. Youth Correctional Counselors (YCCs) are not provided with consistent mental health consultation nor do they have adequate training in the management of youth with co-occurring disorders. Treatment plans are not designed to actively involve YCCs or families. YCCs are often left to make decisions on how to manage mentally ill youth without the guidance of a specific treatment plan developed by a mental health professional. In addition, objective measurements of the effects of psychotropic medications -- via regular assessment of how youth are functioning on units, in school, or in vocational settings -- rarely occur.

  Clear evidence exists that efforts were underway to centralize and enhance decision making, implement best practice programs (structured program development in CTCs, ITPs, and SCPs), develop strategies to more effectively assign levels of care

(SPAN) and develop continuous quality indicators (CQI) for psychiatric care (process implemented during July by Dr Templeton). However, action plans and remedial strategies were not implemented during the course of this review.

Despite these efforts, variability in the quality of care across sites persists. A primary deficiency that contributes to this variability is insufficient staffing. Staffing is particularly inadequate for child and adolescent psychiatrists and child psychologists versed in current practice parameters and empirically based treatments, especially with ethnic minority populations experiencing the co-occurring disorders of mental illness and substance abuse. Despite the fact that CYA has 19 fulltime Psychiatrist positions with 4 current vacancies, only a few of these positions are filled by psychiatrists having any formal training in Child and Adolescent Psychiatry and only 3 are either Board certified or eligible in this sub-specialty. None of the psychiatrists have formal training or certification in substance abuse or chemical dependency. It is crucial that CYA work actively with the child and adolescent psychiatric training programs and clinical psychology programs in the State of California to establish formal relationships with faculty and trainees; the recruitment of recently trained clinicians will enhance the quality of care provided to youth with both mental illness and substance abuse disorders. It is our view that the uncoordinated approach to psychiatric care – essentially providing care without an integrated treatment plan or a plan that identifies targets which his/her interventions are designed to address – undermines the effectiveness of the current cadre of psychiatrists' clinical care.

As CTC, ITP, SCP and SMP programs develop more structured and empirically driven interventions, with greater emphasis on family involvement, additional psychologists will be required to provide program direction and supervision. In several facilities, there are an inadequate number of psychologists. In other facilities (e.g. Preston), the numbers appear appropriate but the assignment process does not distribute the workforce in an effective way. In effect, too much time is spent in assessment and report writing and not enough time in individual, family or group interventions. Nor is adequate time spent in disposition and transition planning, staff consultation or training. The staffing concern described by Steiner, Humphreys, and Redlich, related to inordinate amounts of time spent by mental health staff doing paperwork, continues to be voiced by clinicians. However, it is our assessment that many of the new forms (SPAN and SRSQ) that mental health staff are required to fill out will ultimately improve care for youth and are worth the time required.

Low salaries for psychologists, compared to Department of Corrections' psychologist employees, have a significant effect on recruitment and retention of motivated and talented clinicians. This issue needs to be remedied in order to implement and sustain staff for the progressive programs CYA is contemplating.

In general we have grave concerns relative to the competence of the psychiatric staff, historical lack of leadership (which we observed to be in the process of being remedied), and the lack of any effective quality management or peer review process for the practice of psychiatry.

The programs that have implemented an "Enhanced Case Management Model", assigning YCCs to be "off-post" and in the dayrooms, yards, and other areas to provide services directly to youths, are clearly positively effecting positive outcomes for youth. This model can be significantly improved upon with the implementation of intensive training for YCCs on Cognitive Behavioral Treatment (CBT) strategies. CBT should be the primary management and skill development procedure for staff interactions and responding to conflicts between youth and staff. A number of states (Washington, Missouri, New Hampshire) have significantly reduced use of force, youth on youth, and youth on staff violence through the implementation of these procedures.

- *Programming*: There are examples of adequate or even exceptional programming, such as the substance abuse treatment component at Dewitt Nelson (The Karl Horton Facility is referenced in the Steiner report as having a beneficial Substance Abuse program despite their observation that interventions were neither developmentally appropriate or empirically driven), and there were youth interviewed who had been in several other substance abuse programs. This programming was the exception rather than the rule.

The programmatic component of the SMP also varied considerably in that the treatment staff appeared to take a very subservient role to custody staff with regard to the actual purpose of the SMP program. This inconsistency was also noted by Steiner, Humphreys, and Redlich who said, "That is... most facilities feel like correctional facilities with some limited mental health backup" Common sense and community standards suggest that any reasonable attempts to rehabilitate mentally ill offenders would occur in an environment that is secure but more therapeutic than correctional in structure. SMPs are not currently driven by clear therapeutic objectives. The inflexible number of days a youth is required to stay after placement in the SMP undermines and potentiates deviant behavior of the mentally ill youth who are confined in these settings. The core management technique for these units should specify target behaviors to be demonstrated by youth for specified periods of time, earning increased privileges.

Our site visits confirmed that several SMP programs, such as those at Stark, Chad, and Nelles, were very much aligned with a punishment model in that they allowed a youth to be separated from population and housed in one of these areas until they demonstrated they were compliant with rules. Very little emphasis was placed on a youth's skill enhancement or their incorporation of self regulation or distress tolerance strategies. These punitive techniques occurred despite there being clear evidence, in several instances, of a youth in considerable emotional distress, with a history of similar patterns of behavior, and no evidence that this punitive strategy brought about a desired change in a youth's behavior. The use of the SPAs in these programs, including Nelles, was not therapeutic, and we advised they should be used only for the very shortest periods of time until a youth was more therapeutically managed.

We opined early in the review process that the program at Tamarack Lodge at Preston should be closed to any youth in need of mental health services. Remarkably, the facility response was to place these youths in Ironwood, where they were isolated and away from staff observation or interaction, and without adequate staff enhancement to address their mental health needs. The use of the SPAs and OC spray appear to be excessive and ineffective (some youth have had numerous incidents of OC spray and stays in the SMP, but their disruptive behavior has not changed in frequency and intensity). At the facility/administrative level, there does not appear to be any input either prior to the use of these restrictive and punitive measures or after their use, to attempt to alter or develop any meaningful treatment plans or approaches. The frequent use of the SMP, SPAs and OC spray as punishment exacerbates symptoms of mental illness. This is especially true among the approximately 65% of CYA youths who have serious symptoms of mental illness. (Steiner, Humphreys, and Redlich, 2001).

The quality of mental health programs varies widely from facility to facility.

The assessment procedure implemented at the Northern Reception, Southern Reception, and Ventura clinics utilizes the TNA process. This assessment takes approximately a month to complete and produce a report identifying treatment needs. The quality of these reports is good, however, specific empirically based suggested intervention strategies are absent from the recommended treatment suggestions and these reports do not appear to guide treatment direction once a youth is placed in a facility. Youth are provided with a suicide risk questionnaire (SRSQ) within one hour of their arrival. CYA has recently introduced the use of the SPAN to determine the need for a youth to be placed in a specialized treatment program (ITP, SCP or CTC). This tool has been in place for only a few months and has not been effectively evaluated for its accuracy as a method to assign a level of care. However, it appears to be a significant positive advance for using clinical and functional factors in determining level of program need and acuity.

The highest/most acute level of care in the system is in the CTC crisis beds, which are in the developmental stage and are currently inadequate to the needs of the CYA population. The initial crisis beds established at Stark are designed in a manner similar to mental health crisis beds in the adult California Department of Corrections for short stay crisis stabilization (LOS of up to 30 days). The criteria for admission and length of stay for Stark's 13 crisis beds will potentially not lend itself to effective utilization due to the potential of many youth being referred because of inadequate system wide programming and treatment and not having an adequate step down unit in which to transition.

The proposed Licensed Care Plan calls for 10 dedicated state hospital beds with long-term length of stays, 33 CTC beds (13 in place at Stark) and 20 Intermediate Care beds in conjunction with the Division of Mental Health (LOS 30 – 180 days)

The agreement with Metropolitan State Hospital to provide hospital level services to youths 18 years of age and over appears to be appropriate for the small number of youths referred, however, the hospital's services were stated to be substandard and often not helpful for CYA youth, by a number of mental health professionals.

Currently CYA has no crisis beds for females. Although CYA has contracts with various hospitals for all aged youth, these emergent services are often difficult to access without significant negotiation with admitting medical staff and youth are often returned without a viable treatment plan because of the difficult management problems they present. The need for external hospital utilization for younger youth should be mitigated with the addition of the additional CTC beds and the implementation of structured programs in the other specialized units as well as more effective empirically based clinical services offered system wide.

The next level of care, the Intensive Treatment Programs (ITPs), also varies markedly across CYA. The Department has developed 207 ITP beds system-wide, however many of these "sub-acute crisis beds" are not being used appropriately and youth spend inordinate amounts of time on "camera watch". The overuse of camera observation places vulnerable youth at risk for self harm due to less than effective fields of view for these cameras (this issue particularly pertinent at Nelles.)

The Specialized Counseling Program (SCP) demonstrated similar variability. In the SCP at Oak Lodge, for example, the psychiatrist never met with the staff; therefore, there were no discussions as to the overall treatment needs of the youth. This, again, reflects the lack of treatment planning at all levels of care.
Those youths in the general population who are receiving mental health services receive the least attention, and had the most inadequate staffing and programming across the system.

- *Assignment of levels of care*: As noted above, the levels of care are assigned at the Reception Centers. Therefore, a youth who does not get assigned an appropriate level and is in subsequent need of a higher level of care, needs to come to the attention of mental health staff based on either acting out, self or staff referral, or through the disciplinary process. Mental health and custodial staff sometimes do "case finding" but it is a relatively low frequency event. This method of identifying youths in need is inadequate and does not provide for prompt and appropriate mental health care.

- *Credentials and Competence*: In meeting with the psychiatrists working in all CYA facilities visited, it appears they operate on a "private practice" model in which each has his/her own ideas and opinions as to treatment modalities. The psychiatrists are often only marginally members of the mental health treatment team. Post-hoc reviews of clinical practice by the CYA medical director do not seem to occur regularly, as was recommended by *Koson and Dvoskin* . For example, the use of stimulants for the treatment of attention deficit/hyperactivity disorder varies from being used when indicated to never being used, as a matter of professional opinion and/or historical practice. *Koson and Dvoskin* recommended that the CYA medical director review this

issue of stimulants, however, there is no evidence that there is any change in clinical practice. Similarly, youths that have had persistent disciplinary infractions or adjustment problems may or may not be seen by a psychiatrist, depending on facility and the psychiatrist's particular preference. Multiple referrals around disciplinary issues should by policy elicit a mental health referral.

- *Excessive disciplinary responses without meaningful mental health input*: In reviewing the disciplinary process, particularly the SMPs and those instances where a custody response is generated, such as cell extractions, mental health input varies from non-existent to non-impacting. We observed youths that were in clear distress and, in a few cases, mental health staff who recognized this distress attempting to address the youth's issues, only to have the custody response be based on ineffective punitive approaches which only altered the youth's non-compliant behavior temporarily and did not reduce the likelihood of a re-occurrence. The observed procedures included the assignment of lengthy SMP stays, restrictive housing, and/or use of OC spray regardless of the youth's mental status.

- *Poor medication assessments and direct observation therapy*: There is no consistency in the system with regard to medication management. As noted above, much of the medication management depends on the individual psychiatrist's approach, and is without meaningful peer review or oversight. *These inconsistencies seem to violate CYA policy regarding direct observation therapy for psychotropic medications.* There were a number of instances of "poly-pharmacy", with youths receiving from 3-8 different psychotropic medications without adequate justification in the record. We also observed that HS or nighttime medications were not available in some facilities, including CHAD, because of what was reported as inadequate staffing due to nursing vacancies. *Not having nighttime medications available to mentally ill youth is especially egregious because needy youth are deprived appropriate care. In addition these youth metabolize medication on average at a faster rate than adults thus exacerbating the potential for the benefits of the medications to be mitigated promoting deteriorations in mental status.*

2. Are the CYA's mental health care policies and procedures adequate?

Response: The policies and procedures are in the process of being developed. As recently as 7/24/03, we received procedures for the Specialized Behavioral Treatment Program at the Sequoia Lodge at Preston. The policies and procedures, again, need to be reviewed and revised with a focus on their consistency, and the identified purpose of the mental health programs. The staff to youth ratios in these programs need to be increased. The procedures for peer review, quality assurance, quality audits, and quality management have not yet been developed to adequately assess the competence, practice, and quality of services provided. Both the Koson and Dvoskin and the Steiner reports made many suggestions related to policies and procedures that have not been implemented. Most importantly, procedures need to be developed for an integrated model of mental health interventions for both individual and group

treatment and milieu management that rely on empirically based best practice approaches emphasizing cognitive behavioral practices.

3. **Has the CYA implemented appropriate mental health quality assurance procedures?**

Response: These procedures have not been implemented, as noted above. During the course of our site visits, the medical director and chief psychiatrist had directed the CMOs to review psychiatric practice. This review, again, appeared to vary widely as several of the CMOs, despite the best intentions, reported they did not feel they had the competence to review psychiatric practice adequately. Peer review needs to be instituted to assess the treatment modalities utilized by psychiatrists, including medication management. The Unified Health Records (UHR) reflect very poor documentation, and there is no adequate process in place to review the documentation. .

The suicide prevention program although improved continues to need system wide implementation. There have been efforts by CYA to develop standards for suicide assessment, suicide watch, and post-suicide managment. The post-suicide management process has not yet been effectively instituted but is in the process of implementation across instituitions.

Lastly, the need for rapid implementation of additional CTC level care for male and female youths remains critical. With the implementation of these beds and those Intermediate Care beds being developed in conjunction with the Division of Mental Health, CYA will become less dependent on various public (Patton and Metropolitan) and private hospitals who are often challenged by the combination of psychopathology and and criminal behavior CYA youth manifest. Appropriate continuity of care and treatment planning will be better sustained with a model of care derived by an integrated CYA treatment model that can be managed and supervised internally by the CYA clinincians and juvenile justice staff.

4. **Does the CYA have a sufficient number of psychiatrists, psychologists and other health care professionals to provide an adequate level of mental health care services?**

Response: As stated above, we believe the CYA does not have an adequate number of psychiatrists, and there are questions regarding the competence of several of the psychiatrists currently providing care to youth. While the Steiner Report and past consultants have recommended increasing the number of psychologists, in our view there is a particular need for an increase in psychologists at facilities that have only part-time coverage. However, in some of the larger facilities, the issue is one of distribution and supervision of psychologists rather than actual numbers. There appear to be insufficient numbers of youth correctional counselors (YCCs) to provide the Enhanced Treatment Model that appears to be effective in programs where it is currently implemented. The number of caseworkers appears to be adequate.

5. **On a system-wide level, does the CYA appear to have a sufficient number of ancillary personnel, including officers, to appropriately care for youths?**

   Response: There appear to be an inadequate number of ancillary personnel, specifically officers, to escort youths to areas within facilities that can be used for therapeutic programming; the design of several of the older facilities does not allow for sound privacy in treatment areas, or adequate areas in the living units, so escorts to other locations within the facility are necessary. With increased development of structured programs and an integrated treatment model, where all staff utilize cognitive behavioral approaches, officers' roles could be modified to involve them more consistently in rehabilitative activities. There is an inadequate number of nurses to assure direct observation therapy, however, whether this is an allocation or vacancy issue is unclear. There is also a lack of pharmacists at several facilities, so that an effective medication management program cannot be achieved.

6. **On a system-wide level, are the CYA's mental health care clinicians appropriately trained, supervised and disciplined?**

   Response: The training is variable across the system. It appears that while training has been documented, the implementation of the training at the facility level has not been demonstrated. There is a lack of supervisors; only recently was the chief psychiatrist given authority over hiring and appointment of psychiatrists system-wide. Facility level supervision and regional supervision for a number of facilities has been assigned to Chief Medical Officers (CMOs) without adequate demonstration of skill to effectively provide competent supervision. At smaller facilities, such as OH Close and Dewitt Nelson, part-time psychiatric coverage appears to be ineffective, and supervision absent. With regard to disciplinary actions involving mental health clinicians, we were not provided any information to suggest that disciplinary actions have taken place. With regard to disciplinary actions for custody staff, there is some evidence that individual custody staff behavior is being addressed with greater regularity, but staff and officer misbehavior continues to be a source of significant concern for a number of mental health professionals as well as many youth. Access to training opportunities for all mental health professionals is limited and clearly effects morale and limits the implementation of effective and efficient (costs) best practice approaches.

7. **Does the CYA appropriately screen incoming youths for mental health treatment needs?**

   Response: See Response in Section I.A. of the Mental Health Standards, addressing Screening/Assessment (earlier in this report)

8. **On a system-wide level, are the CYA's mental health care records legible, properly organized, and do they contain adequate information?**

Response: The records are not consistently legible, they are not well organized, and may not include basic information regarding a youth's care. The charts often lack treatment plans, and organized progress notes in a SOAP or other recognized format. The CYA has a remarkable practice of having doctors write their orders on progress notes, rather than on doctor's order sheets, which is the community and correctional standard in every facility we have ever seen. This practice lends itself to medication errors (which are not measured in any meaningful way), and a lack of integration of treatment. The system is moving in the direction of having "individual change plans" instead of treatment plans, however, this effort has only recently begun. Important information, useful to YCCs and case workers, is often not shared due to perceived confidentiality issues .Individual Change Plans are not filed in the UHR so they cannot be properly accessed by medical and psychiatric staff.

9. **On a system-wide level does the CYA provide adequate mental health care to its general population?**

Response: No, the CYA does not provide adequate treatment to its general population. There are several deficiencies in this area including access to care, distribution of staff, inadequate staff to patient ratios, and a triage and crisis driven process. Once an inmate has gotten through the screening process, they may not be seen by mental health staff again unless they have some form of crisis, which is inadequate. The vast majority of youths who have mental health needs are made worse instead of improved by the correctional environment.

10. **Are the CYA suicide watch policies and procedures adequate, and, if so, are they properly implemented?**

Response: The policies and procedures have been developed during the course of our site visits, and now include an aftercare (after suicide watch) component. However, the custody YCC/YCO follow-up has not yet been measured to determine its adequacy. Implementation of the policies is just beginning with a central monitoring focus in the developmental stages.
During the course of our tours, there was a completed suicide of a 16-year old youth at NYCRCC. This youth had been in the clinic for two weeks, and had been assessed as a high risk for suicide. A comprehensive "Operational Analysis" was conducted subsequent to the suicide which identified the need for a policy regarding post release from suicide watch follow-up plans. This procedure was developed and, as noted above, is in the process of implementation during our tours. CYA is currently effectively designing appropriate policies and procedures to address the issue of suicide. What remains to be addressed are the implementation and consistent monitoring, supervision and quality assurance that will sustain the policy in practice at a high level of performance compliance. Suicide prevention committees have been developed that coordinate suicide prevention efforts, reviews completed suicides and suicide attempts.

11. **On a system-wide level, is the CYA's use of physical restraints such as restraint chairs and spit masks, appropriate?**

Response: This item is very difficult to track because the system does not break out mentally ill inmates or inmates on the mental health caseload, and does not aggregate results. There is a task force that has begun to review the services a youth may have been receiving and whether or not there was the use of any physical restraints for that youth, as well as individual custody staff performance in those instances where physical restraints have been used. Despite CYA having a seclusion and restraint policy, the policy does not distinguish procedures for the use of force with youth exhibiting mental illness—this needs to be done. The policy should ensure that physical restraints be used as a safety measure and not as punishment. Community standards dictate that this policy should include 1) what measures must be tried prior to physical restraint, 2) what specific behaviors necessitate physical restraint, 3) rules regarding direct observation of youths when he or she is being physically restrained, 4) documentation and reporting rules regarding use of physical restraints, 5) specific behavioral criteria that will lead to the removal of physical restraint.

12. **On a system-wide level, are the CYA's mental health care physical facilities adequate?**

Response: Again, this is an area with considerable variability. There are older facilities such as Preston and Nelles that do not have adequate programming space. The newer facilities, such as Chad, appear to have adequate programming space. We have opined the Tamarack Lodge at Preston should not be used for youth with mental health issues, and the facility's response to use the Ironwood Lodge requires further development of procedures and staffing enhancements to actually address the needs of youths. The use of the SPAs (cages) for both mental health therapies and educational purposes does not adequately address the needs of the youths. While Koson and Dvoskin reported that administrators acted quickly on many of their requests to improve mental health care physical facilities, it is unclear if all facilities have implemented all of their site specific recommendations. Areas of continued concern observed on our visits are: safety issues in video cells, poor utility of video observation systems, undersized observation panels in cells, dangerous restraining beds, inadequate lighting and, of course, cages as holding cells

13. **On a system-wide level, does the CYA have a sufficient number of beds for its mental health treatment programs?**

Response: Again, there is variability for the CTCs when they all become operational, and with a projection of 0.2-0.3% of the mental health caseload requiring a crisis bed at any given time, the numbers appear to be adequate. However, there are age factors that may interfere with the availability of beds for youths. The ITPs and SCPs have waiting lists for youths to get into those programs. The SMPs appear to have an "identity crisis" and do not yet seem to focus on the therapeutic assessment and interventions that may assist youths in reducing the disciplinary infractions they

receive due to disruptive or other objectionable behavior. Instead, the SMPs are currently focused on managing youths through a more restrictive environment governed by time constraints rather than therapeutic responses.

The substance abuse beds are not adequate for the system. We have commented that the intensive substance abuse treatment program at Dewitt Nelson appears to be the most functional, largely because of a very hands-on approach to the youths and a program that focuses on the "total person" rather than simply the substance use and abuse.

In the general population, the dormitory areas appear to exacerbate mental health concerns to the youths interviewed. Youths informed us that Nelles is referred to as "gladiator school", that in Stark the gang problem with "southerners" is dramatic, and at Chad there are efforts at segregation and isolation of "northerners" and "bulldogs" that interfere with the appropriate implementation of treatment programs. Overall, there are an insufficient number of beds for substance abuse programs in the CYA. According to Koson and Dvoskin and Steiner, Humphreys, and Redlich, there seems to be a sufficient number of ITP beds: this obviously has changed, as evidenced by the waiting list. Both of those reports agree that there is a shortage of SCP beds, but disagree on the magnitude of the shortage (75 vs. 800). We agree with the lower figure provided by Koson and Dvoskin, as long as the whole system moves in the direction of providing an integrated treatment approach to all youth based on cognitive behavioral principles. Koson and Dvoskin indicate that there is a sufficient number of substance abuse beds, but they infer that the quality of some of these programs is inconsistent and in some cases suspect. We disagree and it is our recommendation that substance abuse treatment be expanded to the many youth who are merely receiving inadequate educational programs in the general population.

14. On a system-wide level, does the CYA properly prescribe, administer, and distribute psychotropic medication, including during periods of extreme heat?

Response: No, the CYA does not demonstrate through its records the proper prescription administration or distribution of psychotropic medications. There is no evidence of peer review, drug utilization reviews, or record reviews to demonstrate adequacy in such activities. Reviews of the records consistently demonstrate poor documentation of medication practices, great variability of the use of stimulants for the treatments of ADHD and other disorders, and no evidence of quality review regarding medication management. Steiner, Humphreys, and Redlich commented that due to the lack of psychiatrists with specialized training in child psychiatry and pharmacology, modern psychopharmacology was usually not practiced within the CYA. They went on to remark that anti-depressants and anti-psychotics were most often prescribed, and that stimulants, sedatives, anti-anxiety, and anti-manic medications were rarely prescribed. We concur with this finding and a remedy needs to be implemented.

Despite the fact that Koson and Dvoskin recommended the drafting of a "heat plan," there was no organizational heat plan provided that addressed the use of psychotropic medications during periods of extreme heat, the use and management of youths' use of psychotropic medications, or management of youths during periods of extreme heat.

15. Do the CYA's policies and procedures contained in Institutions & Camps Manual Sections 6282-84 set forth an appropriate procedure for the involuntary or forcible medication of youths with psychotropic drugs?

Response: Yes, the CYA policies and procedures are using the Keyhea process for youths who are 18 or over. Parental consent or court ordered medications are the process for youths under the age of 18. Koson and Dvoskin praised the policy of using psychotherapy alone for youths who did not meet Keyhea Criteria, and for whom parental consent for medication administration could not be gathered.

16. Does the CYA offer adequate rehabilitation programs including substance abuse program?

Response: No, the CYA does not offer adequate rehabilitation or substance abuse programs. There are "bright spots" in the system including the substance abuse program at Dewitt Nelson; however, the need for more intensive substance abuse programs with a similar treatment model in other facilities is well known to CYA and needs immediate implementation. Further, the outpatient programs are "informal" and there is a substantial waiting list for youths to be admitted to the intensive substance abuse programs. Koson and Dvoskin noted that these informal programs are "apparently run by YCCs with little specific training and supervision." Given Steiner, Humphreys, and Redlich's finding that 85% of CYA youths have substance use issues, it seems unacceptable that more formal substance use intervention programs are not available for youths in the general population. There are also considerable concerns relative to the lack of vocational rehabilitation programs (even in facilities that appear to have physical plants that support such interventions such as Stark), and the great lack of family involvement in the treatment process. This lack of involvement not only applies to those facilities that are more remote and difficult to reach for family members, but also for those that are located very near to or in metropolitan areas. A plan or program for development to provide transportation to the families of youths should be instituted.

17. Are the rehabilitative programs generally available to youths who have been ordered to participate in them by the parole board?

Response: No, these programs are not available to youths who have been ordered to participate by the parole board because of inadequate number of programs and inadequate staffs. There are waiting lists to get into parole board ordered programs. Substance abuse beds were occupied at a rate of 100%. Given the large number of youths with substance abuse problems, it is likely that those youths may have to wait

to get into parole board ordered substance abuse programs and end up with longer stays in CYA facilities, due to their inability to access these services.

18. Are the CYA's rehabilitative programs, including substance abuse programs, effective?

Response: At this time, it is unclear as to whether these programs are effective; there is no evidence that the programs are effective, and it is also unclear how many of the programs are based on models that have been effective in other settings. In interviews with youth who have participated in such programs (particularly substance abuse programs) and who subsequently violated parole or re-offended by using substances or by attempting to obtain funds to buy substances, these youth provided their impressions that the programs are not effective. Once again, the exception was at Dewitt Nelson and their intensive substance abuse program.

19. On a system-wide level, are the staff who provide rehabilitative programs, including substance abuse programs, qualified and properly trained?

Response: It is unclear as to whether or not the staff is properly trained on a system-wide basis. In specific instances, staff appears to be properly trained and supervised; however, in other facilities it is not at all clear that the staff have had appropriate training. There is a weakness in substance abuse programs relative to their integration with mental health treatment programs. Youths who may be duly diagnosed with a mental illness and a substance abuse problem do not have an integrated treatment plan that broaches all of their needs. Again, Koson and Dvoskin noted that the CYA's substance abuse treatment beds "are apparently run by YCCs with little specific training and supervision." Our review and assessment supported their observations. Without a substance abuse treatment model that is adapted by all CYA facilities, it is likely that training and supervision of substance abuse treatment providers will vary from facility to facility and reduce the likelihood that effective rehabilitation will occur for effected youth.

20. Do the rehabilitative programs, including substance abuse programs, meet regularly and are youths able to attend?

Response: This is, again, a facility specific issue. Where the programs exist, yes, the youths are able to attend, except when staff are on leave. However, there are not enough programs and, other than the program at Dewitt Nelson, there does not appear to be an integrated focus on the development of skills regarding life issues for the youths rather than just their drug abuse.

21. On a system-wide level, are the rehabilitative programs in restricted housing units adequate?

Response: In the SMPs, no. The substance abuse programs are not adequate, and, in programs such as STP at Preston, the program is not adequate because of an inability

to retain staff - for a variety of reasons, including the staff's perception they are not safe.

Medication administration to youths in restricted housing units continues to be a major concern, according to Koson and Dvoskin, and we agree. First, policies should be implemented around the direct observation of medication administration, given the high risk for suicide among youths in SMPs. Medication provided to youths who are cuffed and kneeling continues to be a dangerous practice. Finally, practices such as 23 hours of seclusion and liberal use of shackles and cuffs that occurs in restrictive housing units, serve to exacerbate, not rehabilitate youths' mental health problems.

22. Does the CYA have enough staff to provide an adequate level of rehabilitative programming, including its substance abuse programming?

Response: No, there are not adequate numbers of staff to provide the intensive substance programs that are necessary for the youths who are identified with significant substance abuse problems. The waiting lists for these programs continue. We concur with Koson and Dvoskin that the number of staff isn't necessarily the problem; rather it is the quality of the staff's training and supervision that is most troublesome. If those providing treatment and supervision of treatment are not properly skilled in evidence-based substance abuse treatment, increasing staffing may not increase the quality of substance abuse programs in CYA.