Appendix B

Lee, Trupin, *Farrell Experts' Report on Licensed Mental Health Beds in the California Division of Juvenile Justice*

Farrell Experts' Report on Licensed Mental Health Beds in the California Division of Juvenile Justice (2007)

(Terry Lee and Eric Trupin)

Introduction

The Mental Health Remedial Plan (pp. 35-45) requires the Division of Juvenile Justice (DJJ) to assess the adequacy of its resources for licensed bed mental health care in consultation with the undersigned Farrell mental health experts. This report sets forth the experts' initial assessment and recommendations.

The Mental Health Remedial Plan filed in August 2006 details DJJ's licensed mental health bed resources. The experts reviewed the information with DJJ headquarters and facility staff. DJJ has a 10-bed Correctional Treatment Center (CTC) at the Heman G. Stark Youth Correctional Facility for acute/crisis stabilization care. That facility began admitting patients in April 2006. It was serving only male youth (adolescent and adult) but DJJ sent one female youth there for acute/crisis stabilization level care in late 2006 or early 2007. According to DJJ Chief Psychiatrist, Dr. Ed Morales, the CTC is available as a last option for female youth. By Memorandum of Understanding (MOU) with Department of Mental Health (DMH), DJJ has access to 10 intermediate care inpatient beds in DMH hospitals for adult males and females and the 20-bed Intermediate Care Facility (ICF) for adolescent and adult males that Metro State Hospital operates at the Southern Youth Correctional Reception Center and Clinic (SYCRCC). DJJ has contracts for acute/crisis stabilization care with 2 private psychiatric hospitals that serve adolescent and adult males and females, one in northern California and one in southern California. It indefinitely suspended its use of its contract with the northern California hospital in July 2006, however.

DJJ houses approximately one-half of its approximately 2600 youth in four facilities in the Stockton area in northern California.[1] Their access to licensed bed care is limited by the lack of local licensed beds. Most of the licensed beds for DJJ youth are in southern California. The Heman G. Stark CTC is in Chino, California. The Metro ICF at SYRCC is in Norwalk. The 10 DMH inpatient beds are available to DJJ at any DMH facility with an available bed, including at Napa State Hospital in northern California but those beds are not available for acute/crisis stabilization. Since it suspended the use of its private psychiatric hospital contract in northern California, DJJ has transported northern California youth to the Stark CTC for acute/crisis stabilization psychiatric care, in some cases by air.

Process of Evaluation

The mental health experts were charged to perform a preliminary evaluation of the sufficiency of the numbers and type of licensed beds available to DJJ. The evaluation is preliminary because the many changes DJJ will undergo in the next few years are

[1] *See*, Attachment A. DJJ's census has been falling for many years and continued to fall over the course of the last fiscal year from about 3,000 to about 2,600 youth.

likely to affect referrals to licensed mental health beds. Also, utilization data and other relevant data will be more complete in the future. That data will be the basis for continuous assessment of the match between the need for licensed mental health care beds and the availability of such beds.

The changes that are anticipated as DJJ reforms may increase or decrease the need for and referrals to licensed beds. With planned improvements in conditions and treatment programs, youth now needing licensed beds might successfully be managed in residential treatment program or core unit beds in DJJ facilities. Increases in mental health and other treatment staff and improvements in screening and assessment have the potential to improve effectiveness of treatment in intensive and core treatment unit beds within DJJ and reduce the need for licensed beds; or to result in the identification of more youth with a need for care in a licensed mental health facility. Improvements in mental health and other treatment in DJJ might result in counties sending more youth to DJJ with mental health and other treatment needs which might increase the need for licensed beds. Utilization of and need for licensed beds must be tracked on an ongoing basis, as the Mental Health Remedial Plan provides.[2]

The mental health experts requested DJJ's documentation of licensed bed utilization and of circumstances and events that are indicators of unmet need. The list of documents requested is attached as Attachment B. DJJ provided the experts with most of the documentation that was requested, by substantial staff effort. The experts are working with DJJ to improve DJJ's ability to track utilization and project the need for licensed (and residential) mental health beds.

The experts visited seven of the eight DJJ facilities.[3] At each facility, they met with facility superintendents or their designees and other administrative staff, administrative/supervisory medical and mental health staff, psychiatrists and psychologists. They had a telephone conference with most of the same staff at the eighth facility, El Paso de Robles Youth Correctional Facility (YCF). During their site visits and telephone conference, the experts inquired of current mental health programming and specific programs, location of rooms for suicide watch and high risk observation, identities of youth on Suicide Watch (SW) and High Risk Observation (HRO) then and in the recent past, identities of youth with the greatest acuity of symptoms of mental illness, identities of youth who might currently benefit from transfer to a licensed mental health bed, identities of youth recently in need of placement in licensed mental health beds and outcomes, past experience with youth in need of licensed beds and how the needs were addressed, current need for and access to licensed mental health beds, and process for identifying youth with mental health needs in general and licensed mental health beds specifically.

The mental health experts obtained additional information from senior mental health clinical staff by an informal written survey.[4]

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[2] *See*, Mental Health Remedial Plan, p. 40-41, 45.

[3] They visited Heman G. Stark YCF October 19 – 20, 2006; Ventura YCF November 16; SYRCC November 17; Chaderjian YCF December 18; O.H. Close YCF and Dewitt Nelson YCF December 19; and Preston YCF January 18, 2007.

[4] *See*, Attachment C.

The experts visited all residential mental health program units except the Specialized Counseling Program (SCP) at El Paso de Robles YCF (the experts cancelled that site visit due to exigent circumstances). By questioning staff and youth, they identified youth then-housed at the facility who were thought by others to have the greatest acuity of symptoms of mental illness. They also visited the restricted program housing units at the seven sites they visited, and looked for youth that anyone perceived to have significant symptoms of mental illness. The experts either interviewed or reviewed medical records of approximately 75 youth who had been either treated in licensed bed facilities or identified as someone who might benefit from licensed bed care.

The mental health experts also toured the DMH-run ICF at SYCRCC and interviewed the ICF program manager and psychiatrist.

Observations and Findings

For the first nine months of 2006, DJJ logged 62 admissions to licensed mental health beds involving 43 youth.[5] Five youth had three admissions and nine youth had two admissions in the period, for a total of 19 second and third admissions. Eleven of the 19 repeat admissions for youth reflected changes in level of licensed bed care (not new referrals from DJJ facilities). Of the 50 admissions from DJJ facilities (moves from an unlicensed level to a licensed level of care), one was from El Paso de Robles YCF, 26 were from northern California (Stockton Complex and Preston) and 23 were from southern California (SYRCC, Heman G. Stark YCF, and Ventura YCF). Of the 62 total admissions, 34 involved 19 northern region youth, 24 involved 21 southern region youth, 1 involved an El Paso de Robles YCF youth and 3 involved youth whose region is not apparent. Northern California facilities accounted for 34 of the 62 total admissions, 19 of the 43 youth admitted, and 10 of the 14 youth with multiple admissions during the period. Southern California facilities accounted for 24 of the 62 total admissions, 21 of the 43 youth admitted, and three of the 14 youth with multiple admissions during the period.

Youth from northern California spent more time in licensed bed care, on average, 78 days per youth compared with 47 days for southern California youth. While it is tempting to attribute the significantly longer lengths of stay of northern California youth to the relative paucity of licensed mental health beds in northern California, more data analysis is required before drawing this conclusion.

Of the 43 youth admitted to licensed mental health beds, there were 11 juvenile males, one juvenile female, 30 adult males and one adult female. Of the 62 admissions, 29 were to the CTC at Stark (all male, juvenile and adult), 22 were to the ICF at SYRCC (all male, juvenile and adult), three were to DMH hospitals (adult males, Metro and Napa state hospitals) and eight (including male and female juveniles and adults) were to private hospitals (Aurora Vista Del Mar and Sierra Vista).

The experts do not have complete data for rejected referrals to licensed beds for the first nine months of 2006. DJJ logged four rejections in three months July to September 2006, all adult young men, two from northern California and two from

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[5] *See*, Attachment D. The individual who arranges the transfers to and from licensed bed facilities keeps the log. It does not seem likely that there were any unlogged admissions.

southern California. Three of the four rejected youth were subsequently accepted into a licensed bed facility.[6] There were no rejections due to a lack of empty beds in licensed facilities. Clinical staff generally reported difficulty in getting licensed bed facilities (including the DJJ-controlled CTC) to accept patients with significant externalizing behaviors and/or "primarily Axis II (from Diagnostic and Statistical Manual (DSM)) issues."

The experts reviewed available information on incidents of self-harm. For 2006, the information is incomplete. DJJ has not had a systematic method of recording information about incidents in a uniform way and making the information retrievable. DJJ provided a summary of self-harm incidents recorded in Serious Incident Reports for the period July 1 to September 30, 2006, reflecting 21 incidents during that period and one incident involving the use of force.[7] The *Farrell* Office of the Special Master provided a summary of incidents for the same period, from Serious Incident and use of force reports, reflecting 33 incidents including 14 involving use of force.[8] The experts expect more complete and reliable information on incidents of self-harm as they continue to assess the licensed bed need and resource.

There were few uses of restraint chairs in 2006. One young woman was placed in a restraint chair at Ventura YCF in September 2006 for approximately 3 hours.[9]

DJJ's expressed policy, formulated in collaboration with state and local stakeholders, is to divert youth with serious mental disorders who require long-term licensed bed mental health care.[10] From June to October 2006, DJJ's Chief Psychiatrist reviewed eight cases of youth with indications of serious mental illness or developmental disability, leading to the admission to DJJ of six of the eight.[11]

During site visits, DJJ staff from three different facilities (Preston YCF, Stark YCF and Ventura YCF) described 3 instances of using oleoresin capsicum spray on youth who were engaging in non-lethal self-harm behavior. In these instances, the staff reported that the self-harm behavior ceased. In two of the three instances, the custody staff members indicated that the youth were not place on High Risk Observation or Suicide Watch, because the youths were no longer engaging in self-harm behavior. In the third instance, the staff reported the youth was placed on Suicide Watch. The use of oleoresin capsicum spray in response to self-harm behavior was not uniformly inquired about at every unit visited; staff at three facilities reported this practice when asked about recent self-harm behavior. Additional incidents are documented in the Attachment G summary of incidents prepared by the Farrell Office of the Special Master. The mental health experts have asked DJJ to more systematically track the use of oleoresin capsicum spray in response to self-harm behavior.

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[6] *See*, Attachment E.
[7] *See*, Attachment F.
[8] *See*, Attachment G
[9] *See*, Attachment J. The experts learned of no other uses of restraint chairs during site visits.
[10] The guidelines for diverting seriously mentally ill youth to alternate placements are set forth in TDO 06-70, attached hereto as Attachment H.
[11] *See*, Attachment I.

A chart review of one of the charts at Ventura YCF revealed an old (the order was relatively brief and no longer in effect) standing order for involuntary administration of medication. There was not evidence of a court process leading to this order. The use of involuntary medications is appropriate only during emergency situations; standing orders for involuntary medications without a court order are not acceptable. This was discussed with the DJJ Chief Psychiatrist. The mental health experts asked DJJ for a list of youth given emergency involuntary psychiatric medications at the beginning of this process; this is information DJJ will try to track more systematically.

DJJ personnel from all interviewed facilities consistently described difficulties accessing beds at the ICF at SYCRCC. They related that the ICF typically refuses admission to youth who are aggressive and/or have "primarily Axis II issues." The ICF program administrator also expressed frustration over the situation, stating that the contract was not set up to treat the youth most frequently referred for admission. The low census on the ICF was a concern to her. She expressed a willingness to change the nature of the ICF to better serve youth in DJJ custody, if there is a corresponding change in the contract to provide appropriate staffing and programming. DJJ mental health professionals described problems with receiving information from the ICF when youth are transitioning from the ICF back to DJJ facilities. Despite sharing a building with and essentially hosting the ICF, SYCRCC staff related that the only information typically received from the ICF is a brief email notification that the youth will be transferred back to SYCRCC in a number of days.

DJJ personnel also described various barriers and concerns relative to admitting DJJ youth to licensed mental health beds at contracted community hospitals. One group of concerns relate to potential for "secondary gain" from more permissive or favorable conditions in a community hospital, relative to conditions in DJJ facilities, such as mixed gender facilities and smoking privileges, and the possibility that peers will mimic behaviors to experience the more favorable conditions of community hospitals. Other DJJ mental health professionals expressed concerns over the ability and willingness of the community hospitals to treat the patients with significant externalizing behaviors and/or "primarily Axis II (from Diagnostic and Statistical Manual (DSM)) issues" which are common among DJJ referrals to licensed beds. The combination of these concerns led to the indefinite suspension of the community hospital contract through which DJJ was providing crisis/acute services to northern California youth. Some DJJ mental health professionals worry that some community hospital staff members may not treat DJJ youth as well as non-DJJ youth. Youth transitions from community hospitals were described as variable. Good communication with community hospital personnel was described as occurring some of the time. DJJ mental health professionals described other examples of less than ideal transitions, with limited communication and transfer of information. The experts were able to review some of the charts of youth who had been admitted to community hospitals; there were a few that did not appear to contain psychiatric discharge summaries and DJJ mental health and health care professionals were also unable to locate discharge summaries in these instances.

DJJ personnel described a history of problems with admitting youth to the CTC, due to relatively rigid and complicated admission procedures. Since approximately November or December of 2006, DJJ Headquarters and the CTC have made a concerted effort to facilitate easier access to the CTC. The exchange of information between the

referring DJJ treatment units and the CTC was not always seamless. For instance, in one chart review, referring facility documentation clearly characterized a referred youth's cognitive functioning as being low. The CTC treating professionals' admission notes for this youth did not reflect awareness that the youth had compromised cognitive functioning. After admission, the progress notes indicated the CTC treating professionals began to question whether the youth had cognitive limitations.

DJJ personnel report that the current plan for admitting females to the Stark CTC involves separating males from females, because males and females are not allowed to mix in other DJJ programs and concerns regarding secondary gain. Given the relatively low number of females referred and admitted to the Stark CTC at any one point in time, there is a high likelihood that females admitted to the Stark CTC will be programming alone.

Given limited access to other licensed mental health beds, DJJ personnel expressed appreciation for having the CTC as an option. However, mental health professionals at northern California facilities related that they were reluctant to move youth away from their families at a time when family support and involvement in treatment are critical. Other concerns include the logistics of the transfer, and associated delays of one to three days from initiating a referral until physical transfer of the youth. Mental health professionals in northern California facilities reported that they have a higher threshold for admitting youth to the CTC in southern California, relative to a hypothetical licensed mental health bed in northern California.

In evaluating youth internalization and generalization of treatment, interviewed youth were not able to consistently describe skills or coping strategies that they learned in DJJ treatment that they would use to address self-harm urges and/or aggressive and/or impulsive behavior. DJJ mental health professionals reported that there is not one treatment approach used in DJJ, and described treatment approaches that are relatively individualized and idiosyncratic to the mental health professional; when youth move between programs and levels of care, the treatment approach may change. The various therapeutic approaches described as being used for suicidal or self-harming youth in DJJ facilities were typically not based on empirically supported treatments or principles.

DJJ had access to many more licensed care beds than it used during the period monitored, roughly twice as many.[12] Though the experts found many youth who were receiving substandard care for their mental health conditions, they identified few who needed a licensed bed level of care at the time of the facility visit. One youth, who was being assessed and treated by a psychologist on Suicide Watch, was identified by the mental health experts as being in need of a licensed mental health bed. After discussion with the DJJ Chief Psychiatrist, the youth was transferred shortly afterwards. Another youth was already identified by the facility staff, but was having difficulties accessing a licensed bed; this youth also transferred shortly afterwards.

It does not appear at this time that the current number of licensed beds is insufficient for the current youth population of approximately three thousand or fewer. However, there are problems with the current distribution and utilization of licensed beds.

DJJ needs a more local resource for crisis/stabilization and intermediate licensed care for northern California youth. DJJ needs to assure appropriate and reliable licensed

[12] *See*, Mental Health Remedial Plan, pp. 36-37 and Attachment D.

mental health bed resource for females. Youth need an evidence-based integrated treatment approach that is more uniform throughout DJJ facilities and levels of care. Transfer of youth and corresponding information between DJJ and licensed mental health care treatment programs must be more facile.

Recommendations

The many caring, dedicated and hard-working people in DJJ who are committed to providing good care to the youth in DJJ are to be recognized. However, mental health care remains substandard throughout DJJ facilities.

Given the current contracts, overlap in missions and clinical populations treated and the potential for synergies in program development, the executive manager of DJJ should meet with the executive manager of DMH and plan the future collaboration regarding placement of DJJ youth in DMH beds in the ICF and state hospitals, and broader strategies for youth with mental health needs and juvenile justice involvement. The state agencies should examine whether they can collaborate more effectively to meet more of DJJ's need for licensed bed care.

DJJ needs to more actively and assertively manage contracts with DMH and community hospitals. This includes appropriate language to ensure that DJJ youth will be served by contract beds, monitoring the clinical services of contracted providers, and regular meetings to discuss, develop and address problems with collaboration.

For youth in northern California, DJJ must develop a CTC, or contracts with community providers which ensure admission and no premature discharge ("no reject, no eject"). DJJ must assure similarly appropriate and accessible licensed mental health bed resources—a CTC or "no reject, no eject" admissions with community providers—for females. Given that there are considerably more male youth in northern California than females and current consideration for contracting out secure residential placement for females, DJJ may or may not arrive at different solutions for the 2 populations. If secure residential placement for females is contracted out, potential contracted providers should demonstrate access to licensed mental health beds.

DJJ should renegotiate the contract with the ICF to provide a service that is more appropriate and useful for a larger number of youth in DJJ facilities. The ICF administrator expressed openness to serving a qualitatively different group of youth if additional resources were provided. Depending on the results of these negotiations, DJJ might explore options for running its own licensed intermediate level of mental health care.

DJJ should also examine the feasibility and utility of creating licensed mental health beds that are a hybrid of the acute and intermediate lengths of stay, in order to benefit from simplification and economy of scale. This will include reviewing the CTC and ICF regulations. If DJJ determines this is not allowed, feasible or useful, then DJJ should explain why to the mental health experts.

Given one instance of not identifying a youth appropriate for licensed mental health care and some indicators (such as use of oleoresin capsicum spray in response to self-harm behavior) possibly suggesting a relatively small under-identification of youth appropriate for licensed mental health beds, DJJ needs to improve identification of youth in need of licensed mental health levels of care. Staff should be trained on signs and

symptoms appropriate for consideration of referral to licensed mental health beds. Senior mental health staff, such as two psychologists and one psychiatrist, should be identified at each facility to serve as expert screeners for licensed mental health beds. DJJ should consider administering a brief structured instrument such as the CALOCUS on a regular basis to all youth in DJJ facilities to more systematically and uniformly assess functioning and mental health need, and improve on accuracy of the psychiatric screening and assessment process by implementing the V-DISC. When access to licensed mental health beds is improved, DJJ mental health professionals will regard identification of youth requiring this level of care as being more meaningful. Access to licensed mental health beds needs to be communicated on a regular basis to mental health professionals until they routinely consider this level of care in treatment planning.

DJJ needs to develop and implement a more uniform, coherent and evidence-based therapeutic model for the youth in its custody, especially youth in mental health treatment programs and/or youth with elevated suicide risk. Initial training in cognitive-behavioral therapy and behavioral analysis will benefit youth in DJJ custody more immediately, and form a good foundation for the subsequent implementation of the DJJ Integrated Behavior Treatment Model.

Dated: May 30, 2007

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Terry Lee, M.D.
Eric Trupin, Ph.D.

Attachments

A – Weekly Population Reports 5-16-2007 and June 30, 2006

B – List of documents relevant to the analysis of the need for licensed bed care, requested of DJJ

C – Survey Questions for Senior Clinical Staff

D – Log, Psychiatric Inpatient Bed Utilization, January 1 – September 30, 2006

E – DJJ Log, Rejected Referrals to Non-DJJ licensed bed facilities

F --DJJ Log, Incidents of Self-Injury July 1 – September 30, 2006

G – OSM Chart, Incidents of Self-Injury July 1 – September 30, 2006

H -- TDO 06-70, Acceptance and Rejection Criteria for Youth with Medical or Mental Health Conditions

I – DJJ Log, Pre-Acceptance Reviews (youth with medical and mental health conditions)

J – DJJ Log, Restraint Chair

Attachment A

Weekly Population Reports 5-16-2007 and June 30, 2006

DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE
INFORMATION SYSTEMS UNIT - OBITS

Weekly Population Report as of May 16, 2007

INSTITUTIONS	DESIGN CAPACITY	FY 2006-07 BUDGET 05/2007	ACTUAL POP 5/16/2007	VARIANCE FROM BUDGET	PERCENT OF DESIGN CAPACITY
SYCRCC **	350	219	234	15	67%
N. A. CHADERJIAN	600	392	240	-152	40%
FRED C. NELLES	650	0	0	0	0%
O.H. CLOSE	379	178	236	58	62%
EL PASO DE ROBLES	690	203	181	-22	26%
KARL HOLTON	388	0	0	0	0%
DEWITT NELSON	433	246	327	81	76%
PRESTON	720	374	380	6	53%
HEMAN G. STARK	1200	688	738	50	62%
VENTURA - MALE	381	60	86	26	23%
VENTURA - FEMALE	295	201	142	-59	48%
PINE GROVE	80	78	83	5	104%
TOTALS	6,166	2,639	2,647	8	43%

** The ward population includes 26 contract ("J") cases from Los Angeles County.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
JUVENILE JUSTICE DIVISION - RESEARCH
INFORMATION SYSTEMS UNIT - OBITS

Monthly Population Report as of June 30, 2006

INSTITUTIONS	DESIGN CAPACITY	AVAILABLE CAPACITY*	FY 2005-06 BUDGET 06/2006	ACTUAL POP 6/30/2006	VARIANCE FROM BUDGET	PERCENT OF DESIGN CAPACITY	PERCENT OF AVAILABLE CAPACITY
NYCRCC	326	0	0	0	0	0%	0%
SYCRCC **	350	218	243	271	28	77%	124%
N. A. CHADERJIAN	600	454	425	311	-114	52%	69%
FRED C. NELLES	650	0	0	0	0	0%	0%
O.H. CLOSE	379	235	239	234	-5	62%	100%
EL PASO DE ROBLES	690	183	231	209	-22	30%	114%
KARL HOLTON	388	0	0	0	0	0%	0%
DEWITT NELSON	433	253	364	358	-6	83%	142%
PRESTON	720	308	483	424	-59	59%	138%
HEMAN G. STARK	1200	689	699	819	120	68%	119%
VENTURA - MALE	381	80	56	58	2	15%	73%
VENTURA - FEMALE	295	115	135	129	-6	44%	112%
PINE GROVE	80	80	80	74	-6	93%	93%
TOTALS	6,492	2,615	2,955	2,887	-68	44%	110%

* Available capacity includes only living units currently *budgeted* to be open.

** The ward population includes 27 contract ("J") cases from Los Angeles County at SYCRCC.

Attachment B

List of documents relevant to the analysis of the need for licensed bed care, requested of DJJ

OFFICE OF THE SPECIAL MASTER
FARRELL v. HICKMAN
605 MARKET STREET, NINTH FLOOR
SAN FRANCISCO, CALIFORNIA 94105-3211
EMAIL lodb@earthlink.net
Tel.: (415) 348-0853; Facs.: (415) 495-7204

MEMORANDUM

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TO: Monica Anderson, Michael Hanretty, Katie Riley, Eleanor Silva, Ed Morales, Margaret Wall
FROM: Donna Brorby
DATE: October 6, 2006 (sent October 10, 2006)
RE: Documentation Requested For Site Visits By Mental Health Experts
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As we have discussed, Drs. Trupin and Lee are about to visit all facilities in connection with developing their opinions about DJJ's need for licensed inpatient beds. DJJ provided information in May responding to the request I made on their behalf, to the extent that it could. Not all information requested was retrievable. This is to request an update of the information requested, to the extent that DJJ is able to provide it. In connection with the site visits, we would like to work with DJJ to develop a list of documents/information that might track and produce in its quarterly reports for the mental health experts.

For the most recent quarter (July 1 – September 30, 2006), please produce to the extent that you can:

1. A list of DJJ youth who have spent any time in facilities outside of DJJ for psychiatric reasons, and associated documentation. This includes DMH facilities (including the ICF located at a DJJ facility), private hospital acute care beds, and emergency rooms. Drs. Trupin and Lee would like to have all reasonably available documentation of the reasons for referral, acceptance, discharge, evaluation (admission and discharge summaries, if possible). Please show dates of admission and discharge in a way that makes it easy to identify youth with multiple admissions. Please also show the youth's facility, mental health program assignment and whether the youth was on restricted program status immediately before his transfer and immediately after his discharge.

2. A list of DJJ youth who have been rejected or administratively discharged by any facility outside of DJJ (see above), when DJJ has referred them for psychiatric reasons, and associated documentation. Please show dates of referral in a way that makes it easy to identify multiple referrals and rejections. We are especially interested in the reasons for referral, indications of the youth's condition, and reasons for rejection. Please also show the youth's facility, mental health program assignment and whether the youth was on restricted program status immediately before his transfer and immediately after his discharge.

3. For each facility, an alphabetized list of youth on high risk observation, suicide watch and crisis watch, showing date entered and left each status, and mental health level of care before youth entered observation/watch status, and level of care to which discharged.

4. A list of youth who have had time-adds to receive mental health care or because they are mentally ill, and mental health program assignments during initial incarceration and after time add.

5. A list of youth on the mental health caseload who are serving "time-add" time for reasons other than to receive mental health care or because they are mentally ill.

6. A list of youth referred to DJJ by a county but rejected by DJJ for reasons of mental illness, with related documentation (enough to depict reasons for rejection and the youth's mental health status).

7. A log of youth referred to an MH level of care, with date of referral and date of placement. (A trackable waiting list.)

8. Two lists of youth who have gestured or committed self-injurious acts, by facility, with date, nature of act, nature of injury, what if any medical treatment was needed, what if any force was used, the mental health level of care for the youth before and after the incident, whether the youth was in restricted program status before and after the incident. The lists should be the same except one should be sorted chronologically and the other alphabetically list. By "gestured" self-injurious act, we mean incidents where there appears to be an attempt to harm oneself, such as having a rope around one's neck, even if there has not yet been any self-harm.

9. All Serious Incident Reports for incidents of self-harm. Please let us know if there are other documents that are available to document incidents of self-harming behavior.

10. A list of youth receiving anti-psychotic medication with medication and dosage. The list should separately show youth who have been injected with psychotropic medication and whether the youth was assigned to a residential mental health program before and/or after the incident. *Per 10/17 email, Doug Ugarkovich noted that Dr. Lee made an additional request, for "the number and names of mental health wards that had been chemically restrained during this last quarter." I had thought that was included here, but maybe the phraseology should be changed.*

11. A list of youth on mental health caseload in restricted program housing for the same date each month of the quarter.

12. A list of youth put in a restraint chair or in 5 point restraints, by facility. The list should show the mental health level of care for the youth before and after the incident, and all other force used. Related use of restraint reports should be produced.

For all of 2006, please provide:

13. A list of youth referred to licensed beds by Dr. Morales, and all associated documentation (see ## 1 and 2 above).

Drs. Trupin and Lee would appreciate as much information as possible from Stark before they go there October 19 and 20, and all of this information that can be produced as soon as DJJ can arrange that comfortably (before the November 16 –17 site visits). When DJJ is ready, let's arrange a conference call to discuss DJJ's plans for producing information in response to this request, and what can be arranged to be produced on a quarterly basis.

Attachment C

Survey Questions for Senior Clinical Staff

Questions for DJJ Clinicians

Since we are asking questions of the senior mental health staff, it might be an opportune to ask the more general questions 1-5. If these types of questions have already been asked previously and/or they are redundant to other efforts, they can be omitted. Questions 6-9 are more specific to the task at hand.

1. What is working well in the DJJ mental health system; what are the strengths of the DJJ mental health system?
2. As DJJ reforms its mental health system, what aspects of the current system should be maintained in some form?
3. What are the most important things to change in the DJJ mental health system?
4. What would help you to be more effective in your job?
5. Are there additional trainings, skills, tools, administrative modifications or therapeutic interventions that would be helpful?
6. Do you feel the current system is well-equipped to serve the wards in DJJ with the most severe mental health needs?
   a. If so, please describe the critical components of the DJJ mental health system for wards with severe mental health needs (such as particular therapeutic approach, ability to staff intensely, physical aspects of facility, involuntary medications, etc).
   b. If not, what else would be helpful in working with and treating this population?
7. Is there a need for therapeutic restraints within DJJ facilities?
8. Does the current therapeutic restraint system (therapeutic restraints used at the Stark CTC, youth at other DJJ facilities transferred to outside psychiatric units if therapeutic restraints required; restraint chair currently being used at 2 facilities for <90 days, but for purposes of this discussion, assume no use of restraint chair in "current" system) work well?
9. Would the wards in DJJ be better served if DJJ had the ability to use therapeutic restraints within DJJ facilities (beyond the Stark CTC)?

Attachment D

Log, Psychiatric Inpatient Bed Utilization,

January 1 – September 30, 2006

Psychiatric Inpatient Bed Utilization

January 1, 2006 Thru September 30, 2006

Region	YA#	Admitted	Age Upon	Referred from:		RP Before			Discharged To:		RP After	Days At This
		To:	Admission	Facility	LOC	Admission?	Date Admitted	Date D/Ced	Facility	LOC	Discharge?	LOC (thru 9/30/06)
3 N		**CTC**	21	NAC	ITP	**NO**	8/3/2006	8/18/2006	SRCC	ICF	**NO**	15
3 N		**CTC**	15	PYCF	ITP	**NO**	7/19/2006	8/31/2006	SRCC	ICF	**NO**	43
4 N		**CTC**	20	HGS	GP	**NO**	5/18/2006	6/13/2006	HGS	ITP	**NO**	26
8 N		**Aurora**	22	VYCF	ITP	**YES**	6/8/2006	6/27/2006	VYCF	ITP	NO	19
8 N		**CTC**	18	NAC	ITP	**NO**	7/12/2006	7/27/2006	NAC	ITP	**NO**	15
13 N		**CTC**	22	Parole	Acute	**NO**	5/12/2006	6/7/2006	SRCC	ICF	**NO**	26
13 N		**CTC**	23	HGS	GP	**NO**	9/21/2006	9/27/2006	HGS	ITP	**NO**	6
13 N		**CTC**	20	HGS	ITP	**NO**	4/20/2006	5/24/2006	SRCC	ICF	**NO**	34
17 N		**CTC**	20	MSH	Interm.	**NO**	6/30/2006	7/5/2006	PYCF	SBTP	**NO**	5
17 N		**CTC**	20	HGS	ITP	**YES**	9/20/2006	10/3/2006	HGS	ITP	**NO**	13
17 N		**CTC**	17	SVH	Acute	**NO**	6/11/2006	6/27/2006	SRCC	ICF	**NO**	16
20 N		**Aurora**	17	VYCF	SCP	**NO**	9/25/2006	9/28/2006	VYCF2	ITP	**NO2**	3
20 N		**CTC**	18	NAC	SCP	**NO**	6/16/2006	7/5/2006	NAC	ITP	**NO**	19
20 N		**SVH**	18	NAC	SCP	**NO**	6/16/2006	7/7/2006	NAC	ITP	**NO**	21
22 N		**CTC**	23	HGS	ITP	**NO**	6/28/2006	7/7/2006	HGS	ITP	**NO**	9
22 N		**CTC**	16	SRCC	ITP	**NO**	6/9/2006	6/27/2006	SRCC	ITP	**NO**	18
23 N		**CTC**	20	NAC	SCP	**NO**	7/27/2006	8/16/2006	SRCC	ICF	**NO**	20
23 N		**CTC**	18	HGS	GP	**NO**	4/21/2006	5/5/2006	WVDC	SCP	**NO**	14
23 N		**ICF**	22	HGS	CTC	**NO**	6/7/2006				*N/A*	116
24 N		**CTC**	24	HGS	GP	**NO**	5/5/2006	5/11/2006	HGS	ITP	**NO**	6
26 N		**CTC**	20	PYCF	SBTP	**NO**	7/25/2006	9/6/2006	WVDC	SBTP	*N/A*	43
28 N		**CTC**	23	HGS	ITP	**NO**	8/29/2006	8/31/2006	HGS	ITP	**NO**	2
28 N		**CTC**	19	NAC	ITP	**NO**	8/22/2006	8/30/2006	HGS>NAC	SCP	**NO**	8
31 N		**CTC**	19	NAC	ITP	**NO**	8/11/2006	8/23/2006	NAC	ITP	**NO**	12
31 N		**CTC**	16	SRCC	ITP	**NO**	9/1/2006	9/13/2006	PYCF	SBTB	**NO**	12
31 N		**SVH**	19	NAC	ITP	**NO**	7/24/2006	8/4/2006	NAC	ITP	**NO**	13
33 N		**CTC**	20	NAC	ITP	**NO**	8/1/2006	8/30/2006	NAC	ITP	**NO**	29
34 N		**CTC**	20	HGS	ITP	**NO**	5/11/2006	5/15/2006	HGS	ITP	**NO**	4
37 N		**CTC**	20	HGS	GP	**NO**	5/25/2006	6/7/2006	HGS	ITP	**NO**	13
43 N		**CTC**	20	NAC	ITP	**NO**	7/6/2006	8/2/2006	NAC	ITP	**NO**	27
45 N		**CTC**	18	PYCF	SBTP	**NO**	7/22/2006	8/3/2006	NAC	ITP	**NO**	12
49 N		**CTC**	20	NAC	ITP	**NO**	4/27/2006	5/19/2006	NAC	ITP	**NO**	22
49 N		**CTC**	16	EPdR	SCP	**NO**	9/19/2006	10/17/2006	SRCC	ICF	**NO**	28

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51 N	**CTC**	20	HGS	ITP	**NO**	5/19/2006	5/31/2006	HGS	ITP	**NO**	12
1 S	**ICF**	21	HGS	CTC	**NO**	8/18/2006				*N/A*	44
2 S	**ICF**	20	HGS	CTC	**NO**	8/16/2006				*N/A*	46
5 S	**ICF**	18	PYCF	ITP	**NO**	3/17/2006				*N/A*	197
5 S	**ICF**	15	PYCF	ITP	**NO**	1/26/2006	5/26/2006	PYCF	ITP	**NO**	119
7 S	**ICF**	17	SRCC	ITP	**NO**	1/31/2006	4/10/2006	SRCC	ITP	**NO**	69
9 S	**ICF**	18	SVH	Acute	**NO**	2/9/2006	3/15/2006	PYCF	SBTP	**NO**	33
10 S	**ICF**	18	HGS	ITP	**NO**	2/14/2006	5/16/2006	HGS	SCP	**NO**	91
11 S	**ICF**	19	NAC	SCP	**NO**	6/15/2006	8/3/2006	NAC	ITP	**NO**	47
12 S	**ICF**	20	HGS	CTC	**NO**	5/24/2006	6/14/2006	PYCF	SBTP	**NO**	21
15 S	**ICF**	19	SRCC	ITP	**NO**	3/6/2006	7/12/2006	SRCC	ITP	**NO**	128
18 S	**ICF**	17	PYCF	ITP	**NO**	5/23/2006	9/27/2006	PYCF	ITP	**NO**	127
25 S	**ICF**	20	HGS	CTC	**NO**	5/19/2006	6/14/2006	NAC	ITP	**NO**	26
27 S	**ICF**	18	SRCC	SOP	**NO**	5/12/2006	6/23/2006	SRCC	ITP	**NO**	42
27 S	**ICF**	17	PYCF	ITP	**YES**	7/27/2006	9/27/2006	PYCF	ITP	**NO**	62
29 S	**ICF**	21	NAC	ITP	**NO**	4/20/2006				*N/A*	173
29 S	**ICF**	17	PYCF	ITP	**NO**	8/24/2006				*N/A*	38
32 S	**MSH**	20	NAC	ITP	**NO**	4/28/2006	6/30/2006	SRCC	ICF	**NO**	63
39 S	**ICF**	18	SRCC	ITP	**NO**	4/18/2006				*N/A*	166
41 S	**ICF**	15	HGS	CTC	**NO**	8/31/2006				*N/A*	31
42 S	**ICF**	17	HGS	CTC	**NO**	6/27/2006				*N/A*	96
46 S	**ICF**	17	SRCC	GP	**NO**	8/15/2006				*N/A*	47
50 S	**ICF**	19	SRCC	ITP	**NO**	5/17/2006	8/16/2006	SRCC	ITP	**NO**	91
53 S	**NSH**	18	SRCC	ITP	**NO**	1/20/2006	7/19/2006	NSH	DMH	**NO**	150
56 S	**NSH**	19	SRCC	ICF	**NO**	3/14/2006	9/11/2006	NSH	DMH	**NO**	181
16	**SVH**	19	NAC	SCP	**NO**	5/31/2006	6/15/2006	SRCC	ICT	**NO**	15
19	**SVH**	18	NAC	ITP	**NO**	1/31/2006	2/9/2006	SRCC	ICF	**NO**	10
19	**SVH**	17	PYCF	ITP	**NO**	5/26/2006	6/11/2006	HGS	CTC	**NO**	16
55	**SVH**	15	PYCF	GP	**NO**	6/27/2006	7/11/2006	PYCF	ITP	**NO**	14