OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

• PROMOTING INTEGRITY •

REVIEW OF THE INTENSIVE TREATMENT PROGRAM

CALIFORNIA YOUTH AUTHORITY

NOTE: INFORMATION IN THIS REPORT HAS BEEN REDACTED FOR REASONS OF CONFIDENTIALITY

NOVEMBER 2002

GRAY DAVIS, GOVERNOR

State of California

Office of the Inspector General
801 K Street, Suite 1900
Sacramento, CA 95814

Memorandum

Date: November 4, 2002

To: JERRY L. HARPER, Director
California Youth Authority

From: STEVE WHITE
Inspector General

Subject: REVIEW OF THE INTENSIVE TREATMENT PROGRAM OF THE CALIFORNIA YOUTH AUTHORITY

Enclosed is the final report of the review conducted by the Office of the Inspector General of the California Youth Authority's intensive treatment program. Comments of the California Youth Authority submitted in response to the draft report are included in the final report as an attachment. We have also reviewed suggestions submitted separately by the department for technical changes to the wording of the report and have taken into account those suggestions in preparing the final version. Please note that confidential information pertaining to California Youth Authority wards has been redacted from the report.

If you have any questions, please do not hesitate to contact me.

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency

OFFICE OF THE INSPECTOR GENERAL

STEVE WHITE, INSPECTOR GENERAL

• *PROMOTING INTEGRITY* •

REVIEW OF THE INTENSIVE TREATMENT PROGRAM

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REPORT

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EXECUTIVE SUMMARY

This report presents the results of a review conducted by the Office of the Inspector General of the California Youth Authority's intensive treatment program, which is intended to provide treatment to wards with significant mental health disorders. The review was performed under the oversight responsibility for departments and boards within the Youth and Adult Correctional Agency provided to the Inspector General under *California Penal Code* Section 6126. The Office of the Inspector General conducted the review in consultation with representatives of the National Council on Crime and Delinquency.

The Office of the Inspector General undertook the review in the awareness that mental illness is pervasive among incarcerated youths, including California Youth Authority wards, and that its prevalence both helps to explain delinquent behavior and provides an opportunity for rehabilitation through effective treatment. The purpose of the review was to determine whether the mental health treatment needs of California Youth Authority wards are being effectively identified and addressed in a timely manner. The review was also prompted in part by an earlier examination by the Office of the Inspector General of the department's "23 and 1" detention policies and subsequent observations about the extended detention of wards known to have mental health problems and the absence of psychiatric treatment for wards in institution lock-up units. The suicides in 2001 of two California Youth Authority wards under circumstances that indicated the wards might have had significant unmet mental health treatment needs lent further impetus to the review.

In recent months, two other studies of the California Youth Authority's mental health system have been conducted—a study by a team of researchers from Stanford University, released in December 2001, and a study by experts in the constitutional requirements for mental health treatment in correctional settings, commissioned by the department and released in July 2001. The present review by the Office of the Inspector General both benefited from and builds on those studies.

As a result of the review, the Office of the Inspector General found that, overwhelmingly, wards participating in the intensive treatment program reported favorably on the treatment provided, expressing the belief that the program was helpful to them in overcoming their problems. Far from resisting treatment, the wards appeared to welcome it—a response that might be an indicator of the potential receptivity of the ward population as a whole to more widely available mental health treatment services. The review also revealed, however, that the intensive treatment program presently serves only a small percentage of wards suffering from severe forms of mental illness and that the treatment provided is generally substandard. The Office of the Inspector General acknowledges that during the course of this review, partly in response to earlier studies, the California Youth Authority has recognized and has sought to remedy some of these deficiencies. Those efforts are described in the report.

Specifically, the Office of the Inspector General found the following:

FINDING 1. The Office of the Inspector General found that under existing practices the California Youth Authority's intensive treatment program cannot accommodate all wards needing intensive mental health services.

As presently constituted, the California Youth Authority's intensive treatment program falls far short of providing needed services to all wards under the department's jurisdiction who suffer from moderate to severe mental illness. Instead, the vast majority of wards needing mental health treatment are housed in the general population, where, for the most part, they receive no mental health services at all. Failure to provide adequate mental health treatment to wards who need it not only undermines the ability of the department to rehabilitate offenders and prepare wards for release back into the community, but also exposes the department to the prospect of lawsuits for violation of constitutional mandates to provide needed treatment. Mental health consultants to the department have suggested, however, that changes in the department's use of existing intensive treatment beds, improvements in staffing, and broader distribution of treatment services could significantly alleviate the deficiencies.

FINDING 2

The Office of the Inspector General found that the process used by the California Youth Authority to screen wards for placement in the intensive treatment program fails to ensure that all wards needing intensive treatment are identified and receive the necessary treatment.

Until January 2000 when the California Youth Authority adopted a new screening tool for the intensive treatment program, the department consistently had a waiting list of as many as 30 wards for entry into the program. Once the new tool began to be used, the waiting list vanished. The department now points to the fact that there are no wards on the intensive treatment program waiting list as evidence that all wards needing intensive treatment are receiving it. The Office of the Inspector General found instead that the department's process for identifying wards in need of intensive treatment fails to identify all those who need intensive treatment program services and that the absence of a waiting list may be a symptom of the problem rather than evidence that the problem does not exist.

Under existing California Youth Authority policy, the formal process of identifying wards for assignment to the intensive treatment program takes place during reception center intake. Although wards also can be recommended for placement in the intensive treatment program at a later point in their incarceration, there are no consistent procedures for intensive treatment program placement once the intake process is completed. At present, the gateway to the intensive treatment program is a score of 40 or below on the global assessment of functioning examination, which provides a 100-point scale for measuring psychological, social, and occupational function. Department policies and procedures provide that the global assessment of functioning be administered to any ward identified as needing an in-depth mental health evaluation. In fact, however, a large percentage of wards with mental health problems never receive a global assessment of functioning examination at intake and therefore may never be screened for entry into the intensive treatment program. Moreover, mental health experts have questioned the use of the global assessment of functioning as the only screening tool for the intensive treatment program. In response, the department is in the

process of implementing a new screening mechanism, which is designed to provide a broader measure of a ward's mental health and behavior.

FINDING 3

The Office of the Inspector General found that treatment services provided to wards in the intensive treatment program are limited in scope, lacking in planning, poorly documented, and generally deficient in quality.

The treatment portrayed in the written descriptions of the intensive treatment programs bears little resemblance to the treatment actually provided to the wards. The program descriptions typically promise a range of treatment methods and an individualized treatment plan for each ward. In reality, treatment is limited for the most part to one or two hours a week of group therapy and individual counseling provided by a youth correctional counselor with little counseling expertise or training. Individualized treatment plans are nonexistent. Wards may see a psychologist only once a month, if that, and—if they are on psychotropic medication—may also see a psychiatrist periodically, usually about once a month. Treatment is poorly documented and there appears to be little communication and coordination between staff psychologists and psychiatrists or between the youth correctional counselors and the professional staff. In general, treatment is substandard.

FINDING 4

The Office of the Inspector General found serious deficiencies in the handling by mental health clinicians of suicidal wards in the intensive treatment program.

Intensive treatment wards are at high risk for suicide. Yet, the review showed that members of the intensive treatment program mental health staff consistently failed to document important information about wards referred for suicidal evaluation, failed to specify recommended treatment for wards, and failed to communicate to the custody staff how the wards should be monitored.

FINDING 5

The Office of the Inspector General found a lack of follow-up care for wards leaving the intensive treatment program.

The Office of the Inspector General found that 69 percent of the 221 wards leaving the intensive treatment program during the twelve months preceding the review were either transferred to the general population or released on parole. The statistics show that the majority of intensive treatment program wards leaving the program are likely to receive no further treatment for their mental illness at the California Youth Authority.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following actions:

- **Require the reception centers to develop computerized tracking systems to ensure that every ward receives a treatment needs assessment within specified time limits.**

- **Institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.**

- **After the first six months of operation, conduct a thorough evaluation of the Special Program Assessment Needs system to assess its efficacy in identifying wards with specific mental health treatment needs.**

- **Continue to pursue efforts to institute mental health treatment according to the continuum of care model, including extending treatment services to all California Youth Authority wards, with treatment levels closely tied to mental health treatment needs.**

- **Continue efforts to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education training for psychiatrists, psychologists and other members of the mental health staff.**

- **Require the development of comprehensive treatment plans for all intensive treatment program wards.**

- **Institute quality control procedures and monitoring to ensure that constitutional standards of mental health treatment and documentation are met.**

- **Standardize the process and forms for obtaining parental consent to administer psychotropic medication to minors.**

- **Standardize the intensive treatment program at the various institutions to ensure that the most effective treatment modalities are used consistent with differences in age groups, wards with special problems, and DSM-IV diagnoses.**

- **Provide specific training to staff psychologists and psychiatrists in the proper completion of the standard referral and disposition report to ensure that the forms specify the custody and treatment recommended for wards exhibiting suicidal behavior.**

INTRODUCTION

This review was conducted by the Office of the Inspector General in consultation with Dr. Barry Krisberg, PhD., president of the National Council on Crime and Delinquency, Dr. Madeline Wordes, Ph.D., of the National Council on Crime and Delinquency, and Claude Arnett, M.D. Dr. Arnett is a former staff psychiatrist at the University of California, Davis Medical Center. He is currently a contract psychiatrist for the Sacramento County Juvenile Hall in addition to his private practice in psychiatry. The review was conducted under the provisions of *California Penal Code* Section 6125, which established the Office of the Inspector General to provide oversight of the Youth and Adult Correctional Agency and its subordinate departments.

BACKGROUND

The intensive treatment program of the California Youth Authority is intended to provide treatment services to wards suffering from moderate to severe mental illness, including schizophrenia, psychosis, depression, and bipolar disorder. The department presently operates an intensive treatment program at each of six institutions. The first programs were established in 1979 at three institutions: the Southern Youth Correctional Reception Center and Clinic, the Northern Youth Correctional Reception Center and Clinic, and Preston Youth Correctional Center. In 1991, a fourth intensive treatment program was established at the N.A.Chaderjian Youth Correctional Facility. A fifth intensive treatment program was added at the Ventura Youth Correctional Center in 1999, and a sixth program was established at the Heman G. Stark Youth Correctional Facility on June 1, 2001.

In addition to the intensive treatment program, the California Youth Authority operates two additional programs for wards with mental health problems: the specialized counseling program for wards with chronic emotional and social disturbances and a new specialized behavioral treatment program at Preston Youth Correctional Facility for wards who are aggressively mentally ill, which was established in April 2002. The specialized counseling program consists of 246 beds at four institutions. The specialized behavioral treatment program at Preston Youth Correctional Facility has a design capacity of 35 beds, although during its present start-up phase, the department has limited the program to serving only 11 wards. In addition, the department has designated 1,300 beds statewide for substance abuse treatment and 229 beds for sex offenders, with 119 of the sex offender beds operating as part of the intensive treatment and specialized counseling programs. Under the terms of a court order arising from earlier legislation and a subsequent lawsuit against the department, the California Youth Authority is also mandated to establish licensed correctional treatment centers for wards who need crisis treatment services by December 27, 2002. At this writing, those centers are not yet operating.

The intensive treatment programs at the various institutions generally share the following goals:

- Provide individualized diagnostic and treatment services to wards admitted to the program;
- Identify, develop and clinically test treatment strategies to reduce disturbed behavior;
- Reduce assaultive and other unacceptable behaviors of program participants;
- Prepare wards for possible reassignment to other institution programs or for parole release.

OBJECTIVES, SCOPE AND METHODOLOGY

In this review, the Office of the Inspector General evaluated five of the six intensive treatment programs of the California Youth Authority, which at the time of the review included 194 wards. The intensive treatment program at the Heman G. Stark Youth Correctional Facility was not included in the review because it had been only recently established. The chart below lists the intensive treatment programs covered in the review and the number of wards assigned to each program.

INSTITUTION	INTENSIVE TREATMENT PROGRAM	NUMBER OF WARDS IN PROGRAM AT TIME OF STUDY
Northern Reception Center	Wintu	36
N.A. Chaderjian Youth Correctional Facility	Merced Hall	33
Preston Youth Correctional Facility	Redwood	41
Southern Reception Center	Marshall	41
Ventura Youth Correctional Facility	Alborada	43
	Total	194

The objectives of the review were to evaluate the effectiveness of the California Youth Authority in identifying wards needing intensive mental health treatment and the efficacy of the intensive treatment program in providing the treatment. To accomplish the objectives, the Office of the Inspector General carried out the following procedures:

- Reviewed the policies and procedures used by the California Youth Authority to identify wards in need of intensive mental health treatment.
- Reviewed the intensive treatment program goals and methodologies for delivering mental health treatment to wards in intensive treatment programs.
- Performed an analytical review of the length of stay in four of the five treatment programs for wards leaving the program during the 12 months preceding the review.

- With technical assistance and medical expertise provided by a consulting psychiatrist, reviewed and evaluated the treatment and documentation of psychiatric and psychological services provided to wards in the intensive treatment programs.
- Inspected and evaluated conditions of confinement in the intensive treatment program living units and other locations, such as lock-up units, used to house wards who had been temporarily removed from intensive treatment program units.
- Examined budget changes since the inception of each program.
- Examined training for intensive treatment program staff.
- Reviewed the medical, field, and living unit files of a sample of 97 intensive treatment program wards, representing 50% of the wards in the five intensive treatment programs covered in the review.
- Interviewed all of the 97 intensive treatment wards in the selected sample to obtain their assessments of the quality of care provided by the program staff.
- Inspected intensive treatment program facilities and living units.
- Interviewed key members of the intensive treatment program staff.
- Monitored intensive treatment program counseling and treatment sessions at each institution.

The review was conducted from October 2001 through January 2002.

FINDING 1

The Office of the Inspector General found that under existing practices the California Youth Authority's intensive treatment program cannot accommodate all wards needing intensive mental health services/treatment.

As presently constituted, the California Youth Authority's intensive treatment program falls far short of providing needed services to all wards under the department's jurisdiction who suffer from moderate to severe mental illness. Instead, the vast majority of wards needing mental health treatment are housed in the general population, where, for the most part, they receive no mental health services at all. Failure to provide adequate mental health treatment to wards who need it not only undermines the ability of the department to rehabilitate offenders and prepare wards for release back into the community, but also exposes the department to the prospect of lawsuits for violation of constitutional mandates to provide needed treatment. Mental health consultants to the department have suggested, however, that changes in the department's use of existing intensive treatment beds, improvements in staffing, and broader distribution of treatment services could significantly alleviate the deficiencies.

Prevalence of mental health disorders among California Youth Authority wards. Because delinquent behavior is strongly associated with underlying mental health problems, California Youth Authority wards, like other incarcerated juveniles, evidence far higher rates of mental illness than non-delinquent adolescents of similar age. A study conducted by the California Youth Authority and published in August 2000 found that 16 percent of male wards and 18 percent of female wards committed to the California Youth Authority between April 1997 and November 1999 suffered from the types of mental health problems that point to a need for intensive treatment.[1] Similarly, in a study conducted in 2001 by the Stanford University School of Medicine, Division of Child Psychiatry, researchers found that all but 3 percent of California Youth Authority wards suffer from at least one mental health disorder and that most exhibit numerous mental health problems.[2] According to the Stanford study, 71 percent of male wards have between three and five diagnosable mental health disorders and 82 percent of female wards have between three and nine mental health disorders.

The Stanford researchers divided the mental health disorders identified in the ward population into five "clusters" and noted the percentage of wards suffering from disorders in each cluster as follows:

Cluster I (51%)	mood, anxiety, borderline personality, and oppositional defiant disorders
Cluster II (15%)	psychosis, attention deficit-hyperactivity, schizoid, and schizotypal disorders

[1] "California Youth Authority Mental Health and Substance Abuse Treatment Needs Assessment: Description and Preliminary Findings," August 2000.

[2] "The Assessment of the Mental Health System of the California Youth Authority: Report to Governor Gray Davis," prepared by Principal Investigator: Hans Steiner, M.D., Co-Principal Investigator: Keith Humphreys, Ph.D, and Project Manager: Allison Redlich, Ph.D. Department of Psychiatry, Stanford University School of Medicine, December 31, 2001.

Cluster III (6%)	Eating, somatoform, and adjustment disorders
Cluster IV (20%)	Alcohol and substance abuse (Includes only those not included in Clusters I-III)
Cluster V (27%)	Alcohol and substance dependence (Includes only those not included in Clusters I-III)[3]

Number of wards needing intensive treatment services. As a result of its study, Stanford University estimated that approximately 836 wards a year require intensive mental health treatment—788 wards falling into Clusters I, II, and V; 36 wards in Clusters III and IV; and 12 wards falling into other categories. The department has far fewer intensive treatment beds than that number. At present, intensive treatment program beds in the California Youth Authority number 273, and, in response to another study[4] commissioned by the department, the California Youth Authority is in the process of attempting to improve treatment services by decreasing the number of beds to 210 in order to reduce the staff-to-ward ratio. And even though the intensive treatment program is intended to provide short-term treatment, at present, wards remain in the program for an average of 19 months. As a result, under current practices, only about 273 wards can be accommodated in any 19-month period—and, if the department follows through on its plan to reduce the number of intensive treatment program beds without making other changes, the number of wards served in that time span will drop to 210.

The Stanford researchers commented:

> *It was immediately obvious that the resources CYA has to provide mental health services are not adequate to meet the needs of the wards for whom it is supposed to care....*
>
> *For example, ...the number of wards with serious substance abuse and psychiatric disorders far exceeds the total number of specialty beds in the system, so by extension we know that many of such wards are only receiving general population services which are currently so thinly staffed that they are not adequate to address even less serious psychopathology.*

The failure of the California Youth Authority to provide necessary mental health services to wards may open the possibility of litigation against the department similar to the *Madrid v. Gomez and Coleman v. Wilson* lawsuits against the California Department of Corrections. *Madrid v. Gomez* set out the following requirements as measures of the constitutionality of a correctional mental health system:

- *An inmate must have a means of making his or her needs known to the medical staff.*
- *Sufficient staffing must allow individualized treatment of each inmate with serious mental illness.*
- *An inmate must have speedy access to services*
- *There must be a system of quality assurance.*

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[3] When wards in Clusters I-III who also suffer from alcohol and substance abuse disorder or dependency are added to Clusters IV or V, the totals reflect that 85 percent of all wards have alcohol and substance abuse problems.

[4] Koson, Dennis F., MD, and Joel A. Dvoskin, Ph.D, "Report of Forensic Mental Health Assessment: Mental Health Services to California Youth Authority," July 5, 2001.

- *Staff must be competent and well trained.*
- *There must be a system of responding to emergencies and of preventing suicides.*[5]

Changes proposed in the intensive treatment program. As a result of its study, Stanford University recommended a number of changes to the intensive treatment program in the context of improving the department's overall system of providing mental health services to wards. The recommendations, described in more detail later in this report, center on adherence to a continuum of care model in which mental health services are closely linked to assessments and to a ward's overall treatment plan. Under the recommendations, mental health services would be made more widely available to all wards, including those in the general population, with treatment levels geared to the ward's needs. "Step-down" treatment to lower levels of care would be provided as the ward's needs change. Consistent with that model, Stanford recommended that the intensive treatment program be used as short-term treatment, with stays averaging three months and wards moving to a lower level of care in a specialized counseling program or general population bed after they have been clinically stabilized. The Stanford researchers estimated that those changes, along with improvements in staffing, more effective use of medications, and a program of continuing education for the department's mental health staff, would make it possible for the intensive treatment program to provide services to all wards needing intensive mental health care without increasing the number of intensive treatment program beds.

FINDING 2

The Office of the Inspector General found that the process used by the California Youth Authority to screen wards for placement in the intensive treatment program fails to ensure that all wards needing intensive treatment are identified and receive the necessary treatment.

Until January 2000 when the California Youth Authority adopted a new screening tool for the intensive treatment program, the department consistently had a waiting list of as many as 30 wards for entry into the program. Once the new tool began to be used, the waiting list vanished. The department now points to the fact that there are no wards on the intensive treatment program waiting list as evidence that all wards needing intensive treatment are receiving it. The Office of the Inspector General found instead that the department's process for identifying wards in need of intensive treatment fails to identify all those who need intensive treatment program services and that the absence of a waiting list may be a symptom of the problem rather than evidence that the problem does not exist.

Under existing California Youth Authority policy, the formal process of identifying wards for assignment to the intensive treatment program takes place during reception center intake. Although wards also can be recommended for placement in the intensive treatment program at a later point in their incarceration, there are no consistent procedures for intensive treatment program placement once the intake process is completed. At present, the gateway to the intensive treatment program is a score of 40 or below on the global assessment of functioning examination, which provides a 100-point scale for measuring psychological,

[5] American Psychiatric Association, *Psychiatric Services in Jails and Prisons,* second edition, 2000.

social, and occupational function. Department policies and procedures provide that the global assessment of functioning be administered to any ward identified as needing an in-depth mental health evaluation. In fact, however, a large percentage of wards with mental health problems never receive a global assessment of functioning examination at intake and therefore may never be screened for entry into the intensive treatment program. Moreover, mental health experts have questioned the use of the global assessment of functioning as the only screening tool for the intensive treatment program. In response, the department is in the process of implementing a new screening mechanism, which is designed to provide a broader measure of a ward's mental health and behavior.

Reception center screening does not identify all wards needing intensive treatment. California Youth Authority procedures call for wards to undergo educational, medical, and mental health diagnostic services during the reception center intake process soon after they arrive in state custody. As part of the intake process, every ward, within three weeks of arrival, is supposed to receive a treatment needs assessment—a four-test evaluation—to identify special treatment needs, including treatment to address depression, suicide risk, and substance abuse. Those whose treatment needs assessments indicate the need for additional evaluation are supposed to be referred for a global assessment of functioning administered by a team of mental health clinicians. Under department guidelines, scores of between 40 and 60 on the global assessment of functioning indicate a need for specialized counseling, and scores of 40 and below point to a need for intensive treatment and possible assignment to an intensive treatment program bed. When a ward is identified for possible intensive treatment program placement, the institution submits a referral to the California Youth Authority's Population Management Division in Sacramento, which makes the actual placement on the basis of space availability.

A large proportion of wards do not receive a treatment needs assessment. In this and a number of other audits and reviews, however, the Office of the Inspector General has found that wards do not consistently receive treatment needs assessments. As a result, wards suffering from mental illness and in need of intensive treatment services may never receive a global assessment of functioning examination. Although the department has ordered reception center superintendents to ensure that every ward receives a treatment needs assessment and to monitor for compliance, none of the California Youth Authority's three reception centers—the Southern Youth Reception Center and Clinic, the Northern Youth Reception Center and Clinic, and the Ventura Youth Correctional Facility—have developed automated tracking systems to ensure that all wards are given the assessment.

No established procedures for later placement in the intensive treatment program. Wards who are not placed in the intensive treatment program during reception center processing may still be recommended for placement in the program later because of suicidal behavior or other perceived mental health or behavioral problems, but the department has no systematic procedures for that action to take place. In the absence of clear department-wide procedures, the Office of the Inspector General found that procedures for referring wards for placement in the intensive treatment program vary widely throughout California Youth Authority institutions, with some institutions using forms and procedures developed in-

house. The result is inconsistency among institutions and randomness and unpredictability in access to intensive treatment for mentally ill wards.

Most wards needing intensive treatment program services do not receive it. Although the review by the Office of the Inspector General centered on wards in the intensive treatment program, during the course of the review, reviewers also discovered a number of wards in the general population who appeared to be functionally equivalent to wards in the intensive treatment program—with scores of 40 or below on the global assessment of functioning examination, prescriptions for psychotropic medication, suicidal behavior, and other factors indicating the presence of mental health disorders and possible need for intensive treatment. Yet these wards had not been identified for intensive treatment or placed in the intensive treatment program. Stanford University researchers made a similar observation:

> *On the site visits, it was not always clear from a clinical perspective why particular wards were in the programs they were in, and why other wards with similar problems were not in any specialized program at all.*

The Stanford researchers found, in fact, that 80 percent of the wards who fall into one or more of the designated clusters of mental health disorders have never been in an intensive treatment program and that 77 percent have never been in a specialized counseling program, even though the researchers estimate that 35 percent of wards in clusters I, II, and V need intensive treatment and specialized counseling program services.

Half of intensive treatment wards were not identified at intake. As evidence of deficiencies in reception center screening for the intensive treatment program, the Office of the Inspector General found from reviewing the files of intensive treatment program wards that only 50 percent had been identified for placement in the intensive treatment program during the intake process and that 56 percent of the files contained no documentation showing that a treatment needs assessment had been performed. Thirty-one percent of the wards were transferred into the program between six months and a year or more after commitment to the California Youth Authority. It is possible that not all of the wards eventually placed in intensive treatment were in need of intensive treatment program services at the time of intake, but the failure to consistently administer treatment needs assessments points to the potential for wards needing intensive treatment services to be missed. The Office of the Inspector General found from reviewing the files of the intensive treatment program wards that in fact many of them exhibited the need for intensive mental health treatment in the months after they had completed the intake process. Often placement in the intensive treatment program followed numerous referrals to the institution mental health staff for suicidal behavior. On average, the wards had been referred for suicidal behavior three times since the date of commitment and fully 25 percent had been referred for suicidal behavior five times or more since the commitment date. Poor documentation in 20 percent of the files precluded identifying the reasons other wards were placed in the intensive treatment program.

The following cases illustrate examples of wards who were not identified for placement in the intensive treatment program during the intake process despite evidence of serious mental health disorders.

[Information redacted for reasons of confidentiality]

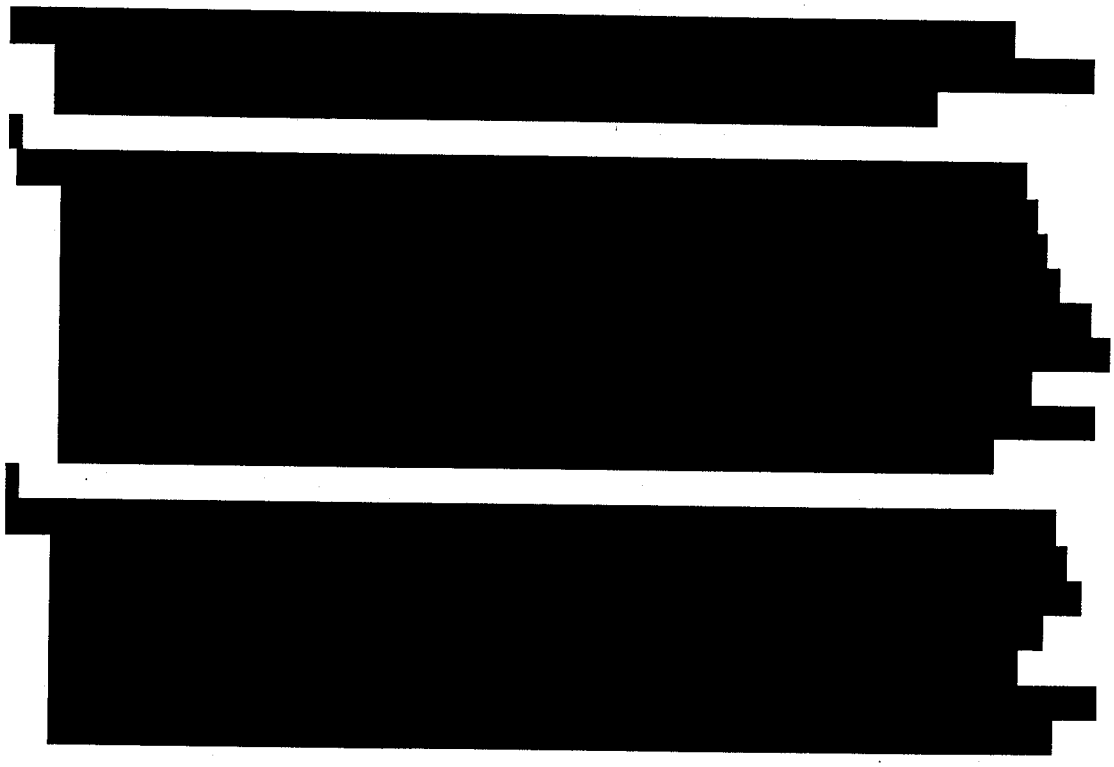
Deficiencies of the global assessment of functioning as a screening tool. The California Youth Authority adopted its version of the global assessment of functioning (the "YA-GAF") as a screening tool for the department's mental health treatment programs in January 1, 2000. The assessment is based on axis V[6] of the global assessment of functioning published in the *Diagnostic and Statistical Manual of Mental Disorders* of the American

[6] An axis identifies specific behavioral and mental health elements.

Psychiatric Association, 1994, often referred to as the "DSM-IV." Before January 2000, the department used a different screening tool—the global assessment system—which had been adopted in the 1980s. The department converted to the new assessment, according to the chief of the department's Health Care Services Division, because the older global assessment system had come to be regarded as overly subjective, with wide variation in scores given to the same ward. The department also had evidence that mental health clinicians sometimes assigned high test scores to wards who were difficult to handle in order to manipulate them out of the intensive treatment program. The new global assessment of functioning was designed to overcome these deficiencies, in part, by requiring that the examination be administered by a team of two mental health clinicians, usually a psychologist and a casework specialist.

The Office of the Inspector General found indications in the files of intensive treatment program wards, however, that the global assessment of functioning—and the use of its 100-point scale to determine program placement—may be equally unreliable as a screening mechanism. The review showed that 42 percent of the intensive treatment program files contained documentation of more than one global assessment of functioning score and that 44 percent of the multiple scores varied by more than 20 points. The Office of the Inspector General also found indications that the scores may sometimes be changed with the motive of removing troublesome wards from intensive treatment programs. Following are examples of inconsistencies and other indications of unreliability in global assessment of functioning scoring:

[Information redacted for reasons of confidentiality.]



[redacted]

Mental health consultants to the California Youth Authority have recommended against using the global assessment of functioning as the single screening tool for program placement, partly because of its narrow scope and partly because of its unreliability for adolescents. In the July 2001 study conducted for the California Youth Authority, cited earlier, the authors noted:

> *Of all aspects of mental illness, the functional aspects of illness measured by the GAF are the most fluid and changeable. While an "axis II disorder" or "characterological problem" in adults usually has connotations of immutability, the opposite is true in adolescents. Emerging Axis II disorders or traits and the functional aspects of mental illness are much more fluid and malleable in adolescents.*
>
> *We recommend against using the YA GAF as the sole or primary criterion for determining mental health level of care. (W)e believe strongly that each ward, especially those with serious mental health issues, should receive an individualized assessment that goes far beyond the GAF.*[7]

Stanford University researchers made a similar recommendation:

> *Though it is useful for planning treatment and measuring its effectiveness, the GAF should not be the only determinant of assignment to a special program or in elevating one level of care. The type of diagnosis, comorbidity, developmental (and probable causal) sequence of events and available treatments should all be considered. The GAF could instead have a gateway function which triggers a more detailed clinical assessment, which in turn leads to program reassignment approved by mental health staff.*

Implementation of the special program assessment needs. In response to these recommendations, the California Youth Authority has announced its intention to replace the global assessment of functioning with a new computerized assessment tool—the special program assessment needs, or SPAN system. The new system differs from the global assessment of functioning in that it will be administered by one institution mental health clinician instead of by a two-person team, and will be scored in Sacramento by the Health Care Services Division of the California Youth Authority. The new assessment includes a file review and an interview with the ward. It requires all five DSM-IV axes to be completed, rather than only axis V, and it incorporates all relevant diagnoses, the ward's history of psychotropic medications, suicidal tendencies, previous hospitalizations, arson, sex offenses, and any other psychiatric and behavioral factors. According to the department, the assessment can be completed in less than an hour, compared to the estimated seven hours of staff time required for a two-member team to administer the existing global assessment of functioning. To preclude manipulation, after the assessment is completed, it will be sent electronically to the Health Care Services Division, where it will be scored by a psychologist using a computerized scoring system. The score will not be reported to the

[7] Koson, Dennis F., MD, and Joel A. Dvoskin, Ph.D, "Report of Forensic Mental Health Assessment: Mental Health Services to California Youth Authority," July 5, 2001.

institution; rather the institution will be notified only of the ward's resulting placement in treatment priority. According to the department, the new system will begin operating in September or October of 2002.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following actions:

- **Require the reception centers to develop computerized tracking systems to ensure that every ward receives a treatment needs assessment within specified time limits.**

- **Institute a formal and uniform process for admitting wards to the intensive treatment program at any time during their confinement subsequent to intake processing.**

- **After the first six months of operation, conduct a thorough evaluation of the Special Program Assessment Needs system to assess its efficacy in identifying wards with specific mental health treatment needs.**

FINDING 3

The Office of the Inspector General found that treatment services provided to wards in the intensive treatment program are limited in scope, lacking in planning, poorly documented, and generally deficient in quality.

The treatment portrayed in the written descriptions of the intensive treatment programs bears little resemblance to the treatment actually provided to the wards. The program descriptions typically promise a range of treatment methods and an individualized treatment plan for each ward. In reality, treatment is limited for the most part to one or two hours a week of group therapy and individual counseling provided by a youth correctional counselor with little counseling expertise or training. Individualized treatment plans are nonexistent. Wards may see a psychologist only once a month, if that, and—if they are on psychotropic medication—may also see a psychiatrist periodically, usually about once a month. Treatment is poorly documented and there appears to be little communication or coordination between staff psychologists and psychiatrists or between the youth correctional counselors and the professional staff. Treatment in general is substandard.

Program components. Although the intensive treatment programs at the individual institutions vary in practice, written descriptions of the programs are similar. Features common to most of the program descriptions are the following:

- Individualized counseling
- Small group counseling
- Large group counseling

- Resource group counseling
- Family counseling
- Crisis intervention
- Use of psychotropic medication
- Educational program

The program descriptions also typically include a narrative describing a range of treatment strategies and methods used in the program. The description of the Redwood intensive treatment program at the Preston Youth Correctional Facility, for example, reads as follows:

> *In our work we have a wide spectrum of expertise among our staff as would be expected in a program designing individualized programs for 41 youth. Among the "Tools of the Trade" that we utilize are behavior modification techniques, Transactional Analysis Counseling, Assertiveness Training, various relaxation techniques (including Biofeedback), Values Clarification, "survival skills" training, remedial-to-high-school level academic work, and vocational training.*

Similarly, the description of the Wintu intensive treatment program at the Northern Youth Correctional Reception Center and Clinic declares:

> *Wintu uses a wide range of treatment strategies and test batteries. The major treatment modality utilized is Cognitive Behavior Therapy. Utilizing this model and other related cognitive therapies, treatment teams develop and design a unique treatment strategy for each youth assigned to the program. Cognitive Behavior therapy allows an individual ward to explore and examine his beliefs, thoughts, feelings, actions and consequences related to their personal issues and committing offense.... Other treatment strategies that are utilized on Wintu are Behavior Modification Techniques, Psychopharmacology, Gestalt, Psychodrama, Transactual [sic] Analysis and Re-decision Therapy.*

In fact, though, the intensive treatment programs do not use most of the treatment strategies described. Asked by the Office of the Inspector General to explain how the various treatment techniques work, those operating the programs replied, "we aren't using most of those." The reason, they said, is that no one on the staff is trained in the techniques. Nor do the programs necessarily incorporate all of the elements advertised in the program descriptions. For example, all five of the intensive treatment programs reviewed include "family counseling" in the formal program description—a component intended to address the ward's family dynamics and to encourage family support for the ward to augment staff counseling. Asked how family counseling is carried out, however, intensive treatment program staff members said it consists of making the counseling staff available during visiting hours to speak to family members upon request. Staff psychologists depend on the ward's assigned youth correctional counselor to schedule a meeting with a family member. The Office of the Inspector General found no documentation of the use of family counseling as a therapy tool. Many of the wards interviewed said they receive no visitors and were unaware of any effort in the intensive treatment program to encourage family visits.

What treatment actually consists of. The treatment provided to intensive treatment program wards consists mainly of one or two hours a week of small and large group therapy sessions

led by youth correctional counselors and of one-hour weekly individual counseling sessions, also given by youth correctional counselors. In addition, the wards may be assigned to attend one of the specialized "resource" counseling groups —often mandated for the ward by the Youthful Offender Parole Board—on such topics as anger management, assertiveness, victim awareness, self-esteem, or "relating to women"—these too led by youth correctional counselors. Case conferences with the ward and members of the treatment team, sometimes including the staff psychologist, are held periodically to assess the ward's treatment needs and evaluate his or her progress. The frequency with which the case conferences are held varies widely from program to program. One program, for example, requires an initial case conference to be held within 24 hours of a ward's arrival in the program; another requires only that the initial case conference be held within four weeks of the ward's arrival. Subsequent case conferences to evaluate progress may be held once every 30-60 days or every 60-90 days, depending on the program. Wards lacking a high school diploma must also receive academic instruction.

Deficiencies in the program. The Office of the Inspector General identified numerous problems in the treatment provided, including a lack of training for youth correctional counselors, the absence of treatment plans, and inadequate evaluations and treatment on the part of staff psychologists and psychiatrists.

- ***Youth correctional counselors lack training in counseling principles and methods.*** Youth correctional counselors, who provide the bulk of the counseling and treatment for intensive treatment wards, have minimal training in mental health principles and counseling techniques. Those hired before July 30, 2001 were required to have undergone only five weeks of peace officer training at the academy and 20 hours of training in casework and treatment centering on staff-ward interaction. Since that date, all peace officers have been required to undergo the same training, which includes 109 hours of casework training consisting of 25 hours of report writing and 84 hours of treatment, which is not specific to wards with mental health problems. After the academy training, youth correctional counselors assigned to intensive treatment programs may receive only sporadic training in mental health counseling principles. A review by the Office of the Inspector General of training records for the past two years showed that some youth correctional officers in intensive treatment programs have received in-house training in counseling, but the amount and type of training received is inconsistent among the institutions and even within the intensive treatment programs at the various institutions. Training records for three of the five intensive treatment programs covered in the review showed that some, but not all, of the youth correctional counselors in those programs had received eight hours of training in gestalt therapy, 16 hours of training in transactional analysis, and two hours of training in psychopharmacology. The other two intensive treatment programs had provided no training to youth correctional counselors for the previous two years.

- ***Individual counseling does not always take place.*** Many of the wards interviewed by the Office of the Inspector General, said that they had received no individual counseling from a youth correctional counselor for the previous 30 days and complained that when a ward's assigned youth correctional counselor is on vacation or is otherwise

unavailable, no other staff person is assigned to fill in. A significant number of the wards also expressed a desire for more counseling by the psychologist.

- ***Role of psychologists and psychiatrists in treating wards is vague.*** The role, responsibilities, and activities of staff psychologists and psychiatrists in the treatment of the wards are poorly defined and poorly documented. Because of the inadequate documentation, the type and frequency of formal therapy sessions—how often the wards are actually seen by a mental health professional—cannot be determined from the notes entered into the wards' files. For the most part, the role of the psychologists appears to be limited to carrying out suicide evaluations, performing psychological testing, and occasionally joining in on individual or group therapy sessions, while the role of psychiatrists appears to be merely to prescribe and monitor psychotropic medication. Some of the intensive treatment programs require psychologists to attend case conferences for wards in their caseloads, while other programs have no such requirement. Asked how often psychologists meet with the wards, some of the senior psychologists administering the programs said "once a week," while others simply replied, "whenever they can." None of the programs require psychiatrists to attend case conferences. Three of the intensive treatment programs reviewed lacked even duty statements for psychiatrists. Under California Youth Authority regulations, wards taking psychotropic medication are supposed to be seen regularly by a psychiatrist at intervals "consistent with good medical practice." Although wards taking psychotropic medication appeared generally to be seen once a month by a psychiatrist, the review found minimal documentation of other interaction by psychiatrists with the wards and other members of the treatment staff.

- ***No treatment plans***. In reviewing the field, unit, and medical files of the intensive treatment program wards, the Office of the Inspector General found no evidence of treatment plans to guide the treatment of the ward. The files contained nothing outlining the ward's mental health problems, no documentation about the ward's progress in the program, nothing linking the ward's progress with the treatment provided, and nothing defining the responsibilities of each treatment team member in treating the ward. According to the chief psychologist at one intensive treatment program, the department has never required that such plans be developed.

  Asked about the treatment plans alluded to in program descriptions, the intensive treatment program staff said that the "treatment plans" consist of contracts with the ward developed by the youth correctional counselors about what the ward will accomplish in the program. This limited conceptualization of treatment planning falls short of accepted clinical practice. Stanford University, recommending that the department implement a process for providing a detailed clinical assessment of wards, followed by assignment to a treatment program, described the role of treatment plans in guiding the treatment throughout the ward's tenure in the program:

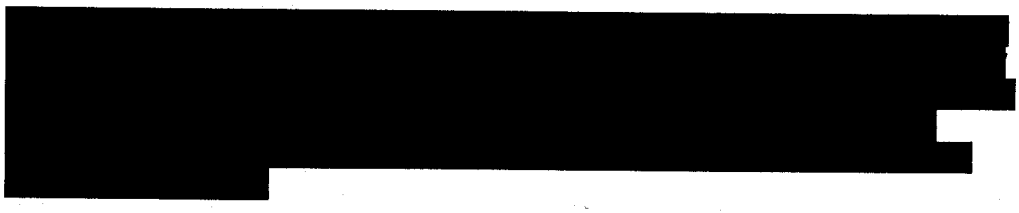
  > *The process would result in a treatment plan which is as specific as possible, delineating not just global malfunctions and symptoms, but also specifying which domains of functioning are*

disturbed, appropriate treatments for these dysfunctions and when one can expect them to resolve, along with a date for re-assessment which will then determine further level of care.

- ***Assessments by psychologists were inadequate.*** Psychologists evaluating wards at entry into the intensive treatment program did not attempt to use an understanding of the ward's personality organization and management of internal and external conflict to direct psychological intervention and did not specify psychotherapeutic approaches to be used, such as supportive listening, cognitive restructuring, or psycho-dynamic interpretation. The evaluations failed to include all of the available history of the ward and rarely included specific psychological testing. They did not consistently include proper DSM-IV five-axis diagnoses, and, most importantly, did not document psychological formulations to direct psychological treatment. In general, psychologists appeared to perform only superficial evaluations centering on symptoms rather than attempting to assess underlying causes of the symptoms. Consequently, treatment appeared to be directed toward alleviating symptoms rather than addressing underlying causes.

- ***Initial psychiatric assessments of new wards were inadequate.*** Psychiatric assessments of new admittees to the intensive treatment program were brief and superficial. None of the psychiatric evaluations in the medical files reviewed by the Office of the Inspector General included all of the relevant facts available from the records. For example, the records for most of the wards reviewed showed histories of early childhood abuse, but that information was not included in the psychiatrist's assessment. The psychiatrists often failed to mention previous diagnoses or medication, both of which are essential to understanding the symptoms of an emotionally disturbed adolescent and formulating a treatment plan. Sometimes the psychiatrist's notes even failed to include a diagnosis. None of the notes included a complete problem list or a well-thought-out treatment plan. Following is an example of one of the inadequate entries by a treating psychiatrist in the medical file of an intensive treatment program ward:

[Information redacted for reasons of confidentiality]



The Office of the Inspector General noted that a pharmacy medication sticker placed below this entry documented a prescription for 5mg. of Zyprexa twice daily by mouth for a period of 30 days. Yet, the note provides no clinical background information about the ward, no clinical diagnosis, no plan for treatment, and, again, no justification for the medication ordered. [Appendix A to this report provides an example of a correctly documented initial psychiatric assessment in a hypothetical case.]

- ***Psychiatrists did not document reasons for placing wards on psychotropic medication.***

From an analysis of nine randomly selected intensive treatment program medical files, the Office of the Inspector General found that psychiatrists failed to meet basic standards for documenting the rationale for pharmacological intervention, the ward's response to the medication, including positive or negative side-effects, and a plan for maintenance, follow-up, or further intervention. Those deficiencies violate the department's guidelines for prescribing psychotropic medication to wards, as set out in the *California Youth Authority Institutions and Camps Branch Manual*. Section 6275 of the manual provides:

> *Psychotropic medication shall be ordered and administered only after a psychiatrist, in consultation with the treatment team, has evaluated the ward, arrived at a differential diagnosis, and concluded that the ward will benefit from one or more psychotropic medications The medication(s) shall be justified by a YA-GAF evaluation and a DSM-IV-TR ™ diagnosis. The medication(s) shall be linked to the mental health diagnosis in Axis I or Axis II with a description of the desired effect and the approximate length of time expected for the desired outcome.*

Similarly, Section 6284 of the policy specifically requires that the staff psychiatrist:

> *Evaluate wards who are on psychotropic medication upon admission and include a complete DSM-IV-TR ™ diagnosis and YA-GAF.*
>
> *Link all psychotropic medication prescriptions to an Axis I or Axis II, DSM-IV ™ diagnosis.*

- ***Psychiatrists did not adequately document response to medications.*** None of the files examined contained adequate documentation of the ward's response to the medications or evaluation of potentially dangerous developments, such as the onset of *tardive dyskinesia*—a potentially debilitating neurological disorder involving involuntary muscle movements resulting from long-term use of certain anti-psychotic drugs. None of the files included documentation of testing for abnormal involuntary movement testing, an essential measure for evaluating the potential onset and progression of *tardive dyskinesia.*

- ***Psychiatrists did not meet community standards in general for documenting treatment.*** Community medical standards require that mental health treatment records reflect an unbroken timeline of documented problems, treatment, and response to treatment from the day of intake to the day of discharge. The Office of the Inspector General found that none of the intensive treatment program medical files examined in the review met accepted standards for a complete, well-organized clinical record. The reviewers found large periods of time unaccounted for, notes out of place, loose pages inserted into the record, and notes out of order in date and time. One ward's medical file included single-page notes pertaining to two other wards. Psychiatrists did not conform to basic clinical standards for content according to the S.O.A.P. model,[8] which should provide a statement of the problem, observation and evaluation of the problem, usually in the form of a mental status examination, physical examination or review of laboratory values,

[8] "SOAP" is the clinical lexicon for medical notations. "S" stands for "subjective" and refers to symptoms. "O" standards for "objective" and refers to observable and measurable findings. "A" stands for assessment of current condition. "P" refers to the plan of treatment.

assessment of the problem, and a plan for intervention. [Appendix B to this report presents an example of an appropriate clinical note by a psychiatrist in a hypothetical case.]

- ***No parental consent for psychotropic medication.*** Fifty percent of the files for wards under the age of 18 who were on psychotropic medication contained no documentation that parental consent had been obtained. California Youth Authority policy requires "informed consent" from a parent or a guardian, which must include a full verbal explanation by the psychiatrist of the reason for the medication and the possible side effects. If the parent or guardian agrees verbally to the medication, the institution staff is to send the parent or guardian a written statement to sign setting forth the requirements governing informed consent. The parent or guardian must sign and return the statement, which is then placed in the ward's medical file. If the parent or guardian fails to respond, department procedures require the institutions to request that department headquarters petition the committing court for approval to administer the medication.

  The review team found numerous instances when these requirements were not carried out. At some of the intensive treatment programs, the staff had no formal system to document efforts to obtain parental consent, and at others, the staff failed to keep the documentation current. At the Marshall intensive treatment program the staff had developed an automated system to track the notification process, yet the review team noted several cases in which the files contained no documentation of efforts to obtain court authorization. At the Northern California Youth Correctional Center, which handles parental consent requests for intensive treatment program wards at several institutions, the staff routinely sends the consent form to parents with a form letter attached that declares, "The benefits and the side effects of these medications have been fully explained to your son." But the form omits the required explanation of what the side effects consist of. When this deficiency was pointed out to the chief medical officer, he replied, "They [the consent procedures] are only guidelines."

- ***Treatment by psychologists is poorly documented.*** Notes entered into the files of intensive treatment wards by staff psychologists also failed to meet basic clinical standards. Although some of the psychologists followed the S.O.A.P model, the notes did not present a clear statement of the problem, how the psychologist evaluated the problem, what conclusions he or she reached, what intervention was used, or what the ward's response was to the intervention. The failure to provide such information prevents the psychiatrist and others viewing the medical file from understanding the ward's needs and tracking his or her progress. The following notations in a medical file by a psychologist in evaluating an intensive treatment program ward who had been referred for a suicide evaluation after self-inflicted injuries provides an example of notes that fail to meet clinical standards:

  Suicide watch

  S - Denies ever being suicidal. States "I believe this was a set-up! Admits he did state that if staff put him in a holding room he did not know what he might do to them.

O – Oriented x 3. No evidence of thought disorder or depression. Affect stable, mood—anger and hostile.
A – Antisocial personality disorder w/possible delusions of persecution.
P – Move to level 2.

The same psychologist saw the ward two days later and made a second almost identical entry without clearly stating what psychological intervention had been provided to the ward or describing a plan to address the problem that caused the ward to threaten suicide. [Appendix C to this report provides an example of an appropriate file entry by a psychologist in a hypothetical case.]

- ***Poor coordination of treatment between psychologists and psychiatrists.*** The review revealed an absence of communication and integration of treatment between psychologists and psychiatrists. Psychologists and psychiatrists do not appear to confer about the treatment needs of individual wards or to coordinate treatment strategies. Because psychiatrists do not attend case conferences or group therapy sessions, they lack information about the ward's problems, behavior, and progress in treatment. In some instances, in fact, psychologists and psychiatrists appear to operate almost at cross-purposes.

- ***Treatment in general is frequently substandard.*** From reviewing the files of intensive treatment wards, the Office of the Inspector General found numerous examples in which treatment by psychologists and psychiatrists appeared to be deficient. In most cases, psychiatrists appeared to do little more than talk to the ward, record what the ward said, and continue medication, as in the following example:

  Ward says he has trouble sleeping; continue on Prozac.

  Notes by psychologists and psychiatrists typically contain no reference to a DSM IV diagnosis, no instructions to the staff about what to watch for in the ward's behavior, and no direction about specific feedback the staff should provide about the ward's behavior—progress in school, interactions with the staff and other wards, or conduct in the living unit. Without information from the staff, information gained from consulting with psychologists, or information from notes entered into the ward's medical file by psychologists, it is difficult to know what the psychiatrist is "reviewing" in order to know how the ward is progressing in order to monitor the medication.

  Often, too, "treatment" by clinicians appears to not even address identified problems. In one such example, a psychologist referred a ward to a psychiatrist for evaluation of depression and possible anti-depressant medication. The psychiatrist met with the ward three days later, but instead of evaluating him for depression, placed him on anti-psychotic medication after the ward reported hearing voices, but failed to perform a thorough evaluation for psychosis to justify the anti-psychotic medication. A week later, the psychologist saw the ward again, but, like the psychiatrist, he also failed to evaluate for depression and he did not consult with the psychiatrist for follow-up on the original referral for possible depression. Instead, the psychologist also centered his assessment on the ward's report of hearing voices and concluded that he suffered from attention

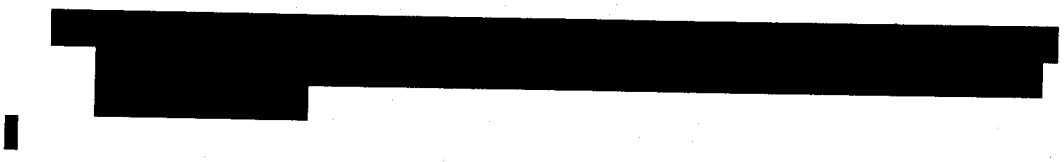
deficit hyperactivity disorder and conduct disorder—diagnoses that had no demonstrated bases and that failed to advance the understanding of the ward's mental health problems or treatment needs. The Office of the Inspector General reviewers noted that the ward may in fact have been suffering from depression with psychotic features in which voices may have been instructing him to kill himself; yet neither the psychiatrist nor the psychologist appeared to consider that possibility.

Stanford University researchers found similar flaws in the treatment provided to the wards. The authors of the December 2001 study commented:

> *The relationship between mental health treatment and active psychiatric diagnosis is much less firm than it should be, given recent advances in our understanding of the best practices available for the treatment of these children. This is particularly evident in the use of medications for the treatment of disorder [sic]. But it is also evident in the institutional assignment of individuals in the system.*
>
> *Because of the rarity of the presence of psychiatrists in the system trained in child psychiatry and psychopharmacology, modern psychopharmacology was not generally practiced. Across all clusters, we find that antidepressants are used [sic] most frequently prescribed, regardless of diagnosis, followed by antipsychotics and mood stabilizers. Stimulants, anti-manic and antianxiety agents are a distant 4th, 5th, and 6th...Most concerning is that there is a substantial percentage (22%) of cluster III wards receiving potent antipsychotics with unclear indication at the present time.*
>
> *[E]xamining the percentages of all wards in all clusters on any psychotropic medication, it is clear that despite the fact that these wards are all currently fulfilling diagnostic criteria, only a minority in Clusters I and II—the most likely to require medication—are in fact on it. By contrast, Clusters III and IV who most likely do not require medication, still have a significant proportion on medication. This could of course mean that they were successfully treated, but it also could mean that they are receiving psychopharmacological treatment unnecessarily.*

- ***Resources to serve developmentally disabled wards are inadequate***. Approximately 22 wards identified as developmentally disabled, who suffer from attention deficit disorder and other physical disabilities, were assigned to the intensive treatment programs at the time of the review. Some of wards attend counseling groups, while others do not, depending on their ability to communicate. Resources for addressing the needs of these wards—such as special education classes and speech and learning therapists—are not uniformly available at the institutions to which they are assigned. As a result, the wards often do not receive needed treatment. Examples:

[Information redacted for reasons of confidentiality.]



- [redacted]

- ***Treatment ordered by the Youthful Offender Parole Board often has limited value.*** In addition to the individual and group counseling inherent in the intensive treatment program, intensive treatment program wards may also be required by the Youthful Offender Parole Board to attend resource group counseling on such topics as victim awareness, anger management, and relating to women before they can be paroled. Like the other intensive treatment program counseling groups, the resource groups are led by youth correctional counselors with limited training in counseling principles and methods. The Youthful Offender Parole Board, likewise, lacks the expertise to assess the ward's treatment needs. The requirement that wards attend the resource groups both duplicates treatment provided in the other therapy groups, and unnecessarily expends limited program resources.

  Stanford University researchers made similar observations about treatment ordered by the Youthful Offender Parole Board and other entities. The authors of the Stanford report commented:

  > *A sad irony of the CYA system is that as limited as staff time is, much of it is spent in unproductive activity. The amount of paperwork, especially board reports is inordinate...*
  >
  > *An additional problem is that clinical staff are subject to the enthusiasms of administrators and YOPB board members who have no training in mental health. The "inner child" focused services, which were originally pushed from outside, are offered in many facilities despite their [sic] being no evidence of their effectiveness. At one facility, the "heartmath program" was being put forward, again without evidence of effectiveness in the population. Other imposed programs include "gang awareness" and "victim awareness." Whether any one of these or the other services is effective in some cases is not known and is not, in any case, the point. Rather the point is that the process through which mental health programs in the system takes on new tasks [is] assigned by those without a mental health background and supported by no empirical evidence.*

Staffing shortages. The California Youth Authority attributes many of the shortcomings in its mental health treatment services to inadequate staffing resources and the difficulty of finding and retaining mental health professionals to provide the needed treatment. Presently, only six of the department's 14 staff psychiatrist positions are filled, partly because of higher salaries offered for the positions at the Department of Corrections. The Stanford researchers

noted that "staffing shortages were ubiquitous, particularly for psychologists and psychiatrists," adding that the situation causes a "crisis mentality, in which:

> *[S]taff are racing from emergency to emergency without having time to think through the organization and planning of treatment, minimal or nonexistent clinical supervision, lack of continuing education for staff, poor continuity of care, low morale, and difficulty competing for job candidates with other systems, including the adult CDC.*

Continuum of care model. The continuum of care model proposed by Stanford researchers for the California Youth Authority is intended to make more effective use of limited resources while extending mental health treatment services to the entire ward population. Under that model, wards with Cluster I mental health disorders—mood, anxiety, borderline personality, and oppositional defiant disorders—would be treated with medication and cognitive behavioral therapy, with some percentage receiving higher levels of treatment in the specialized counseling and intensive treatment programs. The cognitive behavioral therapy would be given in therapy groups led by a psychologist once a week for six months, with some wards also seen individually by the psychologist. The wards would also receive medication for 12 months, and would see a psychiatrist 30 minutes a week for three months and 30 minutes a month after that. Wards with cluster II disorders (psychosis attention deficit-hyperactivity, schizoid, and schizotypal disorders) would receive 24 months of medication and six months of psychosocial group therapy treatment once a week.

California Youth Authority actions. In response to these and other recommendations, the department has taken steps to remedy deficiencies in the system and move toward the continuum of care model. A 2001-2004 strategic plan adopted by the California Youth Authority calls for the ongoing assessment of wards to match treatment needs with treatment, an increase in the number of psychologist and psychiatrist positions, and improved training for psychologists, psychiatrists, youth correctional counselors, caseworkers, and parole agents. A fiscal year 2002-03 budget change proposal submitted by the department, together with mental health funding provided in the state budget approved by the Legislature in September 2002, will implement some of those provisions and complete the staffing necessary to implement the continuum of care model. Plans to use federal funds to provide training for intensive treatment program staff are also underway.

RECOMMENDATIONS

The Office of the Inspector General recommends that the California Youth Authority take the following actions:

- **Continue to pursue efforts to institute mental health treatment according to the continuum of care model, including extending treatment services to all California Youth Authority wards, with treatment levels closely tied to mental health treatment needs.**
- **Continue efforts to provide training to youth correctional counselors in mental health treatment principles and methods and to provide continuing education training for psychiatrists, psychologists and other members of the mental health staff.**

- **Institute quality control procedures and monitoring to ensure that constitutional standards of mental health treatment and documentation are met.**
- **Require the development of comprehensive treatment plans for all intensive treatment program wards.**
- **Standardize the process and forms for obtaining parental consent to administer psychotropic medication to minors.**
- **Standardize the intensive treatment program at the various institutions to ensure that the most effective treatment modalities are used consistent with differences in age groups, wards with special problems, and DSM-IV diagnoses.**

FINDING 4

The Office of the Inspector General found serious deficiencies in the handling by mental health clinicians of suicidal wards in the intensive treatment program.

The review showed that the intensive treatment program mental health staff consistently failed to document important information about wards referred for suicidal evaluation and failed to communicate to the custody staff how the wards should be monitored.

A high proportion of wards in the intensive treatment program are suicidal. Intensive treatment program wards are at particularly high risk for suicide. Wards are often placed in the program as a result of a high score on the California Youth Authority's suicide risk screening questionnaire, which is administered during the reception center intake process, or in response to subsequent events or behavior signaling a heightened risk of suicide. The Office of the Inspector General found that fully 87 percent of the intensive treatment wards covered in the review had been referred for mental health counseling because of suicidal behavior since they arrived at the California Youth Authority. In many cases, suicidal behavior continued after the wards were placed in the intensive treatment program. The review showed that 47 percent of the intensive treatment program wards had received two or more suicide referrals after they were admitted to the program. For intensive treatment wards as a whole, the total number of suicide referrals actually increased 8 percent after the wards were placed in the program—from 181 referrals before placement to 195 referrals after placement.

The California Youth Authority has recognized the greater risk of suicide for wards who are mentally ill. *California Youth Authority Institutions and Camps Manual,* Section 5525 reads:

> *Suicidal thoughts, feelings, or behavior are a health care emergency requiring immediate and effective action on the part of all staff. Adolescents are a high risk population for suicide, and youthful offenders are at a particularly high risk.*
>
> *Wards may become suicidal at any point during their commitment.* ***Wards who are suffering from diagnosable mental illness are particularly vulnerable*** *[emphasis added].*

Requirements for a suicide prevention program. In *Ruiz v. Estelle* and *Madrid v. Gomez* the courts specified that a correctional mental health program must include procedures for responding to emergencies and preventing suicides. The American Psychiatric Association, in *Psychiatric Services in Jails and Prisons,* listed the following as necessary components for suicide prevention programs in correctional settings:

- *Training of all staff who interact directly with inmates in how to recognize danger signs and what to do when they believe that an inmate may be suicidal.*
- *Identification, through admission screening and referral, on inmates at heightened risk of suicide.*
- *Policies to ensure adequate monitoring of suicidal inmates to prevent the loss of life.*
- *Effective and well-understood referral system that allows staff and inmates to bring a suicidal inmate to the prompt attention of mental health staff.*
- *Timely evaluation by mental health clinicians to determine the level of risk posed by an inmate who has been referred by screening or correctional staff.*
- *Housing options that allow for adequate monitoring of suicidal inmates by staff.*
- *Communication between mental health, correctional, medical, and other staff of the specific needs and risks presented by a suicidal inmate.*
- *Timely provision of mental health services, including medication, verbal therapies, and crisis intervention, for chronically or acutely suicidal inmates.*
- *Accurate and behaviorally specific reports documenting behaviors or statements that indicate suicide risk.*
- *Review of incidents of suicide attempts or completed suicides, to improve institutional practices and to prevent unnecessary future occurrences.*
- *Critical incident debriefing in the event of a completed suicide, to assist staff and inmates in dealing with predictable feelings of guilt, fear, grief, and anger.*

California Youth Authority procedures for handling suicidal wards. The department's suicide prevention procedures are set out in *California Youth Authority Institutions and Camps Manual* Section 5528 *et seq.* The procedures call for any staff member who becomes aware of actions or statements by a ward that indicate the ward is in danger of self-injury to complete a standard referral and disposition report. After the report has been filed, the living unit staff and the medical staff are directed to treat the ward as in crisis until a mental health evaluation can be performed. These procedures include placing the ward close to the control center with visual monitoring at least every 15 minutes and observation by camera at least every five minutes. The mental health staff, in turn, is required to respond to the standard referral and disposition report by conducting a face-to-face interview and evaluating the ward for possible formal placement on suicide watch. Following the evaluation, the mental health clinician is required to complete and distribute Part B of the standard referral and disposition report to document the results of the evaluation and provide clear instructions for the ward's treatment and custody arrangements. Part B asks for specific information to be provided by the clinician, including "short-term disposition," meaning whether the ward should be referred for medication, therapy, camera room detention, or suicide watch, or, if the ward had previously been placed in a camera room or on suicide watch, whether those measures should be discontinued. The form also calls for the clinician to provide recommendations for long-term treatment of the ward—such as a recommendation to

provide the ward with therapy twice a day, to reassess medication while the ward continues on suicide watch, or to have a physician examine the ward if he consumes no food within the subsequent 12 hours.

Section 5528 of the *California Youth Authority Institutions and Camps Manual* requires in addition that each institution superintendent "establish procedures to open communication between the treatment team and mental health professionals regarding the status of potentially suicidal wards." At the Southern Youth Reception Center and Clinic, which houses the Marshall intensive treatment program, for example, those procedures require the mental health staff to do the following:

1. *Evaluate ward for formal admission to suicide watch in Infirmary or on Marshall CIP. Review chart and interview ward (face to face).*
2. *Record course of treatment which includes seeing the ward daily until discharged in the medical chart. Note any medication needed and/or prescribed.*

When the ward is to be kept on camera room observation, institution camera use procedures require the senior psychologist, designee or psychiatrist to:

2. *Record course of treatment in the medical chart and in the living unit log book. See the ward daily until discharged from the camera room.*

- *Any medication needed and/or prescribed*
- *Level of program approved for the ward*
- *Whether or not the ward needs to be isolated from others*
- *How frequently he will be seen and by whom*
- *What can be kept in his room, etc.*
- *Whether or not the ward is on suicide watch. (If on suicide watch, the ward will be checked every 15 minutes face to face. If not on suicide watch, the ward will be checked every 30 minutes, during hallway checks, face to face.)*

Intensive treatment program compliance with suicide prevention requirements. The Office of the Inspector General reviewed the training records of all staff assigned to the intensive treatment programs, as well as the lesson plans for suicide prevention training, to evaluate compliance with training requirements. The review showed that the rate of compliance with suicide prevention training requirements for the intensive treatment program custody staff and mental health staff was 97 percent and that lesson plans had been frequently updated to reflect new procedures adopted after ward suicides in 2001.

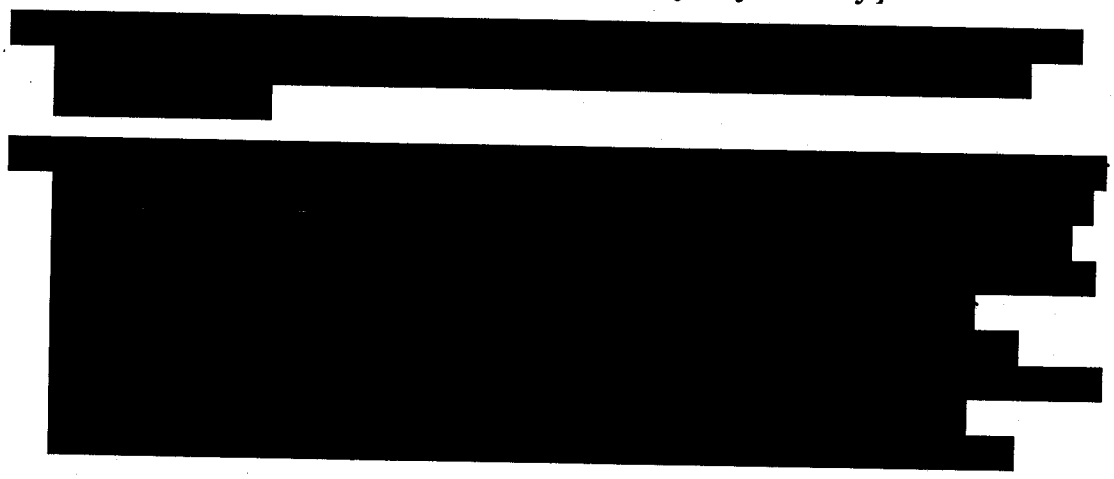
The Office of the Inspector General also reviewed a random sample of 60 suicide referrals for intensive treatment program wards, representing all five intensive treatment programs, to evaluate compliance by the staff with prescribed suicide prevention procedures. The review examined the timeliness of response by medical and mental health personnel and the quality of the documented recommendations by the mental health staff for follow-up treatment. The review confirmed that when suicide referrals were filed, wards generally were placed under increased monitoring by the staff pending the face-to-face interview with the mental health

staff. The review also showed that the mental health staff generally responded to suicide referrals promptly, usually no later than the same day or the following day.

However, the review also revealed the following serious deficiencies on the part of intensive treatment program mental health clinicians:

- In 98 percent of the reports reviewed, the short-term disposition section of the report (Part B) simply described the behavior by the ward that resulted in the suicide referral and gave a brief statement reporting what the ward said during the interview with the mental health clinician.
- In 98 percent of the reports sampled, the question in Part B, "Is ward on medication or requiring medical care?" was not answered.
- In 60 percent of the reports sampled, the mental health clinician provided no recommendation for long-term treatment or custody arrangements or made only vague comments. One report, for example, said, "continue in therapy," yet the medical file contained no entry documenting that the ward was provided with therapy in any form. Another report said, "continue camera review," but the review team found no entry in the living unit log giving the custody staff directions about how to monitor the ward.

[Information redacted for reasons of confidentiality.]



The authors of the July 2001 California Youth Authority study also found that monitoring of suicidal wards in intensive treatment programs, as well as in specialized counseling programs and lock-up facilities, is inadequate. The authors recommended that crisis and suicide watch operations be relocated to crisis beds appropriate for mental health use in outpatient housing units or to correctional treatment centers when those become available.

RECOMMENDATION

The Office of the Inspector General recommends that the California Youth Authority provide specific training to staff psychologists and psychiatrists in the proper completion of the standard referral and disposition report to ensure that

the forms specify the custody and treatment recommended for wards exhibiting suicidal behavior.

FINDING 5

The Office of the Inspector General found a lack of follow-up care for wards leaving the intensive treatment program.

The Office of the Inspector General found that 69 percent of the 221 wards leaving the intensive treatment program during the twelve months preceding the review were either transferred to the general population or released on parole. Some 10 percent went into lock-up after being discharged from the program. The statistics show that the majority of intensive treatment program wards leaving the program are likely to have received no further treatment for their mental illness at the California Youth Authority. The average length of stay in intensive treatment program for all wards leaving the program during the previous 12 months was 8.7 months. Female wards spent an average of 3.6 months longer in treatment than males.

The chart below shows the disposition and length of stay of the 221 wards who left the intensive treatment program during the year preceding the review.

Disposition and Average Length of Stay of Wards Transferred out of Intensive Treatment Programs from October 1, 2000 to September 30, 2001

Program	General Population	Parole	Lockup	Drug Program	SCP	Discharged	Other ITP	Other	Total	LOS (months)	LOS >18 months
Wintu	23	11	1	2	1	1		1	40	7.4	3 (7%)
Merced Hall	12	11	12	1	5	7	1*	7	56	9.5	6 (11%)
Redwood	29	15	8	9	2				63	8.2	9 (14%)
Marshall	8	19		1	2				30	6.0	2 (7%)
Alborado	9	14		4	4			1	32	12.3	14 (44%)
Total and %	81 or 37%	70 or 32%	21 or 10%	17 or 8%	14 or 6%	8 or 4%	1 or <1%	9 or 4%	221	8.7	34 or 16%

*Not included in length of stay tabulations

The California Youth Authority has begun efforts to remedy the lack of care provided to wards who leave the intensive treatment program. The continuum of care services envisioned in the department's 2001-2004 strategic plan would provide step-down treatment through the specialized counseling program and other services made available to general population wards. The strategic plan also calls for improved after-care services for wards released on parole.

APPENDIX A

Example of appropriate documentation of an initial psychiatric assessment in a hypothetical case.

Psychiatrist Initial Evaluation:

Presenting Problem: 16 year-old Hispanic male with previous adequate adjustment to the general population since intake 05/01 now presents with suicidal ideation and several superficial cuts on his left arm. Patient states, "I can't take it here any longer." When asked what has changed the patient is evasive. However, a staff member on his unit related that the patient had become a target of physical abuse by several rival gang members. When asked directly about this the patient becomes visibly distraught and repeats, "I can't take it anymore."

Past Psychiatric Problems: Patient reports one prior hospitalization at age 14 for a Tylenol overdose (took 6 Tylenol). He says he had gotten into a fight with his mother. Records from Hospital of Vallejo indicate an "angry, immature, impulsive youth with fears of abandonment." He was diagnosed with depression and ADHD and started on Imipromine 75 mg qhs. He reportedly had a good effect on this medication and continued to take it for three months after the hospitalization, but stopped it voluntarily. He saw the psychiatrist twice after release for follow-up medication maintenance. He and his mother met with a social worker once in the hospital and once after discharge. He received no other counseling. In March 2001, when incarcerated at Solano County Juvenile Hall, he was placed back on Imipromine 75 mg qhs because of poor sleep, irritable mood, and excessive conflict with peers and staff. He reports the medication was helpful but discontinued upon transfer to CYA. He has had no other hospitalizations, counseling, or other trials of medication.

Review of Psychiatric Symptoms: Patient does report depressed, irritable mood, difficulty falling asleep and often early morning awakening. He has lost his appetite recently and lost 8 lbs. (from 152 to 144). He reports frequent nightmares and waking feeling "nervous and sweaty." He denies auditory or visual hallucinations. He has never had panic attacks or excessive anxiety. He has a history of impulsivity and distractibility. He denies dissociative symptoms like losing time, or depersonalization, but does admit to having odd feelings of "living in a movie, like it's not my life, like it is someone else's life." He says he has those feelings occasionally and could best relate it to a traumatic incident at age 14 when he found out a friend was shot and killed in a gang-related incident. He denies periods of excessive energy or racing thoughts. There are no tics, nor obsessive or compulsive symptoms. He does have a significant history of lying, assaultive behavior, truancy, and theft. He was sent to CYA after a history of several burglaries, car thefts, then a strong-armed robbery where he and several friends forced a woman out of her car and stole her car and her purse. He subsequently was caught on video trying to purchase shoes with her credit card.

Substance Abuse History: Patient reports daily marijuana use since age 13, regular, weekly alcohol use, and experimentation with smoking methamphetamine and taking ecstasy. He likes marijuana because he "can chill out." Methamphetamine made him "too wired, hurt my lungs." He liked ecstasy but "I heard it was bad for you, so I didn't do it anymore." He

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3) Conduct Disorder, adolescent onset, severe
4) Rule-out Post-Traumatic Stress Disorder
5) Rule-out Organic Affective Disorder

Axis II: Deferred

Axis III: History of head injury with prolonged loss of consciousness

Axis IV: 1) Past exposure to family violence and separation
2) Current exposure to physical abuse, incarceration, and separation from his family.

Axis V: GAF – current 35; past year 55

APPENDIX B

Example of a proper clinical note by a psychiatrist in a hypothetical case:

Psychiatric Follow-Up:

(S) Youth with a newly diagnosed psychotic disorder has responded well to Haldol 2 mg at bedtime. He reports no longer hearing voices and that his "mind is clearer." He complains of muscle stiffness in his jaw and neck. No other complaints of side effects. The youth reports doing better in the program. He is off room confinement and attending school and group counseling.

(O) On mental status examination the youth is much more engaging, has good eye contact. His dress and hygiene have improved, though he continues to appear mildly disheveled and unkempt. His speech is spontaneous and fluid. His mood is brighter. His affect is less flat, but still dull. His thoughts are linear and logical. He no longer hears voices telling him to kill himself.

On physical examination he is slow moving, shuffling slightly. He turns in a block and has mild muscular tension on the left side of his jaw and neck. He has mild cogwheel rigidity in both arms.

Screening CBC, urinalysis, and liver function tests were normal.

(A) Psychotic Disorder, NOS, rule-out schizophreniform vs. Bipolar Disorder. The psychosis is improved, but he has developed Parkinsonian side effects.

(P) 1. Continue Haldol 2 mg po ghs to control psychotic symptoms.
2. Start Cogentin 0.5 mg po BID to alleviate Parkinsonian side effects (informed consent obtained from parent dated xx/xx).
3. Return for follow-up in one week.

APPENDIX C

Example of an appropriate medical file note by a psychologist in a hypothetical case:

Psychologist Follow-Up:

(S) Youth reports he is still depressed that his mom moved to Texas, but is no longer suicidal. Medications have helped with sleep, but he remains unmotivated and anhedonic. He has had poor participation in school and group this week. "I don't feel like killing myself. I just don't care," he reports.

(O) Shuffles into the office, still in his pajama top, pants and slippers. Downcast eyes, slow, soft speech, depressed mood, blunted affect. Thoughts are linear and logical. He reports he is no longer suicidal. Improved score on the YA Suicidality Screen, though still in the mild range. Improved score on the Beck Depression Inventory, though still moderately depressed.

(A) Depressed, suicidal, cognitively limited youth. Marginally improved. Have met with him for supportive therapy for feelings of loss and abandonment by his mother. A phone call to his mother was helpful, but he remains angry, frightened, and sad. He is interested in, and responsive to, talking about his mother leaving and options for staying in touch with her. I have begun to discuss with him options for developing plans for living with his older sister when he gets closer to his release date. He can contract for safety by saying he will talk to staff if he feels suicidal.

(P) Discontinue daily suicide watch.
Encourage participation in school and group.
Meet weekly to work on loss of family and plans for release.

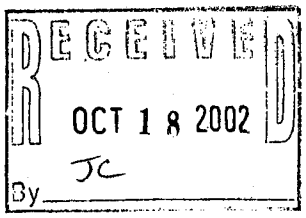
ATTACHMENT

RESPONSE OF THE CALIFORNIA YOUTH AUTHORITY

State of California

Department of the Youth Authority

Memorandum



Date : October 15, 2002

To : John Chen
Chief Deputy Inspector General
Office of the Inspector General

From : Jerry Harper
Director

Subject: **Review of the Intensive Treatment Program of the California Youth Authority**

Thank you for the opportunity to review the Office of the Inspector General's (OIG) draft report "Review of the Intensive Treatment Program of the California Youth Authority". The report includes findings and recommendations in an area of major departmental focus over the past two years - that of services provided to severely mentally ill offenders.

When I took office in May 2000, one of my first directives involved a major operational review of an intensive treatment program. Findings from that review were the catalyst for organizational changes in Institutions and Camps Branch to allow for headquarters oversight for the department's mental health system overhaul. We appreciate recognition in the report of Youth Authority's concerted efforts to remedy many identified deficiencies. While we recognize that our strategic mental health vision requires much additional work, we believe that the department has made much progress in improving the quality and quantity of mental health services for youthful offenders. Since the OIG's review (October 2001 through January 2002) the department has instituted changes that address many of the findings and recommendations included in the report; we look forward to providing detailed information on those changes.

This report, in addition to reports completed by correctional mental health consultants Joel Dvoskin, Ph.D., and Dennis Koson, M.D., and Stanford University, will assist the department in correcting our deficiencies and improving our system. Under the direction of Assistant Deputy Director Kip Lowe, Ph.D., I have assigned Chief Psychiatrist Ben Templeton, M.D., and Mental Health Program Administrator Paul Woodward, Ph.D., to prepare formal responses and actions initiated to address the findings and recommendations in the review.

As always, thank you for your continued interest in the operations of the Department. Should you have any questions, please call me at 262-1471.

Jerry L. Harper
Director