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Reforming the California Division of Juvenile Justice

Lessons Learned

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1. Context and Purpose of this Study

The state youth corrections facilities, known as the California Youth Authority (CYA), were once regarded as the pinnacle of enlightened juvenile justice practice in decades of the 1960s and 1970s.[2] International travelers and practitioners from many US jurisdictions conducted site visits and attempted to adopt many California policies and practices. The CYA was particularly prized for its innovations in offender classification, therapeutic innovations, and its commitment to the use of community-based corrections programs. While all was not perfect in the CYA, its operations were superior to those in most other states.[3]

In the 1980s the political environment changed and became focused on increasing punishment to deter juvenile offenders. The CYA budget for treatment and rehabilitation was reduced and there was a deliberate effort to make the conditions of confinement harsher. Also, cutbacks in community alternatives led to a large increase in the confined population in CYA. By 1995 the population of CYA facilities exceeded 10,000 youth. Lengths of stay for incarcerated youth were also increasing and a larger proportion of parole violators were sent back to CYA facilities. Governor Schwarzenegger merged the CYA under the umbrella of the state prison system, renaming it the Division of Juvenile Justice (DJJ).[4]

For nearly 20 years the CYA, now renamed as the Division of Juvenile Justice (DJJ), experienced a steady decline in its treatment and rehabilitation programs and a serious deterioration in how its youth were cared for and managed. In first decade of the 21st century, there were a series of suicides in DJJ facilities and well publicized media accounts of severe crowding, high levels of violence, and extensive use of solitary confinement and practices of holding some youth in cages not fit for zoo animals as part of their education program. A video that allegedly showed

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[2] Throughout this paper we will refer to the California Youth Authority and the Division of Juvenile Justice. These different names refer to the same state agency at various points in time. Also, the name of the consent decree changed over time to recognize the new directors of DJJ as the defendant. Originally it was referred to Farrell vs Harper and today it is known as Farrell vs Beard.

[3] Barry Krisberg, **Juvenile Justice: Redeeming Our Children,** Thousand Oaks, CA: Sage Publications, 2005

[4] Barry Krisberg, Lihn Vuong, Christopher Hartney and Susan Marchionna, **A New Era in California Juvenile Justice; Downsizing the Youth Corrections System**, Berkeley Ca: The National Council on Crime and Delinquency and the Berkeley Center for Criminal Justice, University of California, Berkeley Law School, 2010.

several DJJ employees beating a young resident was published on the Internet and made almost all the national television network news outlets.

Recidivism rates for youth leaving DJJ facilities were among the worst in the Nation. Some in the legislature called for the abolition of DJJ or at least a halt to new admissions. In 2003 The Prison Law Office and the prestigious corporate law firm of Latham Watkins filed class action lawsuits against DJJ. The California Attorney General Bill Lockyer and the then California Youth Authority ordered an exhaustive investigation led by a panel of juvenile justice experts. This 2003 review found that the DJJ was violating many state and federal laws and engaging in serious violations of the US Constitution.[5] Based these findings, Governor Schwarzenegger agreed in 2004 to a settlement of a lawsuit that is today known as Farrell v. Beard. This consent decree is one of the most far reaching remedial plans in American juvenile justice history. [6]

Here is when the downward spiral of California youth facilities began to slowly change. The Legislature appropriated a significant amount of funding to remedy some of the critical staffing shortages and several new laws were enacted to limit the types of youth who could be sent to DJJ.[7] New leadership was recruited the lead the reforms.

As of July 2014, the DJJ has met virtually all of the requirements and the outside monitors have agree that the DJJ is in substantial compliance with issues in the areas of Safety and Welfare of youth, Health and Dental Care, Education, Disability Rights and effective programs for Sex Offenders. While not completed, the DJJ has made major improvements in Mental Health diagnoses and treatment. It is expected that these areas will be completed within the next 18 months.

Even more remarkably, the DJJ population fell below 680 youth in 2013[8]. The legislature enacted several laws that encourage the counties to hold non-violent, non sex offenders in local programs. Parole violators, once about half of the CYA institutional population, are now also managed at the county level. Localities receive approximately $120 million annually to provide services for these youth. The DJJ closed 8 institutions and 5 camp programs. This decarceration effort is the largest one ever in the history of the juvenile justice system.[9] And, despite predictions of "doom and gloom" by many law enforcement officials, the juvenile and young adult arrest rate has continued to decline and there is no evidence that more young

[5] The complete set of reports that were filed by the experts is available via the Prison Law Office (www.prisonlaw.com)
[6] Prison Law Office (www.prisonlaw.com)
[7] Sue Burrell, "The Legislature's Role in Juvenile Justice Reform: A California Example**", NCCD BLOG**, Oakland CA: NCCD, April 7, 2014.
[8] Nancy Campbell and Associates, **Office of Special Master Report #29**, Sacramento, CA: The California Department of Corrections and Rehabilitation, 2014.
[9] Krisberg, Vuong, Hartney, and Marchionna. op cit., 2010.

people are being sent to adult prisons or jails, or being housed in county detention centers due to the decarceration at the state youth facilities.[10]

The goal of this paper is to understand the key elements of this remarkable success story. The story is not well known outside the DJJ and the people involved in the Farrell consent decree. Lessons learned are highly relevant to the future of other juvenile corrections systems and for adult corrections as well.

While not perfect, the current DJJ is one of the most progressive juvenile corrections systems in the Nation. The DJJ today offers many very valuable policies and processes that could well benefit other jurisdictions. This report attempts to understand the people and the methods that produced this extraordinary step forward in the enlightened treatment of troubled and troublesome young people.

2. Study Methods

To complete this study I reviewed the original CYA consent decree materials and well as the remedial plans submitted by DJJ. I had access to all of compliance reports developed by the various experts that were appointed by the court in the Farrell consent decree. These generally included comprehensive summaries that each of the experts produced at yearend for the period 2009-2013. Most important, I could rely on excellent reports on the progress of the remedial plans that were submitted by the Office of Special Master (OSM). I had in depth discussions with the OSM Nancy Campbell and the Deputy OSM John Chen. [11]

I conducted far ranging interviews with the principal plaintiffs' attorneys Donald Specter and Sara Norman of the Prison Law Office as with Van Kamberian who represented the defendants in the Farrell case.

I developed a very brief questionnaire about the reform process and conducted 30-45 minute phone interviews with many of the Court experts and with virtually every DJJ manager that worked on Farrell remedial plans. I was able to have detailed conversations with the superintendents of all the remaining DJJ facilities. I asked each of these knowledgeable interviewees to reflect on the largest challenges faced by DJJ and their view of major accomplishments. I asked the interviewees to discuss their perspectives on the "unfinished agenda" of reform, the keys to successes. We also discuss remedial strategies that did not yield the expected positive results.

[10] Krisberg , Vuong, Hartney and Marchionna.,, op cit., 2010

[11] All of these materials are available from the Prison Law Office (www.prisonlaw.com) or the California Department of Corrections and Rehabilitation (www.cdcr.ca.gov).

Each of the interviewees was asked to identify other people to be interviewed. In all, I talked with over 50 DJJ and Farrell case insiders. I also reached out to a number of outside youth advocates who had closely followed the DJJ reforms. While I have tried to faithfully reflect these staff, advocates' and management perspectives, I assume the ultimate responsibility for all of the observations and opinions in this report.

While I briefly examined the dynamics of reform in each of the remedial areas, I focused primarily of the major elements of the Safety and Welfare plan with which I had direct familiarity.

In the course of may several site visits to DJJ institutions, I conducted over one hundred interviews with youth residents and staff. These interviews were conducted under strict requirements of confidentiality and privacy. These first hand viewpoints were partially summarized in prior reports written for the court. [12]

I had total access to DJJ data on incident reports, youth grievances and UOF (UOF) reviews. Each month I participated in a multi-disciplinary staff task force that review a cross section of UOF reports, including staff behavior reports about youth, and the case plans and case notes on individual youth. The DJJ allowed me complete access to any information that I requested and respected my request to preserve the confidentiality of the youthful residents. I visited the DJJ facilities many times over the past 10 years and have enjoyed open access to all living units and staff in DJJ.

To place these observations within a broader policy context, I reviewed excellent case studies that were conducted in other state juvenile facilities in Arizona, Massachusetts, Missouri and New York. These were all states that made major strides in correcting legal deficiencies and implementing evidence-based policies and practices. The findings of these case studies will be compared with the DJJ findings.

3. What were the most difficult challenges facing DJJ?

The state facilities faced significant crowding. Even as the population declined from its peak of over 10,000 youth residents in the late 1990s, many living unit were still jammed with youth with often more than 65-70 young people in a unit. Custody staffing levels were inefficient and personnel to deliver core services were inadequate. Further, the CDCR possessed byzantine and

[12] Barry Krisberg**,** "The Long and Winding Road: Juvenile Corrections Reform in CA", **Chuo University Law** Review, May 2011; Barry Krisberg, "Reforming the California Division of Juvenile Justice: What is the End Game?" **Federal Sentencing Reporter**, Volume 25:pp.281-285, 2013; and, Barry Krisberg**, Farrell vs. Beard: Final Comprehensive Report on Safety and Welfare,** Berkeley, CA: Chief Justice Earl Warren Institute, University of California, Berkeley Law School, 2013.

time-consuming policies to evaluate and sanction staff were engaging in serious misconduct. Abuses in workman's compensation and leave practices reduced the actual number of staff that showed up at work to supervise the youth.

Crowding was exacerbated by the closures of some DJJ facilities due to the crumbling infrastructure and the expense of fixing the electrical, sewage, and plumbing systems in these older facilities. Other facilities were shot down for a variety of other reasons including media accounts of abusive practices, and riots and fires that destroyed several older living units. There were consistent budget pressures by the Department of Finance and the Legislature to reduce the costs of the system. Within a few years the DJJ closed 8 major institutions and 5 camp programs. Despite CDCR plans to "re-purpose" these closed institutions, most have remained shuttered or were torn down. Budget cutbacks led to the closure of many vocational and education programs. Even recreation offerings were shrunk. Medical, dental and mental health services were not well funded and reentry or parole resources were disappearing. Staff morale was very poor.

Annual costs per youth had risen seven-fold in the early 2000s due to new union contracts that included significant salary and benefit increases. There were also added overhead costs created by the oversight of the Department of Corrections and Rehabilitation. The substantially enhanced health care, education and treatment services that were mandated by the legal challenges pushed up the costs of DJJ operations. As the resident population declined, DJJ was unable to shrink its Headquarters staffing and costs to match the smaller system... All of these factors made the per youth costs climb.

For several years DJJ staff had embraced the professional orientation of adult corrections officers. To justify increased pay for its members to the level of state police officers, the DJJ union leaders asserted that youth facilities were as dangerous as the state prisons and constituted "the toughest beat in the state". The conventional corrections mentality was to confront, contain and punish misconduct by the young residents. While there were many staff interested in delivering rehabilitation programming, these employees were not supported by management for many years. In almost all aspects of DJJ daily activities, security and custody were the overriding considerations. DJJ lacked written policies in many crucial areas, leaving staff to make snap judgments on how to handle many complex and threatening situations The Division was operated with very informal management methods, Programs and services were not routinely monitored or evaluated by DJJ leaders. Anecdotes, not reliable information, drove facility and Headquarters decision making.

There was a major problem of violence in DJJ facilities. Frequent numbers of fights, staff assaults, facility lockdowns and group disturbances became the daily norm. Fear of out-of-control violence led staff to rely excessively on mechanical and chemical restraints to control

the perceived chaos in the living units. The use of solitary confinement and youth locked in their cells 23 hours a day grew. As noted earlier, there was a rash of attempted and completed suicides.[13]

The totality of the facts listed above eroded support for the in the DJJ among juvenile justice professionals, youth advocates, elected officials, the media, and the public at large. There were questions about how long the state should continue to operate corrections programs for youthful offenders. The largest challenge faced by DJJ managers was to somehow restore confidence that the organization could operate in professional and effective manner. The steady barrage of criticism of the DJJ in a variety of public forums created bitterness and a sense of impending loss of jobs among virtually all DJJ direct care staff and managers. Over the many years of steady decline, the DJJ suffered from inconsistent and ever changing leadership. Since 1980 there had been more than 20 directors acting directors of the agency and several of these political appointments lacked apparent qualifications and training to run a major youth corrections agency. In an era dominated by the rhetoric of "getting tough on crime", Governors generally preferred candidates with law enforcement backgrounds and histories of political party loyalty.

Another dilemma was that DJJ became more and more isolated from juvenile justice professionals at the county level and with those from other states. DJJ managers stopped attending national conferences of juvenile justice professionals. The internationally renowned CYA research division was gutted. Very little research and evaluation was being conducted and the DJJ was not especially welcoming to university-based researchers. DJJ leaders were not exposed to the emerging research on evidence-based programming. Moreover, there was great resistance in the agency to learning about alternative approaches that were being implemented in states such as Missouri, Oregon, Colorado or Washington State.

4. Significant Reform Accomplishments

The DJJ has met or exceeded the mandated reforms that were listed in the Farrell consent decree in most areas involving dental and medical health care, sex offender treatment programs and general and special education issues. There is substantial compliance with the dictates of the remedial plans in the areas of the care of disabled youth and in most of the safety and welfare issues. There are only a few outstanding matters in these last two remedial areas that are being monitored by the OSM.

[13] Barry Krisberg, **General Corrections Review of the California Youth Authority,** Oakland Ca; NCCD, December, 23, 2003 and Steve White, **Review of the Temporary Detention (23-and-1) Program at Six California Tooth Authority Corrections Facilities,** Sacramento, CA: Office of Inspector General, December 18. 2000.

Reforms in the Mental Health domain were last to really get going at DJJ but the Court Expert Bruce Gage has noted that substantial progress is being made and that DJJ was almost halfway through to full compliance the required Mental Health remedial tasks...

Most dramatically, the youth population of the DJJ has been reduced by over 90% from when the initial Farrell case was filed. Today there are less than 700 youth confined in DJJ's three institutions and one camp grogram. This number includes about 140 youngsters who were sentenced as adults and may be transferred to CDCR when they become 18 years old.

As noted earlier, many obsolete DJJ facilities have been closed and the remaining living units are all well below the Farrell goals of 32 youth in a living unit and 16 youth per wing. While staffing at Headquarters and some facility administrative staff have been modestly reduced, the ratio of direct care staff to youth is quite impressive. Staffing ratios have also been improved for teachers, health care professionals and mental health professionals.

Many of these reductions in the youth population and staffing enhancements were produced via legislative actions and consistent support of DJJ budget requests from the Governor's Office and Senate and Assembly Budget Committees.

Reducing policies and practices harming youth

As noted earlier, the alleviation of crowding and the implementation of more appropriate staffing levels produced a significant decline in violent incidents in terms of youth-on-youth assaults, staff assaults, and group disturbances. Reducing violence and fear at DJJ facilities is at the core of the Farrell remedial plans. These drops in violence were most pronounced at the OHCYCF but also were observed at the NACYCF. Violence reductions took longer to manifest at the VYCF which was the most troubled of all the DJJ facilities for the past several years. But in the first half of 2014, Ventura recorded lower levels of violence than in previous periods. And it appears that more improvements could be expected in the near future.[14]

Reductions on youth violence were also accompanied by a number of very positive outcomes. The frequency of the UOF went down significantly at OHCYCF and NACYCF. There was also progress on this issue at the VYCF. For example, the rate of UOF incidents at Ventura dropped from a high of .73 per 100 days of youth confinement in May 2013 to .48 per 100 days of youth confinement in May of 2014.[15]

[14] Detailed evidence for much of what is reported in this section can be found in Barry Krisberg,**, Farrell vs. Beard: Final Comprehensive Report on Safety and Welfare,** Berkeley, CA: Chief Justice Earl Warren Institute, University of California, Berkeley Law School, 2013 and Nancy Campbell and Associates, **Office of Special Master Report #29,** Sacramento, CA: CDCR, 2014

[15] DJJ, Farrell vs. Beard Consent Decree Dashboard, July 2014.

DJJ developed a set of comprehensive policies designed to limit the UOF and to encourage staff to deescalate the response to youth behavior. Direct line staff received increased training in conflict resolution and safe intervention approaches. The use of chemical restraints has not been completely eliminated but its use is way done in mental health units and in cases involving single youth that do not involve assaults of other youth or staff.[16]

DJJ developed a regular format by which each facility reviews its major UOF incidents on a monthly basis. These reviews are conducted by a multidisciplinary team at the facility and cover topics such as staff compliance with formal policies, the completeness and accuracy of OUF incident reporting, and whether there may have been more appropriate responses to the circumstances that led to the UOF. Where indicated, these reviews lead to internal investigations and/or mandated additional training and close supervision for the involved staff.

Security managers are required to examine whether the UOF was the least amount required to protect the safety and security of the youth and staff. The review must consider the disability status of the youth and if the ADA requirements were followed. The timeliness and adequacy of the medical staff's response to UOF events is also evaluated.

At DJJ Headquarters, an interdisciplinary team of managers, the Deputy OSM and the Court expert on Safety and Welfare convene monthly to examine a sample of the UOF cases at every facility. This Headquarters team assesses the adequacy of the facility-level review process and makes recommendation for further actions as required. The Headquarters team, chaired by the Deputy Director of DJJ, produces a memorandum to each facility on needed corrective actions. Also examined are case notes produced after the event to provide greater insight into causes of UOF incidents and guidance on how to prevent reoccurrences on these events in the future.

The UOF review process evolved from the recommendations of a staff and management task force designed to reduce UOF especially for youth with disabilities. That task force reviewed scores of UOF reports and found that past practices were inadequate. The new guidelines to review UOF were vetted by the OSM, the Court experts for S&W and Mental Health and the plaintiffs' and defendants' attorneys. The resultant UOF scrutiny is comprehensive and thorough. Few if any juvenile corrections systems across the Nation have a comparable UOF review processes. No such careful UOF examinations are routinized in most California county facilities. One exception is LA County that was subject to a major US DOJ lawsuit.

There have been significant reductions in the reliance on solitary confinement in DJJ since 2005. The older and discredited policy and practice of confining youth in a lockup unit for 23 hours a day with minimal services is gone. In its place, the DJJ has developed a range of options that constitute a short term limitation on the program of youth who are in some kind of crisis and

[16] Barry Krisberg, 2013 op city and Nancy Campbell and Associates, 2014, op cit.

who may be a danger to themselves or other. These alternatives include a very short term "cool down period in the youngster's room (or in a separate room in those few remaining dormitory units. Another option for staff is to utilize "room confinement" in which the youth stays in their own room, usually for less than a day. Youth needing more specialized attention are managed in the Treatment Intervention Program (TIP) that is designed to last only a few days.

Data on TIP for June 2014 revealed that more than half of the youngsters assigned to this program were returned to regular programs within one day and only 18% were in TIP for more than 3 days. Most important, the TIP program includes educational services, mental health services and is designed to return youth back to their regular programs as soon as possible. The goal of TIP is not punishment, but closely monitored separation for a very short duration to assist the youth to return to a more appropriate program placement and treatment services. These limited program options permitted DLF to eliminate Temporary Detention that had been a regular feature of past DJJ practice. Further, these programs rely on delivery of counseling and mental health interventions, not depravation of basic services. Youth in TIP generally spend a large number of waking hours out of their rooms and engaged in education, recreation and other positive activities. This approach is consistent with the best professional thinking and the growing literature on the harm to adolescents of extreme isolation.[17]

The most restrictive level of limited programming is the Behavioral Management Program (BTP). These youth have engaged in repeated and very serious disciplinary infractions. The BTP program had 65 youngsters assigned to it in June 2014. The 22 youth in the OHCYCF BTP stayed an average of 37 days. At NACYCF there were 15 residents of the BTP, who stayed an average of 106 days and at VYCF there were 28 youth who stayed and average of 106 days. These average lengths of stay figures are greatly affected by a very small number of young people who might remain in the BTP for a very long period. More typical BTP assignments are for less than two months.

Before the Farrell reforms took hold, the DJJ lockup units had as many as 400 youth on any given day and the length of stay was at least 270 days. In the "bad old days" the lockup units included a wide range of youth who had engaged in serious assaults, had defied staff orders, evidenced severe mental health issues, or were in the lockup unit in protective custody. The BTP is now almost reserved exclusively for very assaultive young people and the DJJ uses its other programming options for other youth people who may need temporary separation from their regular living units.

[17] Paul Demuro, **Toward Abolishing the Use of Disciplinary Isolation in Juvenile Justice Institutions: Some Initial Ideas,** Wilmington, North Carolina, January 22, 2014.

Youth in the BTPs spend most of their waking hours outside their rooms, receiving a full range of education and treatment services. The BTP staff assist the youth to gradually reenter their regular housing units through a phased process of helping the youth increase their personal skills to manage and defuse potential violent situations.

The BTPs are still evolving as a program model. In the early days of the BTPs, these units closely resembled the old 23- and - I units– with extensive use by staff of mechanical and chemical restraints that were employed on a routine basis. As staff on the BTP units received more training and coaching in the new model, the conditions and treatment of the young people in the BTPs markedly improved.

DJJ introduced more services, counseling and groups in the BTP units that focused on cognitive behavioral skills, anger management and preparation for community reentry. Staff assigned to the BTPs have embraced its new philosophy of increasing mental health services, improving youth communication and conflict resolution skills, and providing opportunities for vocational and educational achievements.

Idleness was a big issue at DJJ in the early days of the Farrell case. Youth spent many hours in their rooms or in living unit day rooms. School was often cancelled due to lack of teaching staff. Vocational programs and post-secondary classes, once a strong point in CYA facilities, had all but disappeared. Recreational programming was minimal and art and music offerings had all but disappeared. Religious services were under staffed and underfunded. Library resources were poorly organized and not very accessible to the youth. Almost all the young people wanted work assignments but unemployment in DJJ was epidemic and chronic.

The Farrell experts believed that idleness was a major contributor to violence and other serious misbehavior among DJJ residents. DJJ staff also clamored for more activities to keep the young people positively engaged and motivated to succeed. One important component that cut across most of the Farrell Remedial plans was to establish a target of the number of waking hours that youth would be expected to be involved in positive, prosocial activities. Next it was vital to develop a Program Service Day (PSD) for each living unit that would organize the various services, allowing education, counseling, groups, recreation and health care staff to get work assignments completed Staff struggled over the reconciliation of the different work schedules of differing kinds of DJJ personnel. Management decided to assert the primacy of education services, but insisted that adequate time be devoted to other youth needs. It took some time to development the Program Service Days and to train staff on the necessity of actually following the schedules. The DJJ was also able to make use of a newly completed automated information system to ensure that the PSD guidelines were being followed – or that impediments to offering the PSD were identified and removed. The PSD was commenced on a pilot basis, but it was it

was eventually adapted and expended to all DJJ living units. Staff and youth expressed strong support for the predictability and daily structured that resulted from the PSD.

The implementation of the PSD was indicative of a decisive move by DJJ manager to upgrade and improve virtually all of the agencies policies and procedures. Prior to the Farrell litigation, there were inconsistent and uneven practices between the facilities and within living units at the same facility. Staff were legitimately confused as to what would be expected of them in a multitude of areas. For a major state bureaucracy, it was unusual that the DJJ ran so informally, with little documentation or accountability. When problems would arise, staff were uncertain if they would be blamed for untoward outcomes. DJJ managers and direct care staff became increasingly "risk averse" and thus limited the nature and extent of youth opportunities that could be put in place. Youth interpreted the lack of consistency by staff as prejudice or bias, and they perceived staff reluctance to try new activities as indicative of a general lack of regard for their well-being. If there were rules, no one seemed to know what they were.

In all the DJJ developed or refreshed nearly 800 operational policies and procedures. Rewriting policies encouraged different disciplines to work together and for facility managers to weigh in on particularizing the agency-wide policies for their facilities. The revised policies were closely vetted by the Court experts and the Plaintiffs' counsel. The updated policies were designed to be consistent with federal and state legal requirements, and the policy teams looked to best practices identified in the juvenile justice literature. The DJJ policy development team surveyed several other states for advice and copies of existing policies. Union representatives were included in these discussions through a "meet and confer" process, but did not possess veto power on the central elements of the policies. Once the policies were approved by top DJJ management, the agency mapped out a deliberate strategy to train all of those who needed to understand and implement the new policies. In a sense, this process led to a fundamental reinvention of the DJJ that was consistent with its new mission to be a place of high quality evidence-based services for troubled youth.

Expanding and enhancing treatment and rehabilitation services

The transitions at the DJJ are all examples of the efforts to counteract or eliminate ineffective and harmful methods to influence youth behavior. However, of equal importance were major strides forward towards enhancing the positive interventions with DJJ youngsters. There have been substantial upgrades in the quality and quantity of resources devoted to health care, mental health services, and support of youth with disabilities and educational and special education programming. As part of the Farrell consent decree, the DJJ committed to constructing and implementing a model treatment program. While this objective was very ambitious, and very few states offer good prototypes of model treatment systems, the DJJ

made an unequivocal commitment to offering high quality evidence-based rehabilitation services in a planned and systematic manner..

DJJ managers visited other juvenile corrections systems in Washington, Colorado and Missouri to learn from the treatment approaches in these jurisdictions. The decision was made to develop an Integrated Behavior Treatment Model (IBTM) that was tailored to the unique attributes of youth and to other localized factors including the length of stay, the influence of gangs in DJJ, the shared responsibility with counties, and the larger size of California facilities. The Court experts worked closely with DJJ managers as well as consultants from Orbis Associates, faculty at the University of California campuses at Davis and Irvine, and the University of Cincinnati.to build the IBTM. Representatives of the Prison Law Office were intimately involved in the review and definition of the new IBTM.

The first important element of the IBTM was to implement a validated risk and needs assessment system to inform case plans. Next, DJJ staff needed to develop a comprehensive case management process and train those staff that would fulfill this function. The case planning process would logically lead to DJJ youngsters to be assigned to evidence-based interventions, both group sessions and one-on-one counselling. The IBTM envisioned that case plans would be updated at a regular interval and would help supports subsequent reentry planning.

Another critical element of the IBTM were clear policies to respond to youth conduct with both appropriate negative sanctions and a system of positive incentives or rewards for youth who were actively participating in rehabilitation and educational programming. The older behavior management system was “all sticks and few carrots”. Staff needed to embrace a different viewpoint that valued positive re-enforcements for youth rather than the routine reliance on punishment and deprivation of basic services. The theory of the IBTM envisioned youth going through a series of stages as they progressed towards returning to their communities. Staff at several facilities started up incentive programs that encouraged young people to strive for prosocial behavior and attitudes.

The IBTM was a giant step forward for the DJJ which had not stayed current with the latest research and evidence on what worked to reform chronic and violent youthful offenders. However, it was not enough to just have a set of written policies that articulated the goal and objectives of the IBTM. It was imperative that the leadership of the DJJ, the facility superintendents, the middle managers and direct care staff needed to understand and embrace the new approach. High quality training was required for all staff in many areas that were essential to the success of the IBTM. Further, the IBTM needed clear metrics so that managers and the Farrell and internal monitors could assess progress of individual youth, of particular

living units, and of facilities. Staff buy-in and willingness to try new interventions were very important. Cynicism and poor staff morale had to be overcome if the new IBTM was to live.

The evolution of the IBTM was a very difficult and time consuming struggle that surfaced fundamental issues of trust and cooperation among various DJJ staff. There were myriads of concrete policy decisions that had to be made after appropriate staff input. For several months the IBTM was more a "paper tiger" than a real reform, although that situation changed. The DJJ needed to reevaluate staffing needs to make the IBTM a reality and all levels of personnel from youth corrections officers, to counselors, mental health professionals and administrative and support personnel needed to prepare for changed job descriptions and changing work relationships. More will be said later about the strategies employed by the DJJ to move the IBMT from theory to reality and the continuing challenges to fully actualizing the IBTM.

Part of the IBTM was a significant upgrading of the treatment services available to youngsters. In the past, a very large number of rehabilitation programs would be started and ended without a thorough analysis of whether these efforts were successful. Individual staff would start up groups and introduce treatment curriculum, but these were delivered on an erratic basis. Programs were often responsive to various fads like "tough love, "the inner wounded child", "scared straight" and "correctional boot camps" or to outside vendors who sought to sell curriculum materials to the DJJ. There were many discrete programs tried but no evidence that any one of these interventions had the proper "dosage" to produce positive outcomes No one seemed interested in whether the young people found value in these programs. Too often "treatment meant" sitting in your room for hours and filing out a workbook that might be looked at some point by staff.

One of the most significant positive reforms was that DJJ chose to implement a limited set of interventions that possessed very strong research support. Moreover, the unproven efforts were gradually phased out. Consultants, especially from the University of Cincinnati helped DJJ staff focus on fidelity to the details of the treatment models. A process of ongoing assessment of the selected treatment programs was instituted. Most important, treatment became more interactive and allowed for greater communication and connections among DJJ young people and staff.

Another area of very encouraging reform was improvement of DJJ processes to protect youth rights. Placing great value on fairness in dealing with youth was a vital part of the Farrell consent agreement. Upgrading protections for youth are very important to the overall treatment mission and caused a fundamental shift in staff culture.

DJJ rewrote the Youth Rights Manual and paid special attention to the needs of youngsters with disabilities, eventually the DJJ labored to make sure that the written products were "user

friendly" and available to the youngsters on their living units. Another major area of improvement was a refinement and clarifications to the due process accorded to youth at disciplinary hearings and in determinations about program alterations, especially the process that assigned youth to BTPs and other limited programming units. DJJ also developed clear and consistent criteria and a thoughtful process to decide whether youngsters committing very serious infractions should be subject to criminal charges.

At the beginning of the Farrell case, the grievance and complaint process for youth was completely dysfunctional. In the 1970s, California was recognized as a national leader in advancing the appropriate rights youth. Federal legislation such as the Civil Rights of Institutionalized Persons Act (CRIPA) was strongly influenced by many policies and practices of the California Youth Authority.

The DJJ revamped the entire grievance process and retrained staff in new procedures. There were also several external and internal audits of the grievance system that led to further refinements. Over time, the number of youth grievances declined precipitously and the remaining youth complaints were being handled in a timely manner. Problems of staff manipulation of the grievance process were curtailed and youth and staff were encouraged to resolve minor issues on an informal basis so as to build more trust between them.

Prominently displayed in every living unit was basic information about the grievance process, access to the Ombudsperson, opportunities for religious services and timely access to health care. DJJ eventually agreed to provide more opportunities for its youth to regularly confer with lawyers and community youth advocates. Youngsters were given briefings about the impact of federal laws such as the Americans with Disability Act (ADA), the Individuals with Disabilities Education Act (IDEA) and the Prison Rape Elimination Act (PREA). The Youth were also informed about the requirement of the Farrell consent decree. Staff also received this training and they were sensitized to the renewed and enhanced DJJ focus of fairness and consistency in its dealing with youngsters and with their families... Discussions of these issues were often integrated into the large groups held in the living units each morning. Not surprisingly some staff objected to the heightened attention to youth rights, but their opposition diminished over time. The role of top leadership in explicitly supporting the renewed direction on youth rights was crucial.

The Farrell consent decree placed a strong emphasis on involving families in the care and rehabilitation of DJJ youth. Support for this idea had been traditionally limited among DJJ managers and staff, although there were some superintendents that pushed this concept. Many staff assumed that the youth suffered from the abuse and criminal activities of their parents and guardians, so greater involvement with "negative" adults made no sense them.

Over time with training and coaching, this anti-family bias was greatly diminished. Each facility assigned a person to be the family involvement coordinator, the number of visiting hours was expanded and visiting times were lengthened .The DJJ even experimented with video conferencing to help youth keep in contact with parents and guardians who lived very far from the institutions. Each facility began organizing family days for those youth who were doing the best in their education and programming. The family days often involved special activities that allowed the youth and their families to enjoy more normalized interactions. The visiting rooms were redecorated to minimize the jail-like atmosphere of the institutions and to create a welcoming environment. Staff were asked to attend the family days so that they could give the parents an update on how their child was progressing. The DJJ tracked the visiting process and tried to remove barriers to youngsters who wanted to connect with their families.

The DJJ has made impressive progress in implementing a new reentry process for its youth. The best research makes clear that quality reentry planning and support are closely linked to reducing recidivism. Historically DJJ had a Parole Division that was responsible for youth who exited its facilities. In 2010 the Legislature eliminated parole services within the DJJ and transferred this responsibility to the counties. Under SB 1628, the DJJ discharges youth back to the county of commitment. While the state gives localities some funding for the aftercare function, it is less than was previously allocated to DJJ parole, and counties were given little or no direction on how to best organize aftercare programs. There were numerous reports of prior DJJ youngsters who were homeless, unemployed or drifting without assistance. Former DJJ young people who needed medical care, especially medication, found these services difficult to obtain.

Staff with DJJ decided to “step into the gap” by designing an internally delivered reentry and aftercare program, led by a designated reentry specialist at each DJJ facility. The protocol for this program is very detailed and comprehensive.

The reentry specialists help youth to prepare for their hearing before the Juvenile Parole Board and even invite the Parole Board Members to hold seminars for the youth on the release process. Each youth develops an individual aftercare plan with the assistance of the reentry specialist and this plan actively involves the youth’s family members when possible. The plan includes goals in the sectors of housing, education and employment as well as helps the youth to identify local resources to continue work on personal issues after release. Aftercare preparation also includes helping the youngsters obtain a valid driver’s license or ID, registering the young person to vote and signing them up for Social Security, State Disability and Unemployment benefits and the Covered California health program.

The reentry specialist works with the youth to help them to clear up outstanding legal challenges such as warrants, unpaid victim restitution or court costs, and ICE holds. Where

possible, The DJJ aftercare planning and actions are coordinated with county probation officials where the youth will eventually reside.

This aftercare work is very labor intensive and demands that the reentry specialists are committed to" go the extra mile" to make in person or phone contacts and to smooth the transition process as much as possible. The youth report that they greatly value these services and the net public benefits should be realized in terms of fewer young people being rearrested or incarcerated in the future.

5. The Unfinished Reform Agenda

Reforming the DJJ is very much a "work in progress". Many of the excellent changes discussed above are not finished, but are clearly headed in the right direction. More important, it was clear that virtually all of the top leadership, middle managers and a majority of the direct line staff have embraced this new direction for the DJJ.

The current DJJ staff that I interviewed said that they now realized that the reform process would never be completed. They reported that the agency was committed to a constant process of learning about the latest research and best practices, attempting to implement those new ideas, and measuring the results. Ongoing and expanded staff training was seen as a key agenda item for the future.

Other of my interviewees suggested that more progress needed to be achieved on reducing the negative influence of gangs in the DJJ. The DJJ is still in the very nascent stages of a revamped gang intervention model. There has been affirmative progress to improve mental health services but there was broad agreement to more progress was needed.

Several of those interviewed raised concerns about the old and crumbling facilities that were not designed to create a very effective treatment milieu. The "useful life" of the older places such as OHCYCF and VYCF was judged to be not very much longer. Few in the DJJ felt that there would be additional investments in the facilities by the Governor or the Legislature, The best guess is that the worst problems in the DJJ infrastructure would be repaired and efforts should made to humanize the current facilities. It was hoped that future elected officials would tackle the replacement of the DJJ institutions. Many of those interviewed called for reducing the size of the living units even further than the Farrell limits and further enhancing the ratio of treatment staff to youth

The OSM and Court experts pointed to needed further reforms in the implementation of the IBTM. Training in all of the core ingredients of the IBTM still required a more diversified and intensive outreach to staff. In particular, it was noted that there was a need for the top managers to more fully understand the IBTM. There was support for the IBTM in theory but it

was felt that top leadership needed to increase their knowledge and ability to train and mentor others.

Some of the weakest links in the IBTM implementation process were needed improvements and simplification of the needs assessment process and improvements in staff ability to deliver high quality cognitive behavioral training and anger management groups.

A new substance abuse program was piloted from December 2012 to May 2013. In September 2013, the DJJ conducted training for trainers with staff who completed the pilot. The substance program was implemented statewide in December 2013, with the first cycle completed in Jun 2014.

Staff need more training in the operational details of the case management and better tracking of treatment resources for individual youth was needed. Several of those that I interviewed stressed that need for a better integration within the IBTM of counselors, educators and mental health staff. The incentive process and the reinforcement system have really just been launched and there is need to more practicing and adjustments of this core component of the IBTM. Some DJJ staff urged that there should be more opportunities created for youth to play positive leadership roles in a wide range of DJJ programs and services.

DJJ is making admirable steps forward to reintroduce reentry services and to better youth for successful return home. Reentry services must begin earlier in the DJJ process and be tightly connected to the IBTM. Some of my interviewees suggested that the length of stay in DJJ should be shortened further and that there is need for less secure housing options for those youngsters approaching release.

The OSM, the Plaintiffs' lawyers and most of the Court experts believe that the DJJ should further restrict and, perhaps, eliminate the use of chemical restraints – at least for the mentally ill youth or in single youth incidents that presented no imminent threats to the life and safety of youth and staff.

The youth advocates called for better access of the DJJ residents to legal advisors on the range of topics. They also called for continued improvements in the grievance process and the ability of young people to get their concerns heard and acted upon.

Moreover, most of the interviewees were concerned about sustaining the progress made in DJJ into the future. There were worries that future statewide elected officials would abandon the reforms based on public fears about youth crime and violence; what if youth arrests started to increase? It was also expressed that future state budget problems might put closing down the

DJJ back on the table. These DJJ close observers stressed the need for current leadership to aggressively broadcast the "good news story" about the DJJ changes.

Most of those that I spoke with urged that there be stronger coalitions established with county juvenile and criminal justice officials who should be very invested in the continuation of a successful state juvenile corrections agency. It was recommended that the DJJ could offer training and technical assistance to counties in effective policies and practices to treat and educate the most troubled young people. The media and civic groups should be cultivated as powerful allies of the DJJ. The research community should be encouraged to evaluate the effects of various aspects of the DJJ.

A different aspect of sustaining the reforms is to cultivate the next generation of DJJ leadership. Due to state personnel rules, many current DJJ leaders will retire in the next five years or less. DJJ needs to design and implement a process to identify the potential future facility and statewide leaders. There should be high quality training for this next generation of leaders in the latest research and also the best methods to institute and maintain progressive reforms. University-based programs in public policy and management should be asked to assist in this endeavor,

6. How the dramatic DJJ reforms were achieved?

"I get by with a little help from my friends"

Moving from the fairly objective recounting of what occurred, we redirect the narrative to the more subjective and judgmental analysis to identify what led to the successful transformation of DJJ. Reasonable and knowledgeable observers are likely to disagree about the right ingredients of the "reform stew". Interestingly, there was, in fact, remarkable consensus among the diverse interviewees that I polled as to what helped DJJ move from being one of the worst juvenile corrections agencies, to one of the better ones.

The push for major change in of the DJJ came initially from a dedicated group of youth advocates who raised grave concerns about the decline of the California youth corrections system in the 1990s and the early years of the 21st Century. This group included organizations such as Books Not Bars, the Haywood Burns Institute, the Center on Juvenile and Criminal Justice, the Commonweal Institute, the National Council on Crime and Delinquency, the National Youth Law Center, the Youth Law Center, and the Youth Justice Institute. Relying on research and policy viewpoints from federal agencies and other states, these advocates

documented the deterioration of DJJ programs and services. Their vocal critiques of DJJ convinced many in the media and, more importantly, in the Legislature that urgent actions were required.

The calls for reform were mostly ignored by DJJ and the state youth agency hunkered down to defend its tenuous status quo. The proponents for reform pointed to very high rates of recidivism, the growing length of stay of DJJ youngsters that exceeded that of any other state, serious crowding, reports of high levels of institutional violence and the escalating costs of operating the state facilities. Because the advocates were given very limited access to DJJ facilities or data, they often relied on stories that were passed among by former residents and by former staff of the state juvenile facilities.

In 2000 the newly established Office of the Inspector General (OIG) conducted a series of investigations of DJJ in the wake of a series of suicides and riots at several facilities. The OIG pointed to problems of rampant gang violence in the facilities, the prevalence of drugs and other contraband in the facilities, frequent use of solitary confinement and excessive UOF that bordered on torture of some DJJ youth. The OIG noted evidence of the breakdowns in health care, mental health and education services. These OIG reports received little immediate action by Governor Gray Davis but he did appoint new leadership for DJJ.

The Legislature under the guidance of Senator Gloria Romero held a series of high profile hearings based on the OIG reports. The United States Department of Justice Special Litigation Unit conducted a special inquiry into the treatment of youth at NACYCF.

Simultaneously the Youth Law Center filed successful lawsuits challenging the absence of adequate on site health care services and major deficiencies in special education and the DJJ school programs. While these cases took years to resolve, the litigation opened up the agency to levels of outside scrutiny that was not previously possible. In 2003 the Prison Law Office (PLO) filed a comprehensive lawsuit covering virtually all aspects of the DJJ. The PLO had achieved great success in its challenges to the conditions of confinement in the state prisons and enjoyed strong credibility in the Governor's Office and the Attorney General's Office. The litigation was settled and the parties negotiated a detailed set of remedial plans and the Court appointed a Special Master and Court Experts to monitor the remedial agreements. Most of those interviewed for this paper asserted that the lawsuit was a necessary but not sufficient force for reform. These interviewees felt that meaningful reforms would have taken decades to achieve without the lawsuit. Further, the lawyers at the Prison Law Office were genuinely improving the lives of young people in the DJJ. They could the delicate and complex role of lawyers for troubled youth –what national youth law expert Mark Soler referred to as being both "warriors and healers". The PLO was firm in its focus on implementing the Farrell orders, but they evidenced great flexibility and the ability to collaborate and compromise. PLO

attorneys Donald Specter and Sara Norman were “hands on” reformers who got to know and appreciate the staff and the youth in the DJJ.

The Farrell consent decree allowed the DJJ to request substantial additional funds from the Legislature at a time of overall state budget austerity. The consent decree established a clear structure that defined the outcomes to be achieved and timetables for progress. Moreover, the lawsuit resulted in a mechanism of outside accountability that included the Judge, who played a very active role in the case, the plaintiffs’ attorneys, the Special Master and the Court experts. These individuals conducted regular monitoring site visits to all DJJ facilities, assembled massive amounts of information about DJJ operations, and generated public reports on the evolving conditions of the state juvenile facilities.

For its part, the DJJ needed to create an internal cadre of managers that would track the reforms and generate internal and external assessments of progress. Attorneys for the parties, the OSM and the Court experts conferred on a weekly basis and there were settlement compliance conferences before the judge on a quarterly basis. These byproducts of the Farrell case created a new level of transparency and accountability that supported the change process. Reports authored by the OSM and the Court Experts, as well as Court hearings, were open to the public and generated additional media coverage about the conditions in DJJ and the challenges faced by its youthful residents.

The lawsuit also offered state officials political cover as they liberalized and humanized the conditions and programs within DJJ. The more conventional “tough on crime” voices were still powerful in DJJ, the media and the Legislature. However, the Farrell consent decree allowed the DJJ leadership to argue that they had no choice in the matter. While the initial reforms may have been based on the lawsuit, the current leadership and staff have shifted the perspective towards viewing these changes as the right thing to do to achieve better outcomes and to reduce recidivism for DJJ’s youth.

The Farrell consent decree introduced a set of nationally respected outsiders, including the OSM and the Court Experts, who offered their experience and knowledge of the latest research and professional opinions. Most important, DJJ did not have to search for a new mission and vision; the Farrell consent decree provided the basic framework for the organization. The challenge for the DJJ was to embrace that new philosophy at all levels of the organization and to give it life.

The Legislature and the Governor also played a major role in the DJJ reforms beyond providing additional funds There were several major laws enacted that dramatically reduced the DJJ

population and ended the severe crowding.[18] These legislation actions diverted large numbers of youth, especially non-violent property and drug offenders and parole violators, to local programs and mandated the early discharge of some DJJ youth who had previously served their entire statutory time in DJJ facilities. Other new laws reduced the use of "time adds" by staff as punishment for youth and curbed some of the most arbitrary decisions by the Youthful Offender Parole Board. The upper rage to which youth could be housed in DJJ was reduced from 25 to 21 years of age. Moreover, the Legislature granted substantial funding to counties to manage youth who were formerly sentenced to DJJ.[19] The most current research in the field of juvenile justice suggested that a smaller and better resourced DJJ would be less violence prone and produce better outcomes for youth.

The role of leadership of DJJ

The CYA had been fortunate from its very creation of having outstanding leadership. In particular the former head of California's juvenile corrections agency, Allen Breed, was regarded as an internationally celebrated expert on enlightened and progressive juvenile justice and corrections policy. But after Allen Breed was appointed by President Jimmy Carter to run the National Institute of Corrections, the leadership situation at CYA was never quite the same.

From 1980 to 2014, there had been almost 20 formally appointed directors or temporary heads of DJJ. Only a few of them had come up through the CYA agency structure and possessed even basic preparation for the job. The majority of those who joined the parade of DJJ leaders had backgrounds in policing and adult corrections. They were often outsiders that had to win support within the agency to accomplish their agendas. Few of them stayed around long enough to establish a sustained leadership style and direction. Most of the staff who observed this revolving door of directors, assumed that more changes were soon likely to occur and there was a reluctance to become too closely attached to the current office holder. The ever changing directorship reduced the clout and credibility of the DJJ director in the Department of Finance, the Legislature, or the broader juvenile justice professional world.

In 2010 CDCR Secretary Matthew Cate asked Michael Minor to assume the leadership of DJJ. Minor had already completed long career and was eligible to retire. Director Minor had been promoted through various jobs as a Youth Corrections Officer and Youth Corrections Counselor and was Chief of Security at NACYCF during one of its most troubled periods. He also was

[18] Sue Burrell, "The Legislatures Role in Juvenile Justice Reform; A California Example" NCCD Blog, April 7, 2014.
[19] Sue Burrell op cit.

assigned to be the superintendent at several DJJ facilities, often after the major problems had overwhelmed others in leadership positions at those places. Immediately before being named Director of DJJ, Minor was in charge of all of the DJJ facilities in Northern California.

At the time of his interview with Secretary Cate, Michael Minor made clear that he did not want to take on the assignment to shut down the DJJ. He shared with the Secretary his support for the basic direction of the Farrell consent decree and that CDCR maintain the organization. Director Minor this assurance that the goal was to make the DJJ a treatment model to be proud of, as well as working to close the lawsuit. At the end of a distinguished career in corrections, Minor said that he would rather "go fishing" than preside over a failed agency. He convinced staff that "on his watch" there would be no more facility closures and massive staff layoffs, factors that had created a sense of hopelessness among staff and fear of future uncertainty for DJJ youngsters.

While there are volumes written about the attributes in leadership in the public and private sector, there are a few major factors that are reiterated in these academic treatises.[20] Great leaders are not just good managers—they possess a vision of where they want to take the enterprise. Second, leaders inspire trust and confidence in those around them and they can clearly articulate their vision. Leaders are persuasive and can recruit others to their cause. Leaders know how to delegate authority and hold others accountable. In the words of President Ronald Reagan, they understand the dual principles of trust but verify.

Leaders are agile learners who quickly absorb and evaluate new information. True leaders understand that organizational success is not the product of the "great leader" but must be shared and celebrated with many employees. Most of all, leaders are persistence and possess patience. They understand that fundamental organizational transformations take time to realize and to be sustained. Great leaders take their work very seriously but are humble and can listen to criticism and disagreements without rancor. They are honest brokers who know achieve effective compromises among people who must work together to succeed.

Michael Minor possessed a natural instinct for almost all these traits of a great leader. He had honed these leadership skills in a career at the CYA and the DJJ. Moreover, he adapted his hands-on knowledge of the youngsters in the DJJ and its staff to forge his own responses to the implementation of the Farrell consent decree. He was a respected and experienced administrator who was immediately present at all of the DJJ facilities to meet with youth people and with employees to listen to their fears and concerns and hopes for the future.

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[20] Tom Peters and Robert H. Waterman**, In Search of Excellence, Lessons From America's Best Run Companies** New York City: Harper Collins 2006, and Phillip Selznick, **Leadership in Administration: A Sociological Interpretation,** Berkeley: UC Press, 1984.

The Court, the OSM and the Court experts applauded the selection of Minor as the DJJ's director. They respected his intelligence, sincerity and willingness to absorb new ideas. He was not wedded to the "way that we have always done things" mentality that had hamstrung the DJJ for several years after the Farrell remedial plans were approved by the Court. Minor was an excellent and skillful communicator who quickly established his bona fides in the Governor's Office, the Legislature and among important constituency groups. He protected a willingness to learn and to give a fair hearing to conflicting views – but he also was decisive and firm when critical decisions had to be made.

Virtually all of my interviewees gave ample credit to Minor for consolidating past successes and accelerating momentum going forward. Some of his management colleagues were careful not to diminish past DJJ leaders, but that were very clear that Minor made a big difference in the pace and intensity of the remedial plans.

Other strategies for making the Farrell remedial plans a reality

Central to Minor's leadership style was his ability to identify top managers from within the organization and permit them to translate the broad contours of reform into the discrete operational details of the facilities. Directors of the DJJ in the recent past had relied heavily on outside consultants and their colleagues from other states. Michael Minor focused his trust on small cadre of experienced insider staff that he had known over the years. These strategic staff middle managers brought with them detailed knowledge of how DJJ functioned on a daily operational basis. These management allies were generally supportive of the new reform direction, but could also politely confront the OSM and the Court experts if they believed that some of the new concepts were unworkable. Many of this core teams had begun their careers at the DJJ as direct care workers as counselors or corrections officers. They were skillful at convincing the remaining direct care workers that the changed policies and practices would neither endanger the youth or their co-workers, and they were excellent at translating the general road map of the consent decree to specific implementation activities and systems. DJJ is a para-military structured bureaucracy and does best when the details are specified in advance and staff can rely on clearly defined processes and channels of authority to accomplish their tasks.

The new management staff created a strong sense of continuity and credibility of the reform agenda with the agency's past. They were trusted by fellow staff and could leverage longstanding positive work relationships to enlist others in their mission. They understood the daily challenges faced by the front line staff and could also anticipate problems. It was very helpful to have a core group of top staff that possessed extensive experience in basic details

such as budget development, procurement of needed services, hiring, union requirements and personnel rules.

Virtually all of my interviewees from within DJJ placed great value on the expertise and skill of this new management team. This group was credited with accelerating the pace of reform and winning over other DJJ staff to the changes. This group was the central strategy by in which DJJ top managers achieved widespread buy-in with the Farrell reforms and they were instrumental in modeling the new DJJ culture.

While sometimes teamed up with the OSM, the Court experts and a limited number of outsiders such as the group from the University of Cincinnati, the inner management group provided most of the training of other staff in the new methods. They became versed in the central elements of the IBTM and provided strategic coaching to others. Director Minor relied on this group to develop measures of the success of various reform components and this group worked alongside the Court experts and OSM audit the Farrell mandates.

The management team described above led pivotal reform components such as revising the UOF process, minimizing the use of limited programs, establishing new "business rules" governing staffing patterns, and substantially recreating the DJJ approach to gang behavior in its facilities. There managers made frequent onsite visits to the facilities to confer with the local management staff and to gauge the obstacles to achieving the Farrell remedial plans. These Headquarters staff would work together with the facility staff to design "corrective action plans" to advance the reforms in instances in which they were major issues standing in the way.

Other essential people in the reform process were the facility superintendents and local top managers. The uneven success of the Farrell remedial plans at different DJJ facilities was directly related to the knowledge and skill of the local leaders to translate the plans into daily activities. The facilities at the OHCYCF and NACYCF emerged as the leading edge of the reforms; the VYCF experienced great difficulties in managing change. Leadership at the northern facility complex had all worked together in very collaborative and positive manners with each other and with the new Headquarters team. At the VYCF several of the superintendents were replaced after laudable efforts by Headquarters to improve their performance. Managers at the VYCF expressed strong verbal support for the Headquarters policy directives, but compliance was often superficial or token. The level of trust between the southern and the DJJ Headquarters had been problematic for years.

Minor and his team began to spend substantial time at the VYCF. They participated in training, mentoring and auditing the operations there. The short travel distance from Sacramento to Stockton made interaction relatively easy with managers at the OHCYCF and the NACYCF; whereas being present at the VYCF meant flying down to the Los Angeles area and often staying

there for several days. Early attempts by Headquarters to stay connected to the managers at the VYCF relied on emails and voice and video conferencing. These methods proved of only limited value. In recent months Director Minor replaced the superintendent at the VYCF with a member of his close-in management team. Other members of that team continue to work at VYCF on a regular basis. This enhanced effort at better direct communication and joint problem-solving between Headquarters and facility staff has produced substantial progress in meeting with benchmarks of the Farrell remedial plans, especially in the arears of reducing UOF, eliminating the use of solitary confinement and reducing room confinement. The OSM and the Court experts have also devoted a substantial amount of hours auditing and increasing the level of fidelity with the core elements of the IBTM at VYCF

There are two additional strategies that were mentioned by the persons that I interviewed, First, DJJ utilized the approach of pilot testing some of the large scale reforms before rolling these out statewide. The use of testing and refinements was especially important for the more complex changes required in the areas of the Sex Offender Behavior Treatment Program, the IBTM and improvements in the education and mental care sectors.

Earlier DJJ administrators were determined to implement large scale changes at every facility simultaneously. They felt that it was problematic to continue the old practices with a large segment of the youth population. Further, there was perceived pressure to show results in light of the substantial budget enhancements given to the DJJ. It was all possible that the rapid implementation of Farrell reforms would blunt the ongoing calls among youth advocates to close down the entire youth correction system.

This aggressive approach to reform was not very successful. Instead, the DJJ employed a tactic of piloting some of the largest innovations – first in a single living unit, next in a series of other living units and eventually moving to a second facility. The pilots were begun at the OHCYCF which was judged to be most in tune in the philosophy of the Farrell reforms and where there had been a tradition of strong local management.

The pilot approach had major advantages. Primarily, it permitted the DJJ to experiment with different methods and to evaluate the strengths and weaknesses of various aspects of the program and policy design. The pilot approach created a group of staff who had actually lived with the new program and could be used as effective trainers of other staff. Piloting allowed for rapid modifications in the policies and procedures being tested a small scale. Moreover, the piloting strategy allowed the DJJ to move forward without having to be completely blocked by existing union work rules and agreements. While the pilot testing approach may have slowed the initial realization of some of the Farrell reforms, this strategy made the expansion of the reforms go more smoothly in the near term.

Another strategy that proved very valuable was decision initiated by the OSM and endorsed by the Court experts to conduct the auditing of the remedial plans within a collaborative framework. The central idea was that the Farrell consent decree required that the DJJ take over self-monitoring of the remedial plans in the future. The joint audit teams were believed to create opportunities for this handoff of responsibilities.

The joint auditing process was highly structured. Approximately 45 days before a scheduled site visit to a facility, the DJJ audit team would provide a detailed measurement of all the elements that required monitoring. This report would include all of the backup data that were employed by the DJJ team to make their conclusions. The Court experts had already explained to the DJJ auditors that nature of the evidence that was required.

The OSM and the Court expert would review these pre-audit materials and requested additional information as needed. These pre-audit reports were closely scrutinized for areas of partial or non-compliance as well as for the reasons given for less than full compliance. The Court expert would sample the data for areas deemed to be in full compliance to double check the quality of the internal DJJ audits. Over time, the Court experts would also examine changes in ratings and the rationale for these changes. The internal auditors, the OSM, and the Court expert would confer about the pre-audits in advance of the site visits.

The collaborative audit teams would be on-site for the actual audits. At this time, supplemental data was collected and additional interviews were conducted with staff and the Court expert and OSM interviewed a significant sample of DJJ youngsters and staff. All open living units were visually inspected by the audit team. An informal written and oral briefing was given to the facility mangers and to Headquarters staff shortly after the onsite work was completed. Later, the OSM and the Court Expert filed a formal audit report and received feedback from the Plaintiffs' and Defendant's legal representatives as well as other members of the DJJ management team.

The process produced a very significant level of agreement among the agency auditor and the outside Farrell monitors. Most important, the joint audit process allowed members of the team to learn from each other's diverse experiences and areas of expertise. This solidified the goal of working together to successfully meet all of the requirements of the Farrell consent decree. It fostered a spirit of candid communication and a sincere effort to consider many perspectives within the implementation process. Many great ideas surfaced for improving the quality of the audits and there were agreements that some very complex areas such improvements in the review of UOF, the grievance system and the care of disabled youth would demand follow ups and more in-depth monitoring.

In general the joint teams worked very well together. In some of the highly specialized areas involved in the auditing of health care and education issues there was a need for the Court experts to play a larger role in the initial assessments. This process worked well and permitted a very efficient handoff of the primary auditing role to the Office of Audits and Court Compliance, with the proviso that the parties, the OSM or the Court experts could play a larger role in the monitoring process as needed in the future.

Great ideas whose results were underwhelming

Not every reform strategy meets its expected goals, even if those ideas that would appear obvious. I asked each of my interviewees to tell me what "great ideas" did not pan out or failed to meet their expectations. Sometimes these concepts came directly from the consent decree and other times the reform activities were promoted by the parties, the OSM or the Court experts. When the results were less than expected, the DJJ often revamped its approach in these areas. There was remarkable consensus among the people with whom I talked about the ineffective change models.

The interviewees explained that they had all assumed that the massive input of staff training on wide range of pertinent topics would advance the Farrell reforms. Indeed the remedial plans specified a tremendous amount of new training for virtually all DJJ staff that was to be delivered very quickly. At the beginning of the Farrell case, training was primary offered by a joint Academy with CDCR and was almost exclusively focused on security and safety issues. It was assumed that training in a range of treatment techniques per se was a key to reform.

Initially the DJJ struggled with the pure logistics of scheduling and organizing these training sessions. Training was offered at a central location and staff had to adjust work schedules to facilitate the absence of staff that were undergoing the training. Further, the quality of the training was, at best, uneven. Further, staff frustrated because they were being prepared for programs and systems that did not yet exist and might not be operational for years. Moreover, staff promotions, transfers and retirements meant that many of the staff who had these costly educational experiences was no longing functioning in the jobs for which they were being prepared. Agency policies and procedures were in flux and not entirely consistent with the training being offered. Supervisors were not organized to reinforce and model the principles of training in daily activities.

The training was scattershot with a planned approach to how and when the training should be delivered was needed. The DJJ has now moved to establishing a clear training plan with realistic timetables. DJJ is also working to see that the training is delivered proximate to the time when new programs and policies are introduced. The DJJ is relying less on the joint CDCR Academy

and is utilizing its own internal training staff. Outside substantive consultants are required to use a "Training for Trainers" format so that DJJ staff would become more comfortable and expert in the core training areas. Also, the DJJ has learned the need for top administrators and mid-level managers to learn the materials before it is presented to a larger number of front line personnel. It is also very beneficial to deliver more interdisciplinary training experiences that include education and health and mental health care personnel along with security staff. The list of areas for training has been streamlined and the scheduling of various training is more closely aligned the schedule guiding the implementation of the component of the remedial plans. DJJ is revising its training method to be more participatory and less didactic. New ways of assessing the achievement of learning objectives will include a major focus on demonstrating mastery of the content and skills, not just the number of staff who put their names on sign-up sheets.

Another area of very limited returns for the reforms was the amount of time devoted to disagreements over the proper risk and needs assessment system to adopt. There were also weeks spent on a lack of consensus including the exact treatment curriculum to use as part of the IBTM. Initially DJJ relied on outside consultants a small group of managers to specify its version of the IBTM, Several of the Court experts felt left out of this process and felt that the choices made by the DJJ leadership were not the best ones. After months of work by the DJJ and its consultants, there was only the skimpiest written description of the IBTM.

The Court experts demanded a fuller, research-based model, together with an operations manual and training curriculum for the IBTM. The plaintiffs' lawyers asked for an order to the Court experts and the DJJ to deliver the design of the IBTM and the related implementation tool The Judge helped negotiate an apparent agreement in which the Court experts and their staff worked with the DJJ to produce the requested IBTM materials. This joint drafting team could never reach consensus and months went by with little or no progress seen on the IBTM.

The product of the joint group was very vague and generic in its tone. Responding with extreme frustration, the parties and the Court retuned to the original plan that the DJJ would author the IBTM design with input from the Court experts and the OSM. The lengthy dispute weakened whatever trust may have existed among the parties and the Court experts and finally led to the resignation of the Special Master and two of the Court experts. This "era of bad feelings and bruised egos" stalled the commencement of the IBTM for almost two years.

In hindsight this argument over the most proven evidence-based tools and curriculum materials seems to have missed the essential spirit of the reforms. The differences among competing assessment systems or treatment curriculum were relatively small and unlikely to shape the overall direction of the Farrell reforms. Moreover, this battle lost sight of the core principle that DJJ managers and staff had to comprehend and embrace the reforms. The conflict delayed

gaining of staff buy-in and stymied efforts to improve services for youth. In the end, the IBTM model emerged out of a reading of the research literature, the treatment style that best fit the DJJ management style and the considerable adaptation and refinement that happened as the IBTM was piloted in real living units with actual DJJ young people.

Another early implementation dilemma was created as the parties negotiated about staffing levels and the building of data-based accountability systems before it was clear how the reforms would be fully implemented. This decision resulted is the creation of large amounts of time devoted to documenting activities and youth contacts. Staff complained that they were chained to their computers entering information that might never be looked at, rather than increasing the amount of time that staff could devote to one-on-one counselling and personal interactions with the DJJ youngsters. There were also periods in which many new staff were hired without a clear plan on how they would be utilized or how the living unit teams would function. This drove up the per youth costs of DJJ and raised questions as to whether the agency had "priced itself out of the market". As with training, more is not only better. A simple lesson of this experience is to not staff up until you are clear about their job descriptions and responsibilities. Moreover, don't construct complex and difficult data collection and reporting systems until you have specified the desired outcomes and agreed on the appropriate metric for those outcomes.

The levels of violence in the DJJ facilities seemed to decline as a direct result of the living unit sizes being substantially decreased. Other remedial plan components that set up '"Violence Reduction Committees" had fare less impact on youth safety. For a time it appeared that almost every problems in DJJ was met with a special task force at Headquarter or new committee at each facility. Over time these committees met sporadically and included a number of surrogates for the top managers. Staff devoted time to writing up the group deliberations, but few important actions or changed practices emanated from the expanding number of staff groups. In the end, the DJJ decided to combine and consolidate the work of these staff committees.

While these good faith reform tactics never met their fullest potential, the overall achievements at the DJJ were notable. Many of the key ingredients of positive change did produce the desired results. In the best of cases, the time that it takes to reshape a major state bureaucracy is considerable. But, some of the organizational insights discussed by my interviewees might have shortened the duration of the reform process. Major organizational reform does take considerable patience, focus and persistent leadership. The very complexity of the enterprise and its perilous political context explain why these successes are not witnessed very often.

7. Lessons learned about reforming juvenile corrections systems in other states

Besides the very substantial DJJ transformation, there are lessons to be gleaned from parallel efforts in four states that were well documented by outside researchers. I will briefly review the major findings of those case studies. It is worth noting that most of the major findings of the case studies in these states are mirrored in the observation and interviews describing the California success story.

Closing the Massachusetts reform schools and routinizing the continuum of care

The most dramatic reform in the history of juvenile justice was the closure of all of Massachusetts state juvenile facilities in the early 1970s.[21] There had been threats of federal investigation of the abuses in Massachusetts reform schools, but this was an era before there were major civil rights challenges to juvenile corrections. The strategy of change in the Bay State was the rapid closure of all the state's secure facilities and the transfer of youth to a diverse network of community-based placements and alternatives. This radical strategy was adopted after more modest efforts to create therapeutic communities in the reform schools were sabotaged by the corrections officer union. The Massachusetts Division of Youth Services Commissioner Jerome Miller surrounded himself with a group of trusted top level managers who helped plan and execute the closures. Miller provided the broad vision and left the operation details to his colleagues. [22]

Miller was masterful at outreach to the media and to the most powerful groups in the state. His enlisted the aid of professors at Harvard Law School, the state Bar Association, influential women's groups and the Governor. He helped the DYS youth tell their personal stories and elicited great sympathy for their plight and maltreatment by the corrections officers. He was able to obtain a substantial grant from the Office of Juvenile Justice and Delinquency Prevention to defray the initial costs of setting up the network of alternatives

The dramatic closure of the reform schools led to a political reaction designed to protect the jobs of traditional state employees and avert the closure of facilities that were important to the economy of local communities. A new Governor asked Miller to resign and many of the reforms were blunted by legislative budget decisions and the opposition to reform of many of the judges.

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[21] Jerome Miller, **Last One Over the Wall: The Massachusetts Experiment in Closing Reforms,** Columbus, Ohio, The Ohio State University Press, 1998.

[22] Yitzhak Bakal, **Closing Correctional Institutions: New Strategies for Youth Service,** Lexington MA: Lexington Press, 1973

Over the next decade, the DYS had a series of Commissioners that carefully and deliberately moved the reforms forward. These later leaders of the DYS brought with them strong political ties and detailed knowledge of the Legislature, the judiciary and the state budget process. There were also subsequent Commissioners with very strong credentials in adult and youth corrections. These corrections professionals introduced policies and practices that were consistent with progressive thinking in the field and they played down the political and public confrontational style that was Miller's forte.

Despite the reaction to the closures, Massachusetts did not reopen the older reform schools and the state continued to focus its attention on strengthening the community based system. Research and evaluations supported the promising results in the reshaped DYS and national foundations and OJJDP sought to replicate the Massachusetts experiment.[23]

Creating and sustaining the Missouri Model

One of the earliest replications of the Miller vision was in the Missouri Division of Youth Services. There had been repeated investigations of child abuse of the state's reform school at Boonville. In 1983 the legislature voted to close Boonville and to move to a decentralized system of smaller facilities emphasizing therapeutic interventions rather than harsh punishments. Youth in the Missouri DYS lived in dormitories in facilities that resembled college campuses, not jails. Missourians viewed their youthful residents as students and citizens, not prison inmates. Over the next several years, the "Missouri Model" became the desired template for enlightened juvenile corrections practice.

A major reason for the sustained success of the Missouri DYS reforms was the political skill of its leader, Mark Steward, who built a strong and steadfast constituency for reform among the Legislature and the judges. Steward was able to articulate the new vision in concepts that appealed both to liberals and conservatives in the "Show Me" state. For liberals, the new system offered more humane treatment of youth and less incarceration; for conservatives the system appeared to be less costly and emphasized teaching individual accountability to the youth. Decentralizing the location of the Missouri DYS facilities created economic benefits for the many rural communities that hosted the new programs. It is especially notable that the major reinvention of juvenile corrections in Missouri survived with little challenge during changing state political leadership that spanned the ideological spectrum.

[23] James Austin, William Elms, Barry Krisberg and Patricia Steele, **Unlocking Juvenile Corrections: Evaluating the Massachusetts Department of Juvenile Services**, San Francisco: NCCD, 1991.

Noted juvenile corrections authority Richard Mendel has produced the most detailed and persuasive description of the Missouri DYS model. [24] Mendel places great importance on the decision to downsize the population of the facilities. He also notes that the Missouri DYS created a culture dedicated to continuous improvements and to engagement with the outside community; the Missouri Model depends on a strong and hopeful vision of the potential for youth rehabilitation. The agency articulated and reinforced an organization culture that rejected punishment as the dominant behavior management tool and replaced it with a caring and empathetic approach to its young clients. Mendel believes that the Missouri Model requires that there be highly motivated staff that are willing to engage the youth whenever and where these connections are needed. The staff are taught not to fear the youth and to seek safety through relationships with them, not via coercive practices. Missouri makes preparation for aftercare the central focus of all programs and highlights the necessity of very individualized educational and treatment services. Quality case management is the lynchpin of the Missouri system

The role of staff in reforming the New York State Juvenile Corrections System

A somewhat different analysis of the dynamics of juvenile corrections change involves the New York State Office of Children and Family Services. (OCFS).[25] Professor Cox describes in some detail the perceptions of staff to juvenile corrections reform. She helps us understand how staff might be better enlisted to support change efforts.

In the period beginning in 2007, New York State closed a large number of juvenile corrections facilities that were located around the state. There were several staff layoffs and reductions in facility management personnel. Most of these institutions were located in upstate rural communities and their closure exerted a big economic impact on this region.

Some of these closures were responsive to a deep fiscal crisis faced by the state and by a trend of declining juvenile arrests and fewer youth being sent to OCFS facilities by the courts. . The cost of operating the OCFS placements was approaching $275,000 per youth on an annual basis. Besides the severe budgetary pressures, there were reports of brutal and abusive practices in the facilities. The United States Department of Justice began an investigation under the auspices of the Civil Rights of Institutional Act (CRIPA). This investigation centered on five OCFS facilities and the US DOJ demanded changes to stave off federal civil rights enforcement. The OCFS agreed to a comprehensive agreement to remedy the deficiencies and some of the specific facilities were closed.

[24] Richard Mendel, **The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders,** Baltimore, MD: the Annie E. Casey Foundation, 2010.
[25] Alexandra Cox, **Juvenile Facility Staff Responses to Organizational Change,** New Paultz, NY: The State university of New York, 2013.

The Governor recruited a noted child legal rights advocate Gladys Carrion to reform the New York State System. Ms. Carrion bought in a new management team of trusted professional from other states to manage the closures and to fix the inadequate treatment of OCFS youth.

There was intense staff opposition to the new management team and claims that the program and policy changes had generated a wave of youth violence and staff assaults. A video tape of youth attacking staff at one OCFS institution was taken by a dismissed employee and broadcast on a local New York City television station and the video ultimately went viral on the Internet. The employee union staged work stoppages to protest against the new management team. Members of the legislature and state Auditor General conducted an investigation. The relationship between Commissioner Carrion and the OCFS staff remained strained until she left in 2013 to head up New York City's child welfare and juvenile corrections agency.

Against the background of this intense staff resistance to reform, OCFS was still able to meet most of the requirements of its agreement under CRIPA. There were many improvements in the quality and quantity of rehabilitative services for OCFS youngsters. Other litigation was held off as OCFS made steady progress to reduce the UOF, eliminate unnecessary solitary confinement, introduce trauma-informed therapy for its young people and upgrade mental health and education services.

Alexandra Cox observed that in New York as in other locales, the critical nature of the work of frontline staff was often overlooked or undervalued. The front line staff were often victimized by myths that they lacked basic cultural sensitivity with the largely urban and youth of color who were the inmates of the OCFS facilities. In fact, over half of the OCFS direct care staff were African Americans and many came from the same urban communities as the OCFS young people.

Opposition to reform and program closures was explained away by vested economic interests due to the loss wages and fringe benefits. Staff were sometimes viewed as too punishment oriented and unwilling to truly embrace a treatment philosophy. Interview conducted by Cox revealed that staff resistance to change was rooted in a sense of their being excluded in the planning and design of reforms. Changes in policies and procedures were perceived as confusing, ill-conceived and subject to nonstop revisions. The staff wanted to be part of meaningful discussions about reforms and to offer their practical advice on how to best effectuate the desired results.

Uncertainty as to jobs, changing local management assignments and the future existence of these facilities led to a profound sense of being disrespected and treated unfairly. These staff felt they were victim of the stereotype that they did not support treatment. Professor Cox found that there was actually a significant group of OCFS personnel that wanted to advance

treatment goals for youth. This group wanted a larger role for reentry and educational services for the youth and not just social and emotional therapy.

Professor Cox noted that staff felt unsafe if they perceived a loss of control. As the OCFS changed its policies on UOF, disciplinary practices and isolation, the staff wanted alternatives and tools to better manage disruptive youth behavior and defiance of their authority.

Bedlam in Arizona

The last juvenile corrections case study that I examined was produced as part of the tracking of CRIPA reforms undertaken by the Arizona Department of Juvenile Corrections (ADJC).[26] It revealed a familiar story of abuse and neglect of the youth that caused condemnation of the agency by outside youth advocacy groups and many members of the Legislature. However a surge in the number of suicides by youth and one attempted suicide by a staff member heightened the demand for immediate action. There were also instances in which staff had brutally assaulted one of the youth residents and at least one staff member was indicted for having sex with an underage ADJC resident.

The U.S. DOJ conducted an investigation under CRIPA. Resistance to change was strong among the corrections workers and middle managers at ADJC. The Governor Janet Napolitano established a special task force to examine the causes of the crisis in ADJC and brought in new leadership.

Many ADJC staff agreed that the CRIPA reforms were needed but they lacked confidence that the agency would be given sufficient resources to implement these changes. There was suspicion that the impetus for reform would fade as the CRIPA agreement was slowly put into operation,

As progress to change the organization was too slow, Governor Jan Brewer threatened to defund the ADJC and transfer its youth to privately run programs. The combination of strong outside pressure by advocacy groups and the U.S. DOJ combined with a real possibility that the entire system would close down, produced the impetus of sped up reforms.

Key to the advanced reform momentum was a forceful and influential new Director of ADJC, Michael Branham who built an internal management team devoted to change. Branham had a past career in law enforcement not in juvenile corrections, and some were concerned that his

[26] Scott H. Decker, Melanie Taylor and Charles M. Katz, **A Case Study of the Response of the Arizona Department of Juvenile Corrections to the Civil Rights of Institutionalized Persons Act Consent Decree,** Phoenix, AZ: School of Criminology and Criminal Justice, Arizona State University, 2013,.

police background would send ADJC backwards. But Branham, and his deputy Dianne Gadow, were generally credited with changing the culture of the organization to meet the objectives of the CRIPA consent decree. Branham instituted data-driven accountability systems and created quality assurance processes to sustain the positive changes. There were many more checks and balances that ensured that young people in ADJC were being accorded the care that they were entitled to by law and common morality. Even as Director Branham retired, another leader with a strong background in corrections came in and continued Branham's vision and protocols

Branham immersed himself in agency operations and spent substantial time at the facilities and in the living units. Similar to California DJJ Director Michael Minor, Branham put a high value on transparency and shared the results of the CRIPA monitoring reports throughout Arizona. The level of compliance with the CRIPA agreement rose quickly as ADJC articulated the value of the CRIPS reforms to judges, legislators and the law enforcement community.

Compliance with the requirements of the CRIPA agreement was not uniform in every area. Strides forward were accomplished in discovering and punishing misconduct by staff. Educational services improved but progress in providing adequate medical and mental health care lagged behind.

8. Reforming California juvenile corrections: concluding observations

There are several policy conclusions that should be drawn from this study and analysis. First and foremost, large and constructive improvements can be actualized even in the most troubled juvenile corrections systems. These reforms do not happen overnight and sustaining new methods of treating youth takes patience and a steadfast focus on the goals to be achieved.[27] Central to the humane care of troubled youth is a fundamental shift in the organization culture away from containment, confrontation and coercion and towards empathy, basic knowledge about adolescent mental and social development, and supportive relationships between staff and young people.

Leadership is essential to promoting and expanding the needed culture shift. Staff needs to feel valued and included in the change process. Effective leaders broadcast their vision and rely on others to flesh out the operational details and day-to day reality of this vision. There must be systems of accountability and checks and balances for youngsters and agency personnel. The Leader should be committed to transparency and skilled at establishing and nurturing strong allies for the reforms and there must be sufficient resources dedicated to the human care of

[27] At one Court hearing, the S&W Court expert (me) opined that it should take no more than three years to meet all of the obligations under the Farrell c decree ---I was way off in my estimate of the time needed for reform.

troubled youth. Creating and nurturing an atmosphere of trust among the many individual who will be involved in the reforms is a must.

Litigation or related civil rights enforcement is a valuable predicate for change. Few troubled bureaucracies change spontaneously. However the legal route must be tempered with ultimate attention to improving the care of youth, not just court victories.

Outsiders including Special Masters, Court experts and renowned national juvenile justice figures can add great value by exposing the juvenile corrections agency to the latest research and best professional opinion. They can also create a structure of accountability and standards of performance that are difficult to generate internally.

Change needs to planned, managed and monitored closely. There must be clear lines of authority and responsibility for reform and these must be grounded in the chain of command. It is unwise to try to fix everything that broken all at once. Pilot testing new policies and programs is a very important strategy.

Making progress in upgrading the basic care of youth including medical, dental, and mental health services can lay the foundation for the culture shift that is necessary. The conditions of the living units and the physical plant of institutions clearly communicate what value the adults place on the young people that they serve. It is often promising to start by upgrading the education program because these services are vital to the future success of all of the young people in juvenile corrections.

The preeminent need to develop and assist young people in realistic plans to return home is the centerpiece of high quality juvenile corrections programs. Youth who can see the way back to the community will be more enthusiastic customers of treatment and educational services.

Lastly, we return to the principle that smaller is better. Living units must be made even smaller and the large reform school will likely be a memory in the not too distant past. Smaller facilities promote greater safety and permit the sorts of positive role modeling and counseling that staff want to offer and that the youth desperately need.

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