SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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

NINETEENTH REPORT OF SPECIAL MASTER

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APPENDICES

I. INTRODUCTION

The Special Master submits for filing the Nineteenth Report of the Special Master. This report reviews the *Farrell* Disabilities Expert and Education Expertsô comprehensive reports for their 2011 rounds of audits and summarizes and analyzes the status of the California Department of Corrections and Rehabilitation, Division of Juvenile Justiceôs (DJJ) compliance with the *Farrell* remedial plans. The sixth comprehensive reports of the Education Experts (site visits, February 2011 to April 2011) and the Disabilities Expert (site visits, January 2011 to April 2011) are attached to this report as Appendix A and B respectively.[1] In addition, the Special Master will report on progress from two items identified in her last report, when and how force is used and progress at the Ventura Youth Correctional Facility (Ventura) in implementing a Behavioral Treatment Program (BTP) to effectively address youth with behavioral problems. Finally, the Special Master will discuss Defendantôs decision to close the Southern Youth Correctional Reception Center and Clinic (SYCRCC) and provide an analysis of the outcome of the transfer of monitoring from experts to Defendant.

In previous reports, the Special Master prepared for the Court detailed summaries of the expertsô comprehensive reports. In the ñEighteenth Report of the Special Master,ò the Special Master began to identify significant successes as well as remedial plan areas that the Special Master believes pose the greatest difficulties for Defendant. Consistent with her 18th report, the Special Master will again make recommendations for

[1] Appendix A, OôRourke and Gordon, ñCalifornia Division of Juvenile Justice Summary Education Program Report for School Year 2010-2011;ò Attachment 1, ñCalifornia Remedial Plan Site Compliance Report;ò and Attachment 2, ñComparison of Office of Audits and Court Compliance Report and Education Experts' Audit Ratings; and Appendix B, Hopper, ñCalifornia Department of Corrections and Rehabilitation, Division of Juvenile Justice, Wards with Disabilities Program Remedial Plan, Auditorôs Comprehensive Report for FY 2010-11." (June 27, 2011)

improvement. Recommendations may range from simply identifying or suggesting resolution to advising DJJ about addressing issues that require immediate attention. The parties have agreed that a more useful Special Masterôs report would limit the summaries of the expert reports and instead identify the major areas of improvement as well as areas for concern.

II. EDUCATION

Over a three-month period, from February through April 2011, the *Farrell* Education Experts, Dr. Tom OôRourke and Dr. Robert Gordon (Education Experts), completed their sixth round of monitoring compliance with the Education Services Remedial Plan (Education Plan). The Education Experts and Defendant are commended as the Education Plan implementation is nearing completion. The successful transfer of monitoring of most Education Plan elements will be discussed in Section III of this report. This section of the report focuses largely on the few remaining issues that must be addressed in order for Defendant to achieve substantial compliance.

In Appendix A, the Education Experts provide, (1) a summary report, California Division of Juvenile Justice Summary Education Report For School Year 2010-2011 (Education Summary Report); (2) Remedial Plan Site Compliance Reports for each facility (Attachment 1); and (3) a comparison of the Office of Audits and Court Compliance (OACC) findings with the Education Expertsô findings (Attachment 2). The Education Summary Report includes the expertsô methodology and findings for each area of the Education Plan monitored. Numerous commendations are detailed in the Education Summary Report. Two out of six of the Education Plan elements, curriculum and education exit plans, are in substantial compliance. Of the remaining four elements,

staffing and special education continue to be areas that pose the greatest challenges for Defendant. Each of the Education Plan elements that are not in substantial compliance will be reviewed to identify the remaining issues that must be addressed in order to achieve substantial compliance.

A. Overview, Philosophy and Program Policy

Defendant needs to ensure that the semi-annual reviews of high school graduation plans are completed semi-annually.

The Education Experts have also noted that since DJJ now has only four schools and is preparing to close another, the number of Central Office positions is significantly higher than another comparably-sized school system would have. The Education Experts have worked with senior DJJ administrators to assist in the development of a Central Office staffing structure that meets the needs of the now much smaller school district. While not a specific requirement of the Education Plan, the experts have worked with DJJ senior management in this effort to ensure that resources are targeted where they are most needed--in teaching positions.

Transition planning is an Education Plan element that should be revisited in light of legislative changes that have transferred parole jurisdiction from DJJ to the counties. Re-entry from an institution to the community is most successful when planning for return to the community begins in the institution. Though DJJ no longer has the authority to ensure a structured transition to the community, transition planning should still be done and shared with the county parole authorities. In light of these changes, Defendant should work with the Education Experts to reassess whether it is reasonable to attempt to create evaluation measures for such services as employment, school and/or housing upon

youthsô release.

B. **Staffing**

The Education Experts determined that certain DJJ schools were insufficiently staffed in a timely manner with appropriately credentialed teachers, particularly in the area of special education. Defendant reports that there were 51 teacher vacancies statewide of which 34 exemptions were granted. The ñmost acute teacher shortagesò were at the Ventura School.[2] A hiring freeze made it impossible for Defendant to hire the necessary staff to meet the Education Plan requirements. The Special Master shared the expertsô concerns that youth were not receiving mandated education services and reported these concerns to the Court in the Eighteenth Report of the Special Master.[3] The Special Master agreed with the experts and concluded that staffing shortages, insufficient classroom space and a lack of effective technological support posed substantial obstacles for DJJ in Education Plan implementation.[4]

The Special Master supported DJJôs request to the Governorôs Office for an exemption from the current hiring freeze in order to meet studentsô needs as well as Education Plan requirements.[5] DJJ now reports that the Governorôs office approved its request to fill teacher vacancies at all schools.[6]

Defendant is reportedly making substantial progress in filling the positions. As of July 27th, 19 of the positions had been filled, seven positions had candidates who accepted the positions and were in the pre-employment process (which is being

[2] *Ibid.*
[3] *See* Eighteenth Report of the Special Master, July 1, 2011, pp.14-19.
[4] *Id.* at 19.
[5] *See* Eighteenth Report of the Special Master, p. 54, recommendation 10 and Appendix A at p. 6.
[6] *See* Memorandum, "OSM 19," Associate Director Nylund to Special Master, July 29, 2011. This is also the information source for the next paragraph.

expedited), four positions will be filled with lateral transfers from SYCRCC and will likely coincide with the youth transfers from the closure of SYCRCC and four positions are still in the recruitment stage.[7]

On August 4, 2011, the Honorable Judge Jon S. Tigar granted Plaintiffôs Motion to Enforce Court Ordered [Education and Safety and Welfare] Remedial Plans.[8] ñThe Court required Defendant ówithin 90 days of the date of this order, [to] hire adequate staff to provide the general and special education services mandated in the Education Remedial Plan for youth in general population and restricted programs in DJJô and ówithin 150 days of the date of this order, [to] secure and begin to use adequate and appropriate programming space to provide the general and special education services mandated in the Education Remedial Plan for youth in restricted programs in DJJ.ò[9] Specifically, within 90 days of the Courtôs August 2011 order, DJJ must, ñ. . .hire adequate staff to provide general and special services mandated in the Education Plan for youth in the general population and in restricted programs in DJJ.ò[10] Within 150 days, Defendant shall, ñ. . .begin to use adequate and appropriate program space to provide the general and special education services mandated in the Education Remedial Plan.ò

C. Student Access and Attendance

The Education Experts report that poor school attendance and access to education services remain impediments to compliance with Education Plan requirements. Problematic scheduling with the Program Service Day implementation, youth refusals

[7] *Ibid.*
[8] *See* "Order Granting Motion to Enforce Court-Ordered Remedial Plans and to Show Cause Why Defendant Should Not be Held in Contempt of Court,ò *Farrell v. Cate,* August 4, 2011.
[9] Order Granting Motion to Enforce Court-Ordered Remedial Plans and to Show Cause Why Defendant Should Not Be Held in Contempt of Court, August 4, 2011, at 5.
[10] *Id.* at p. 5. This is also the source for the following sentence.

with lack of appropriate disciplinary action or follow-up, and insufficient provision of educational services for youth in restricted programs, including TD (Temporary Detention) and TIP (Temporary Intervention Program), are still among the Education Expertsô recommendations for improvement.[11] Restricted programs must have in place sufficient custody and treatment personnel to meet plan requirements.[12]

DJJ reports that from February through April 2011, it provided staff ñretrainingò on the Program Service Day with the goal of improving the provision of the mandatory 240-minute school day.[13] The Special Master and the experts have observed and commend DJJ for: (1) Improved access via School Consultation Team referrals; (2) Cooperative agreements between service providers that educational services in all cases supersede other activities except those identified as urgent or needing immediate attention; and (3) Improved documentation in the Ward Information Network (WIN). DJJ leadership reports that each facility now has PSD implementation committees and chairpersons responsible for communicating PSD issues or conflicts to Central Office staff.[14] Unfortunately, as of the experts report, mental health treatment providers continued to compete for youth time during the school/work day. Based on the OSMôs most recent Ventura audit, for example, it appears that staff has improved in tracking youth activities throughout the school day.[15] However, activities are not properly categorized and there is no indication that youth are receiving more services than they received prior to the improved tracking of activities.

[11] Appendix A at p. 8.
[12] *Id*., at pp. 8 and 10 respectively.
[13] Memorandum, Program Service Day, from Alicia Glynn to Dorene Nylund, July 28, 2011.
[14] Statements, DJJ Administrators, OSM/Expertsô meeting, August 1-2, 2011.
[15] *See* Memorandum, Chen to Special Master, July 5, 2011, observations noted during the Ventura Youth Correctional Facility site visit. This is also the source for the following sentence.

Youth continue to refuse educational services without sufficient follow-up by DJJ staff to determine the reason(s) for the refusals. The experts recommend that Defendant develop a plan to identify and remedy problems with unexcused youth absences.[16] DJJ has reported to the Education Experts that it now has the WIN capacity to identify youth school attendance and track excused and unexcused absences. The Education Experts will monitor this WIN documentation process for accuracy during their seventh round.

D. Special Education

DJJ is commended for achieving substantial compliance with most special education audit items; however, additional requirements must be met if DJJ is to succeed in providing a full continuum of services to youth with special education needs.[17] Among the most significant remaining requirements and areas for improvement include the timely provision and tracking of mandated services identified via Individual Education Plans (IEP), including those for youth in restricted custody. Defendant needs to provide a continuum of placement options noted on studentsô IEP's (including a full range of time, frequency, and duration within each option). The Education Experts identify staffing shortages as a primary reason for failure to implement this plan requirement. Defendant has hired a full-time Language, Speech and Hearing Specialist for O.H. Close Youth Correctional Facility (Close) and N.A. Chaderjian Youth Correctional Facility (Chad) which will help to remedy the situation. If DJJôs staffing update is accurate and Defendant is filling teacher vacancies, special education ratings will likely improve in the Education Expertsôseventh monitoring round.

DJJ reports that Defendant continues to work on providing appropriate education

[16] Appendix A at 7-8; and *See* Tenth Report of the Special Master, 2009, Appendix A at p.6; and *See* Sixteenth Report of the Special Master, 2010, Appendix B at p. 8.
[17] Appendix A at p. 10.

services as part of the Behavioral Treatment Programs (BTP).[18] The Education Experts report that sufficient services are usually offered on DJJôs BTP units.[19] The experts are concerned, however, about the provision of services to youth on Temporary Detention (TD) and Temporary Intervention Programs (TIP), particularly youth with Special Education needs. DJJ believes that Defendant has improved the provision of educational services to youth placed on TD or TIP.[20] In March of 2010, DJJ issued a protocol for providing education services to youth placed on either of these program designations. Consistent with the Education Remedial Plan, the protocol can deprive youth of education services for the first 72 hours of their placement on these program designations, which raises concerns discussed in the next paragraph. Defendant reports that at the Superintendents meeting on July 20, 2011, the protocol was again reviewed to ensure that Superintendents are aware of the requirement that education services are provided after 72 hours, regardless of the type, length or combination of a program restriction. Further monitoring will reveal whether these measures are effective.

The Education Experts are particularly concerned about Defendantôs 72-hour policy on the provision of services to youth on TD/TIP where services provided are to special education youth. Defendant must not exceed 10 cumulative or consecutive school days per year during which educational services are *not* provided without the Individual Education Plan (IEP) review and program modifications that address what the Individuals with Disabilities Education Act (IDEA) considers to be a change in placement. Additionally, the IEP team must determine if the behaviors exhibited are

[18] *See* Memorandum, *"*OSM 19," Associate Director Nylund to Special Master, July 29, 2011, p. 2.
[19] Statement, Education Expert, Dr. Tom OôRourke, OSM/Expertsô meeting, August 1-2, 2011.
[20] *See* Memorandum, *"*OSM 19," Associate Director Nylund to Special Master, July 29, 2011, p. 1. This is also the source document for the remainder of the paragraph.

related to the individual's disability. Under the current 72-hour policy, DJJ will quickly reach the 10-day allowable maximum. If Defendant exceeds the 10 school day requirement, he will be in violation of federal law under the IDEA.[21] The Education Experts are also concerned about the practice of extending youthsô stays on TD/TIP beyond the initial 72 hours. The Special Master has agreed to conduct a review of relevant documents to ensure that DJJ is: (1) following its own policy, and (2) determine if the 72-hour policy is feasible given the IDEA and Education Remedial Plan requirements.

The Education Experts are optimistic that once Defendant addresses the remaining issues, described above and detailed in Appendix A and its attachments, he will be in a position to successfully assume the Education Plan monitoring function entirely. Among other tasks, Defendant must first fill remaining vacancies with qualified educators. He must ensure the provision of services to all qualified youth within mandatory timeframes, guidelines and regardless of changes in the student demographic following facility closures. Defendant must meet attendance requirements and ensure that the technology used to measure school absences is current and accurate. Finally, Defendant must rally staff to work cooperatively to ensure that youth get to school, or that school gets to youth, without compromising youth access to other mandated services.

III. DISABILITIES

From January to April 2011, Logan Hopper, the *Farrell* Expert in programmatic access for youth with disabilities (Disabilities Expert), completed his sixth round of monitoring for compliance with California Department of Corrections and Rehabilitation-Division of Juvenile Justice (DJJ) Wards With Disabilities Program Remedial Plan

[21] Statements, Education Expert Dr. Tom OôRourke, OSM/Expertsô meeting, August 1-2, 2011.

(WDP or WDP Plan).[22] As with the expertôs previous reports, this report contains a description of the expertôs auditing and reporting methodology as well as a grid that identifies and explains facility-by-facility compliance ratings for each WDP Plan item audited. For items rated less than substantial compliance, as well as some items rated in substantial compliance, the expert makes specific recommendations for DJJ to meet WDP Plan compliance goals or to improve upon current conditions.

The Special Master has reviewed each of the Disability Expertôs reports for the fourth, fifth and now sixth rounds. The expertôs fourth round report was completed and summarized in the Special Masterôs tenth report. The expertôs fifth round report was completed and summarized in the sixteenth Special Masterôs report.[23] The Disability Expert and Defendant are commended as the Disability Plan implementation nears completion. The Special Master identifies those steps that she believes must be taken to achieve substantial compliance with the WDP Plan.

After years of steady improvement, the overall percentage of audit items rated in substantial compliance declined between the fifth and sixth round of WDP audits, from 86% to 82%.[24] This rating variance alone is not significant because it was largely the result of a misunderstanding during the monitoring process in which Defendant assumed some of the monitoring responsibility from the expert. The misunderstanding resulted in lower ratings for a number of items that, if excluded, would result in the overall rate of substantial compliance to be fairly consistent between the fifth round and the sixth

[22] WDP Expert Hopperôs sixth round audit schedule: January 12-13, 2011, NACYCF; February 9-10, 2011, Ventura; March 2-3, 2011, SYCRCC; March 23-24, 2011, OHCYCF; April 20, 2011, DJJ Central Office.

[23] The Expertôs 4th round report is dated May 29, 2009 and it was summarized in the 10th Special master Report, September 3, 2009 , The Expertôs 5th round report is dated June 12, 2010 and was summarized in the 16th Special Masterôs Report, dated November 19, 2010. Lastly, the Expertôs 6th round report, dated June 12, 2010 will be analyzed in the 19th Special Masterôs Report that will be filed in 3rd quarter, 2011.

[24] *See* DJJ Quarterly Compliance Report as of March 15, 2011.

round.[25] This issue is discussed in greater details in the Transfer of Monitoring Section of this report.

The Special Master has reviewed and analyzed the Disability Expertôs recent comprehensive reports and discussed the issues with the expert and Defendant. In general, the remaining issues can be broadly categorized into those that are WDP specific and those that cross over into other remedial plans. Having reached a clear agreement regarding roles in the monitoring process,[26] the Disability Expert and Defendant should be able to successfully address WDP-specific issues in the next round of monitoring. The Special Master believes that the crossover issues are longer-term efforts that are more appropriately addressed in Defendantôs efforts to implement the Safety and Welfare Remedial Plan and the Mental Health Remedial Plan with advice and input from the Disability Expert.

A. WDP-Specific Issues

The Special Master identified the following outstanding issues that are WDP-specific and should be addressed in the next audit round.

Annual ADA Staff Training in DJJ Policy and Procedure and Awareness, Sensitivity and Harassment (Item 25)

The Disability Expert found the exact number of staff trained in ADA requirements cannot be established until DJJ implements planned Ward Information Network tracking system changes that will identify exactly when and what training has been provided to all DJJ staff. The tracking system is also expected to shed light on the

[25] Based on telephone conversation between Sandi Becker, Wards with Disability Program Manager, and Deputy Special Master John Chen on August 4, 2011.

[26] The WDP Expert is to spot check the results of the Office of Audit and Court Complianceôs (OACC) 45-day review of the items transferred to Defendant. OACC may modify its preliminary ratings if it determines that the facility has taken corrective action to remedy the deficiencies noted during the 45-day review.

reasons for any failure to attend required training. Currently, the Disability Expert estimates that approximately 60 percent of all staff has been trained in ADA requirements, which is insufficient to meet training goals and achieve substantial compliance in WDP implementation.[27]

There may be a misunderstanding or miscommunication between the expert and Defendant on this issue. According to Defendant, the required training has been incorporated into curriculum of the 40 hours of mandatory classroom training, commonly referred to as ñBlock Training,ò which is required annually for all Bargaining Unit 6 staff in accordance with the state's collective bargaining agreement with the California Correctional Peace Officers' Association.[28] Other classifications at the facilities receive parts of the annual training.[29] The "Block Training" is tracked at each facility by the In-Service Training Manager in the Training Information Management System(TIMS).[30] The 60 percent figure cited by the expert may have been caused by a timing difference as ñBlock Trainingò is tracked on a calendar year basis whereas the Disability Expertôs site visit of Defendantôs Central Office was made in May 2011 when not all staff had completed the training. The expert and Defendant should meet and clarify any misunderstanding and reach agreement on documentation requirement to resolve this issue.

Youth not precluded from assignment to a work or camp program based solely upon the nature of the disability (Item 26)

[27] Appendix B, pp. 5 and 16.
[28] Based on email of August 8, 2011 from Sandi Becker, Ward with Disability Program Manager, to Deputy Special Master John Chen.
[29] *Ibid.*
[30] *Ibid.*

The expert recommended Defendant develop a form to demonstrate compliance with this remedial plan item. This recommendation does not appear to be unreasonable. Defendant should consult with the expert to develop a form or some other viable tracking mechanism.

Program for youth with certain developmental disabilities (Item 21)

Defendant indicated that he has completed an assessment of all youth and is in the process of recording and documenting the assessment in its WIN system starting August 2011. The assessment was made in accordance with a protocol that was adopted after incorporating comments from the Disability Expert. Defendant also indicated that, to date, only six youth have been identified under the protocol who meet the criteria of having a developmental delay[31] and Defendant has identified four concepts for providing programs and services for these youth.[32] However, the Disability Expert questioned the validity of the Defendantôs assessment as he believes the number may be too low.[33] The Disability Expertôs belief is based on the following considerations:

- The Disability Expert indicated that there are another 10 to 12 youth who were previously diagnosed as developmentally disabled but were excluded from the current list of six youth.[34] He believes some or all of these previously diagnosed youth should be included on the list. Defendant staff indicated that all of these youth have been evaluated under the adopted protocol and were not deemed to be developmentally disabled. Nevertheless, due to the expertôs concern, Defendant has initiated a

[31] *See* Memorandum, Associate Director Dorene Nyland to Special Master, July 28, 2011.
[32] Teleconference, Sandi Becker, WDP Manager and Deputy. Spec. Master, John Chen, August 4, 2011.
[33] See letter, Disability Expert Logan Hopper to Special Master, August 30, 2011.
[34] Ibid.

reevaluation of this group of youth. The reevaluation is to be conducted by clinical staff independent of staff from the initial evaluation.[35].

- The Disability Expert indicated that he was informed by a Defendant staff that there were approximately another 40 youth pending follow-up evaluation based on initial low IQ scores.[36] The same Defendant staff informed the Office of Special Master that follow-up evaluations for an overwhelming portion of these youth have been completed, which resulted in one additional youth being identified as potentially meeting the adopted criteria and the youth is undergoing further evaluation.[37]
- The Disability Expert indicated that the WDP Remedial Plan defines youth with developmental disability rather broadly. It includes youth with developmental disability and youth with ñsimilar conditions.ò There apparently are no clear criteria governing what constitutes ñsimilar conditions.ò

As stated in his August 30, 2011 letter to the Special Master, the Disability Expert and the Defendant have had differing opinions about the actual number of youth appropriate for the developmental disabilities program for several years. As a result of the difference in opinion, the program needs of this segment of the youth population remain unaddressed. The Special Master will promptly arrange a meeting with Defendant, Plaintiff, and the expert to resolve any difference governing identification of developmentally disabled youth. Once the difference is resolved, the Special Master

[35] Statement of Sandi Becker, Wards with Disability Manager, to Deputy Special Master John Chen, September 6, 2011.
[36] See letter, Disability Expert Logan Hopper to Special Master, August 30, 2011.
[37] Statement of Sandi Becker, Wards with Disability Manager, to Deputy Special Master John Chen, July 21, 2011.

urges Defendant to seek input and advice from the expert to evaluate various programming concepts and work collaboratively to implement a viable program to accommodate youth with developmental disabilities.

B. Cross-Plan Issues

Based on a review of the latest WDP Report and discussion with the Disability Expert, the Special Master has identified the following issues that can be most effectively addressed by ensuring input and advice of the Disability Expert but the leadership for the issues are provided by the expert in another remedial area.

Use of Force on Youth with Disabilities (Item 53)

The issue of use of force against youth with mental health diagnoses and other disabilities is an issue of grave concern to the experts, parties and the Special Master. It is addressed in Section V of this report.[38] Experts from several remedial plans were called upon to study this issue and to provide recommendations for remediation.

Various reports by the *Farrell* Experts, the Eighteenth Report of the Special Master and input from an external use-of-force expert and Defendantôs staff have served as data sources for the parties to meet, confer and prepare a stipulation and proposed order to remedy the identified problems.[39] Oversight for implementation of the stipulated agreement falls with the Safety and Welfare Expert. To avoid duplication of effort, the Safety and Welfare Expert should be the lead for the issue of use of force against all youth. For example, analyzing accommodations for youth who use inhalers due to breathing disabilities, the Safety and Welfare Expert should rely on the expertise of the

[38] OSM 19, Section V.
[39] This issue was also discussed during the Case Management Conference held by the Court on July 7, 2011.

Disability Expert. The Office of the Special Master will continue to monitor this issue and provide regular reports to the Court.

Youth With Disabilities Identification and Self and Staff Referrals for Youth With Disabilities. (Items 12, 46, 88-90, 99)

The Disabilities Expert credits Defendant for having begun to implement a protocol for the cognitive screening/testing and identification of six youth with developmental disabilities.[40] Defendant anticipates being able to access and report results via WIN by August 2011. The expert stresses, however, that Defendant must implement processes and assessment measures to identify youth with all other ADA qualifying disabilities. The expert further notes that his recommendations for satisfactory implementation have remained virtually the same for the last three monitoring roundsð Defendant must develop and utilize appropriate, standardized identification and referral processes, staff must coordinate to provide consistent services, and Defendant must ensure careful on-going monitoring by Central Office to maintain compliance.

The Special Master still believes the extent of the Disability Expertôs monitoring effort should be considered within the context of the efforts of the other remedial plans. For example, developing and implementing a process to correctly diagnose youth with mental health disabilities is an essential element in Defendantôs remedial effort on the issue of use of force against youth with disabilities. The Mental Health Experts should engage in a more prominent role in the development of accurate and reliable criteria for diagnosing youth with mental health qualifying disabilities and the Medical Experts for physical qualifying disabilities.

Grievance process for WDP youth (Item 72-77)

[40] Statements, Logan Hopper, OSM/Expertsô meeting, August 1 and 2, 2011. This is the source for the following two sentences as well.

Although not specifically highlighted in his comprehensive report, the Disability Expert expressed a concern about the suitability of current grievance process for WDP youth. Specifically, the expert stated that he interviewed approximately 40 WDP youth, all of whom stated that they do not utilize the grievance process because they do not believe the process is useful, fair or objective.[41]

For the six audit items related to youth grievances, the Disability Expert rated all Defendant facilities in substantial compliance during his fifth round of audits. During his fourth round of audits, the expert rated all facilities in substantial compliance for five of six audit items and three of six facilities were rated in substantial compliance for the remaining item (Item 76). During his sixth round of audits, the expert rated all four facilities in substantial compliance on three of the items (Items 74, 75, and 77), three of the four facilities in substantial compliance on two of the items (Items 73 and 76), and one of the four facilities in substantial compliance on one item (Item 72).

Defendantôs grievance policy was adopted and implemented after review and comments by the *Farrell* Experts. There have been no significant issues raised regarding the grievance process until the Disability Expertôs recent disclosure. The Safety and Welfare Expert opined that the issue may be remedied through periodic reiteration to staff and youth the purpose and intent of the policy and clarify procedures.[42] Based on the Disability Expertôs ratings during the fourth and fifth rounds of audits, the problem indeed may be an inadequate reinforcement effort. The Special Master believes this issue should be addressed through the Safety and Welfare Remedial Plan subject to advice and input from the Disability Expert.

[41] Statement, Logan Hopper, WDP Expert, OSM-Experts meeting, August 1-2, 2011.
[42] Statements, Barry Krisberg, Safety and Welfare Expert, OSM-Experts meeting, August 1-2, 2011.

Educational issues for youth with disabilities while on Temporary Detention (TD) or Temporary Intervention Program (TIP) status

The Disability Expert identified a concern about treatment and service to youth with disabilities, particularly in the area of youth enrolled in special education programs. This issue was discussed extensively in the Eighteenth Report of the Special Master and the Defendant is closely monitoring the situation. As noted above, this matter is being pursued by the Education Experts and the Disability Expert also stated in his comprehensive report that there is an overlap on this issue between the WDP Remedial Plan and the Educational Remedial Plan. The Special Master believes this issue should be addressed through the Education Remedial Plan with advice and input from the Disability Expert.

IV. TRANSFER OF MONITORING

A. Development of the Monitoring Process

In late 2009, Defendant filed a motion with the Court seeking relief from monitoring certain items in the Education and WDP Remedial Plans based on Paragraph 23 of the Consent Decree, which states:

> When a facility is found to be in substantial compliance on an issue for one full year, and is found to remain in substantial compliance after review by the relevant expert(s) one year later, expert tours regarding that issue at that facility shall end. If a violation of the relevant remedial plan(s) occurs within the two-year substantial compliance period that is serious or systemic but, in the opinion of the relevant expert, may be fully resolved and repaired within 30 days, the period for measurement of substantial compliance shall continue to run, unless the matter is not fully resolved and repaired within thirty (30) days.

The Court on February 9, 2010 denied Defendant's motion for several reasons including that ñé the historical record of the case contains instances in which a facility was in substantial compliance as to an individual audit item, then fell back out of compliance.ò Clearly, the Defendantsô ability to sustain reform is contingent upon its

capability to monitor and to develop internal quality assurance systems. The Special Master has worked with the parties and the experts to develop an approach to the transfer of *Farrell* monitoring that supports these objectives.

In July 2010, the Special Master organized a meeting of *Farrell* Experts to discuss issues of mutual interest, identify priorities for the upcoming year, and explore means to improve the efficiency and effectiveness of the monitoring process. General agreement was reached to initiate a process to allow Defendant to gradually assume monitoring responsibility for certain items in the remedial plan that meet the consent decree requirement of two rounds of substantial compliance.

The purpose of the partial transfer is two-fold. First, it helps Defendant to start building into daily operations of facilities on-going quality assurance strategies, which is critical to sustain reform after the expertsô eventual exit from the case. In addition, by relieving the experts from the task of monitoring items that have already been corrected, greater focus can be devoted to addressing the remaining issues that are essential in accomplishing the purpose and intent of the remedial plans.

Following the expertsômeeting, transfer of monitoring occurred in the following three remedial plans:

- Educational Remedial Plan -- The Education Experts had completed five rounds of auditing under the plan and the percentage of items rated in substantial compliance has increased with each round of audits. The overall percentage was 90% after the fifth round of audits.[43]

[43] DJJ Quarterly Compliance Report as of March 15, 2011, p. 6. As the items in the Standards and Criteria of the Educational Remedial Plan and other remedial plans are not weighted by the level of importance, the overall percentage of items in substantial compliance by itself is not a valid indicator of effectiveness of DJJ's remedial effort. However, it does provide certain perspective on the progress of remedial effort and the degree of which monitoring responsibility could be transferred to DJJ.

- Wards with Disability Remedial Plan (WDP) ï The Disability Expert also completed five rounds of audits and the overall percentage of items rated in substantial compliance was 86% after the fifth round of audits.[44]

- Safety and Welfare Remedial Plan ï After three rounds of audits, the overall percentage of items rated in substantial compliance was 75% under the Safety and Welfare Remedial Plan.[45] The Standards and Criteria (audit instrument) of the remedial plan divides audit responsibilities between the Safety and Welfare Expert, Mental Health Experts, and the Office of the Special Master. The standards and criteria assigned to the Office of the Special Master are items that are more easily quantified to measure compliance. The Office of the Special Master agreed to transfer monitoring of these items to Defendant, subject to spot-check.

To facilitate the transfer of monitoring, the Office of the Special Master analyzed compliance ratings and developed a preliminary list of proposed items to be transferred. The list was based primarily on the past compliance ratings of the experts. The Office of the Special Master then met with each of the experts to refine the list. Exceptions were made based on the experts' qualitative judgment and the systemic nature of some of the items. For example, under the WDP Remedial Plan, the expert retained most of the monitoring of Central Office items because they impact the operations of all facilities. Therefore, whereas approximately 60% of the audit items for the facilities were transferred to Defendant, only 8% (2 of 24) of the Central Office items were transferred. The refined list was presented to Defendant for comment and adjustments were made before it was finalized.

A protocol was developed to promote a smooth transition of monitoring from the experts to Defendant, which consists of the following:

- The experts and the OSM provide training to Defendant staff performing the monitoring function. Defendant decided that the staff of the California Department of Corrections and Rehabilitationôs Office of Audits and Court Compliance (OACC), an entity external to the Division of Juvenile Justice, would

[44] *Id*. at p.14.
[45] *Id*. at p.37.

conduct the audit with assistance from a team of DJJ Court Compliance staff and DJJ subject matter experts.

- Approximately 45 days prior to the expertôs site visit, the staff from OACC accompanied by the staff from the DJJ Court Compliance Unit conduct an audit of the facility and identify compliance items that may result in non-compliance or partial compliance ratings and afford the facility an opportunity to correct deficiencies.[46]

- Defendantôs audit team accompanies the experts on their audit of each site. The purpose of this practice is to provide documentation of continued compliance, and to ensure an understanding of what constitutes compliance from the expertsô perspective.

- The experts monitor the items for which they retained audit responsibility and spot-check those items transferred to Defendant.

Defendant eventually decided that, as a part of his 45-day review, the OACC audit team should expand the scope of its review to include all items in the audit instrument rather than only the transferred items. This is Defendantôs prerogative and the Special Master supports this approach as it accelerates the development of Defendantôs self-monitoring capabilities.

B. Progress and Assessment

To date, both the Education Experts and the Disability Expert have completed an audit round under the new protocol and issued their comprehensive reports, which are analyzed and discussed above. The Safety and Welfare Expert is in the middle of his round of audit, so the process is still evolving. The Special Master focuses on the transfer process itself by comparing the rating variances between the ratings in OACCôs 45-day review and the Expertsô.[47]

Education Remedial Plan

[46] *See* Memorandum, July 29, 2011, John Blackwell of OACC to Special Master Nancy Campbell.
[47] Appendix C, Vanderburg, ñEducation Audit Ratings Analysis,ò ñWDP Audit Ratings Analysis,ò and ñSafety and Welfare Audit Ratings Analysis,ò July, 2011.

The transfer of monitoring for the Education Remedial Plan was highly successful. Both the Education Experts and Defendant indicated their experience under the new protocol was positive. The fact that OACC staff accompanied the Education Experts in their fifth round of audit for on-the-job training undoubtedly facilitated the transition effort. In their report, the Education Experts noted that,

> The experts feel that the OACC internal auditing system will allow monitoring responsibilities to be shifted from the court appointed experts to this independent audit team. This process demonstrates DJJ's ability to meet the mandates of the Education Consent Decree Remedial Plan and continue to maintain ongoing reform efforts.[48]

The Special Master shares the Education Expertsô viewpoint. Each of the four facilities audited during the last round consisted of 115 items that were audited for a total of 460 items (115 items multiplied by four). The Education Experts changed the OACC rating in only 48 of the 460 items (10%). Of the 48 rating changes, the experts rated 30 items higher (63%) than the OACC auditors and 18 items lower (37%).[49] According to Defendant, most of the higher ratings stemmed from the corrective action taken by the facilities to address the issues identified during OACCôs 45-day review. This suggests that OACCôs 45-day reviews were conducted thoroughly, objectively and added value to the process by correcting items identified as deficient by the OACC auditors. The Special Master commends the Experts and Defendantôs staff for working collaboratively and for communicating effectively to implement the new protocol.

Wards with Disabilities Remedial Plan

Given the significant differences in function and purpose of the remedial plans, the experts and Special Master agreed that there can be some variation regarding how the

[48] Appendix A, p.11.
[49] Appendix C, ñEducation Audit Ratings Analysis,ò July, 2011

transfer of monitoring occurs. The approach to the transfer of monitoring is to be determined jointly by the expert and Defendant. The Disability Expert, like the Education Experts, provided training to the OACC and Court Compliance Unit staff. Despite the training, confusion existed regarding roles and responsibilities of the expert and Defendant that led to a less satisfactory outcome than that of the education remedial plan transfer of monitoring.

During the first joint audit, the Disabilities Expert and Defendant staff realized they had different understandings regarding the expertôs role in reviewing OACCôs work product during the 45-day review. Defendant believed that the expert was to review all items in OACCôs reports and the facilitiesô remedial efforts during his site visit and to issue new ratings focusing on those items that were less then substantially compliant during OACCôs audit. The expert indicated at the first site visit that he was not prepared to review all items since he only planned to review those items for which he retained monitoring responsibility. Thus, he only spot-checked the items transferred to Defendant. [50]

Apparently, there was also a lack of clarity regarding how the expert would report the OACCôs ratings of the transferred items in his report. Defendant was surprised and disappointed to learn that, unlike the Education Experts, the Disability Expert did not take into consideration the facilitiesô remedial efforts after the OACC site visits.[51] By only reporting OACCôs rating, the substantial compliance ratings for all four facilities declined. For example, for Chad, Defendant believes it corrected four deficiencies following the OACC audit and before the WDP Expert's audit that were not reflected in

[50] The Disabilities Expert called and spoke to the Special Master during the site visit about this dilemma. She agreed they should continue the audit based on the Expertôs understanding.

his report. Since monitoring for these items had already been transferred to Defendant, OACC could have modified its own ratings if the facility provided sufficient and competent evidence that remedial action had been taken to correct the deficiencies noted in the 45-day review. The experts agreed that in the future, any remedial efforts by OACC will be noted and credit reflected in the experts' ratings.[52] Analysis of rating variances between OACC and the Disability Expert disclosed greater disparities than those between OACC and the Education Experts. The expert changed OACCôs ratings on 53 of the total of 360 items (15%) for the four facilities and the Central Office audited during the last round.[53] This compares to a 10% change from the Education Experts.

The Special Master also analyzed the rating variances between the items transferred to the Defendant and those retained by the expert. The OACC audit team apparently has been able to monitor the transferred items effectively as the expertôs spot-check resulted in rating changes for only 3 of the 211 items (1%) transferred to the Defendant. According to the Defendant, all three rating changes stemmed from the Ventura Youth Correctional Facility using two staff members part-time to carry out the functions and duties of the WDP Coordinator.[54] However, the rating disparity for the audit items retained by the Disability Expert was very significant and suggests there may be a disconnection between the expert and OACC. Of the 149 items for which the expert retained monitoring responsibility, he changed OACCôs rating in 50 instances (33%). For the 50 rating changes of items monitored by the Expert, eight were higher, 34 were lower, and eight were to other categories. While the expert-retained items certainly are

[52] This agreement was reached at the Expert Team meeting in Berkeley, CA on August 1-2, 2011.
[53] Appendix C, ñEducation Audit Ratings Analysis,ò ñWDP Audit Ratings Analysis,ò and ñSafety and Welfare Audit Ratings Analysis,ò July, 2011
[54] *Ibid.*

more complex and subjective, the disparity could be addressed through enhanced training and communication. The Special Master will engage with the Disability Expert and Defendant and work collaboratively to resolve any difference or misunderstanding before the seventh round of audits.

Safety and Welfare Remedial Plan

The Safety and Welfare Expert is in the middle of his third round of audits. To date, the Safety and Welfare Expert has completed an audit of the Ventura Youth Correctional Facility and released a draft report. The expert also completed a site visit to O.H. Close Youth Correctional Facility. The Office of Special Master staff accompanied the expert during both site visits to provide support and assistance. Based on the review of the OACC 45-day reports and related data and documents, the Special Master and the Safety and Welfare Expert found the work performed by OACC staff to be professional, thorough and objective.[55]

The transfer of monitoring from the Disability and Education Experts (and the experience of the Safety and Welfare Expert to date) to Defendant demonstrated that the combined OACC and DJJ Court Compliance audit model is effective. Defendantôs auditors demonstrated rigor, integrity and an ability to garner change and improvement from DJJ staff. The process has proved to be highly valuable as a learning tool and will lead to enhancements in Defendantôs internal monitoring capabilities. Any problems encountered during the last round could easily have been addressed through better coordination and communication between the expert and Defendant throughout the audit process. The Special Master has reviewed the outcome of the transfer of monitoring with

[55] *See* Memorandum, July 5, 2011, from Deputy Special Master John Chen to Special Master Nancy Campbell providing supplemental observations noted during the Ventura Youth Correctional Facility site visit.

the experts to support the type of collaboration and communication that is required to ensure a successful process.

As previously noted, one of the objectives of the new audit protocol was to create an opportunity to enable the experts to focus their attention on the more systemic and significant issues that remain in the remedial plans. This approach is particularly important for the Safety and Welfare Remedial Plan as it contains a number of core issues that affect other remedial plans. The Special Master and the Safety and Welfare Expert agree that the current monitoring approach needs to be reexamined and that they will work with Defendant in identifying measures to streamline and improve the monitoring process to include the transfer monitoring of many issues in the Safety and Welfare Remedial Plan to Defendant.

C. Next Steps

There is a general consensus among the experts and Defendant to continue the transfer of monitoring process.[56] The Special Master believes that if Defendant addresses the few remaining partial or non-compliant issues in the Education and WDP Plans that Defendant could monitor the plans in their entirety after the seventh audit round. In addition, the Special Master has had discussions with the Medical Experts, who indicated that they are ready to start transferring monitoring responsibility to Defendant in their next audit rounds. The Dental Expert is finishing his second round of audits and has already begun training the OACC auditor and the Supervising Dentist. He indicates the process is going well.[57]

[56] The issue of transfer of monitoring was the focus of much of the OSM/Expert meeting on August 1-2, 2011. The consensus was that the transfer is going well and should continue.

[57] Conversation between Don Sauter, Dental Expert, and the Special Master on August 4, 2011 upon completion of the Chad audit.

During the seventh round of audits, the Special Master encourages the parties, in consultation with the experts, to begin exploring an exit strategy for the Education and Disabilities Remedial Plans. At a minimum, Defendant should monitor the majority of audit standards and criteria and, ideally, the experts in conjunction with Defendant should create an exit strategy for the Plaintiff to review. Based on discussion with the experts and Defendant staff, in addition to maintaining the items that are currently substantially compliant, the following items must achieve substantial compliance:

Education

- Ensure that the semi-annual reviews of high school graduation plans are completed semi-annually.
- Ensure schools are staffed in a timely manner with appropriately credentialed teachers.
- Increase school attendance to provide a minimum 240 minutes educational programming with at most, seven percent absence rate.
- Respond effectively to unexcused absences.
- Ensure youth in TIP and TD receive timely and effective access to education services.
- Provide a full continuum of services to youth with special education needs.

Disabilities

- Implement a program to identify and accommodate developmentally disabled youth.
- Ensure all staff are trained in ADA requirements with a tracking system to demonstrate compliance.
- Provide treatment services to youth with certain mental and/or physical disabilities while on Temporary Detention (TD) or TIP status.
- Provide appropriate documentation to demonstrate youth not precluded from assignment to a work or camp program based solely upon the nature of the disability.

The Special Master congratulates both the Education and Disability Experts and Defendant for their continued excellent work in these areas.

V. USE OF FORCE

In her last report (OSM 18), the Special Master reviewed and analyzed reports of the Defendantôs use-of-force practices by the *Farrell* Experts, an outside expert, and a self-commissioned internal study group. The reports collectively presented overwhelming data and evidence that suggest the Defendantôs current use-of-force model is not effective in achieving the desired outcome that was envisioned in the Safety and Welfare Remedial Plan. The Special Master identified key issues that need to be addressed to achieve the overarching goal of the Safety and Welfare Remedial Plan which is to create a safe and secure environment in Division of Juvenile Justice institutions that supports the development of new pro-social behaviors. The key issues include:

- Provide staff with appropriate training and skills in addressing youth behavior issues.
- Reexamine and revise the current use-of-force policy, especially the application of controlled and immediate use of force.
- Devote greater effort, especially by mental health professionals, to intervene and accommodate youth with certain mental and/or physical conditions.
- Reexamine and revise the current force review committee model to improve accountability and provide greater emphasis on intervention, de-escalation and prevention.
- Reduce application of chemical agents in living units.

Subsequent to the release of the Eighteenth Report of the Special Master, the Defendant, on July 6, 2011, issued a report of its Use-of-Force Implementation Committee.[58] The multi-disciplinary committee was formed on May 2, 2011 to review

[58] Appendix D, Division of Juvenile Justice Use of Force Implementation Recommendations, June 26, 2011.

previous reports and recommendations on the use of force and to formulate one overall recommendation and implementation plan. According to its report, the Implementation Committee supported 86% of the recommendations from the Use-of-Force Sub-Committee report dated March 17, 2011 and the majority of recommendations in the *Farrell* Expertsô Use of Force in DJJ and Mental Health Youth, Supplemental Report dated May 10, 2011. The process is continuing to evolve as Defendant formed another subcommittee to refine the work of the Implementation Committee.[59] The Office of the Special Master will continue to monitor this issue and provide regular reports to the Court. While encouraged by the positive response, the Special Master believes the Defendant confronts significant challenges to affect meaningful reform in a timely fashion. In order to achieve the desired outcome and to meet the purpose and intent of the Consent Decree, the Defendantôs senior management must fully recognize and embrace the need for change and exert strong leadership to affect cultural changes throughout the entire organization.

A. Implementation Plan Challenges

The challenges faced by the Defendant in modifying the way staff respond to behavior problems by youth are discussed in this section of the report.

Immediate Action is Required

When the panel of *Farrell* Experts issued their April 26, 2010 report, which found disturbing patterns and practices of force incidents against youth in mental health living units, the Special Master encouraged the experts and the parties to engage in a process where both the methodology and underlying data was available for review. Defendant

[59] *See* Memorandum transmitting the Use-of-Force Implementation Recommendations from Rachel Rios, July 6, 2011.

agreed and initiated a review. Unfortunately, completion of the review process took far longer than expected. The review by the multi-disciplinary use-of-force subcommittee did not begin until September 2010 and the subcommittee report was not released to the full committee until February 26, 2011. There were numerous factors that led to the lengthy timeframe of the multi-disciplinary use-of-force subcommittee. For example, the scope of the project was broader and much more complex than originally anticipated. The Plaintiff expressed concerns about the composition of the use-of-force committee, which took time to address. Other conditions, such as locating missing records, also contributed to the delay.

After directing its Office of Research staff to analyze the report outcomes, Defendant released the report on March 17, 2011. The Implementation Committee was formed about six weeks later on May 2, 2011. It issued its report after another two months on July 6, 2011. Fourteen months after the *Farrell* Experts issued their report, the Implementation Committee recommends further statistical examination of use-of-force incidents by the Office of Research. It is unclear as to what additional information the statistical examination is expected to disclose given the fact that Defendant had already analyzed the subcommitteeôs recommendations and developed an implementation plan.

Although some of the factors that contributed to the lengthy timeframe may have been unavoidable, it has been more than 14 months after the *Farrell* experts released their preliminary report in April 2010 expressing their concerns regarding the level and type of force used in mental health units. Curtailing violence and use of force is a core issue in the *Farrell* case and has significant direct and indirect impact on all remedial plans. Addressing how to change when and how force is used is highly complex. Changing how

staff responds to youth behavior requires engagement and commitment by staff throughout the organization. It is imperative that Defendant continues to treat this as an urgent situation and take concrete steps to affect the needed improvement and changes. Defendant apparently recognizes the gravity of the situation and is taking positive action to address it. The actions that have been taken are discussed later in this section of the report.

Implementation Plan Lacks Specificity

The Implementation Committee reviewed each of the Subcommittee and the *Farrell* expertsô recommendations and developed an ñImplementation Planò that is supposed to be completed within 12 months. From the Special Master perspective, the plan does not provide clear direction that describes how the reform effort is to be organized and measured. It is also unclear as to whether the 12-month timeframe is realistic. Typically, implementation plans of projects of this magnitude and complexity would, at a minimum, include the following:

- Objectives.
- Tasks and subtasks to be performed to achieve the objectives.
- Responsible individuals or units for each task and subtask.
- Completion date for each task and subtask.
- Deliverables.
- Quality Assurance Mechanisms.
- Process Measures.
- Outcome measures (if applicable).

Defendantôs Implementation Plan provides a very general framework for some of the elements identified above. However, the timeframes and deliverables lack the level of detail and specificity needed to guide the implementation effort to achieve the desired outcomes. For example, under ñDocumentation Recommendationsò section, one of the tasks is to identify a committee to revise the use-of-force policy and make modifications

within six months. Under ñTraining Recommendations,ò one of the tasks is to train staff on use-of-force policy changes within nine months. If it takes six months to modify the use-of-force policy, it would be extremely difficult to provide training on the policy changes that will affect a large group of staff within what would be a time frame of three months. Under ñProgram Recommendationsò the first two tasks are to identify the committee to develop the program guide and to identify two programs, one in the north and one in the south, that have the highest level of force. The deliverables for each of the two tasks are to issue a memorandum. Given the nature of the tasks and the deliverables, it would appear that the timeframe for completion of these two tasks could be more precise than the 0 to 3 months range provided in the Implementation Plan.

Other than an overall goal of a 20% reduction in force incidents in the first 12 months, none of the sections in the report contain process or outcome measures. The 20% goal is not specifically tied to any of the identified tasks and the Defendant has provided no basis as to how the 20% figure was determined. The lack of identified process and outcome measures seems to imply that the Defendant may not understand what type of steps are necessary to reduce use-of-force incidents.

Defendant indicates that yet another team is being formed to guide the implementation effort.[60] Presumably the team will address the lack of specificity in the current Use-of-Force Implementation Plan. Given that the current implementation plan will require significant work to provide the level of detail and specificity needed to be a viable plan and that the new team had not been formed, the feasibility of the proposed timeframe prescribed in the Implementation Plan is questionable.

[60] *See* Memorandum transmitting the Use of Force Implementation Recommendations from Rachel Rios, July 6, 2011.

B. Impact of Staffing Shortage

Based on data gathered by the Defendantôs Use-of-Force Subcommittee, it appears that two facilities, Ventura and Chad, face the most challenges with how force is currently used. These same facilities are at risk of significant staffing shortages. For example, in the quantitative review of 245 cases, 32 cases involved force used against a single youth for failure to follow staff orders. Of the 32 cases, 28 cases occurred at these two facilities (16 at Chad and 12 at Ventura).[61] Both facilities also house mental health units. As disclosed in previous study reports, a disproportionately high number of use of force incident occurred in mental health units.[62]

Unfortunately, both Chad and Ventura are experiencing high vacancy rates in their custody classifications. The problem is particularly acute at Chad when it had one Senior Youth Correctional Counselor, 32 Youth Correctional Counselor, and seven Youth Correctional Officer positions vacant as of July 28, 2011.[63] At Ventura, the overall vacancy rate was 13% in custody classifications as of May 25, 2011 with the highest vacancy rates in the following supervisor positions[64]:

- Senior Youth Correctional Counselor ï four of seven positions (57%) were vacant.
- Lieutenant ï four of 11 positions (36%) were vacant.
- Sergeant ï four of 10 positions (40%) were vacant.

The CDCR management has been responsive and supportive in identifying short-term and long-term solutions to address the staffing challenges. At Chad, besides temporarily reassigning staff from adult institutions, other measures are being pursued

[61] Appendix E, Use of Force Review, Summary of Data Used in the Quantitative Analysis, pp 2-3.
[62] See Use of Force in DJJ and Mental Health Youth: Preliminary Findings, pp 1-2., April 26, 2010 and DJJ Use of Force Subcommittee Report, p. 29, March 17, 2011.
[63] See email of July 28, 2011 from Acting Superintendent Erin Brock to Deputy Special Master John Chen.
[64] See email of May 25, 2011 from Superintendent David Finley to Deputy Special Master John Chen.

such as permanent transfer of coverage of staff from adult institutions under an expedited process, use of retired annuitants, streamlining the academy background clearance process and allowing for expedited hiring of employees on a temporary status. Nevertheless, given the transitional status of some of the personnel and the uncertainty as to when the vacant positions will actually be filled, the Special Master is concerned about the ability of these two institutions to address the issue of how and when force is used within the next 12 months. For example, at Chad, the facility has temporarily postponed the mandated 40 hours of block training scheduled for the first half of 2011 and is now planning to provide the training during the second half of the year. This delay may impede the facility's efforts to deliver other training during this period. Some of the target dates in the Use-of-Force Implementation Plan may not be realistic in light of the impact of the current staffing shortages.

C. Addressing the Mental Health Diagnosis

Before and throughout the course of the use-of-force review, the Chief Psychiatrist repeatedly asserted that the current criteria for diagnosing youth with mental health conditions are inaccurate and unreliable. The Use-of-Force Implementation Team reports that the Chief Psychiatrist was contacted and stated that the criteria for mental health designation will be evaluated and modified and institutional application of these modifications will be implemented. This issue highlights the important role of the Mental Health Remedial Plan in resolving issues involving use of force. The Mental Health Experts will be encouraged to assist DJJ staff in addressing this issue as soon as possible.

D. Case Management Conference Follow-up

After the Case Management Conference on July 7, 2011, the parties had a meeting on July 12, 2011. On July 20, 2011, Acting Director Rachel Rios issued a letter to the Plaintiff indicating that the Defendant is committed to working collaboratively on the Implementation Plan and provided ñpreliminaryò measures that have been taken to demonstrate that the Defendant is committed to changing use-of-force practices.[65] The Special Master believes that this is a positive development as the letter demonstrated that the senior leaders recognize the gravity of the situation by providing concrete examples on actions taken or to be taken. Examples include:

- ñOn July 13, 2011, I met with the executive staff and advised them of my expectations that all UOF employee discipline must be coordinated and discussed with the Management Team before submitting a disposition.ò

- ñOn July 15, 2011, Deputy Director Michael Minor issued a memo to facility superintendents to implement weekly treatment team meetings by August 1, 2011, on all living units to discuss force issues.ò[66]

- ñA second memo was sent on July 15, 2011, by Deputy Director Michael Minor instructing superintendents to have Crisis Prevention & Support Plans completed on all youth by October 15, 2011.ò [67]

- Deputy Director Mike Minor and Chief Psychiatrist Ed Morales have met with executive staff, managers, supervisors and clinicians at the Northern California Youth Correctional Complex (NCYCC) to discuss UOF expectations and are scheduled to meet with administrators at Ventura on August 23, 2011.[68]

The parties met again on August 2, 2011 to discuss the development of a stipulation on use of force to present to the Court. The level of collaboration and commitment between the parties on this issue is demonstrated by increased communication and prompt follow-through on agreed upon tasks by both parties. To

[65] *See* Letter, Acting Director Rachel Rios to Don Specter, Director of Prison Law Office, July 20, 2011.
[66] *See* Memo, Acting Deputy Director Michael Minor to Superintendents, July 15, 2011.
[67] *See* Memo, Acting Deputy Director Michael Minor to Superintendents, July 15, 2011.
[68] *See* E-mail, Mike Minor, Acting Superintendent to Special Master, August 7, 2011.

ensure progress on this issue, resources should be focused not on analyzing the underlying issues that demonstrate there is a problem but, rather, on developing a high-quality project implementation plan that details with specificity the steps to implement the changes agreed to by the parties regarding when and how force is used.

VI. VENTURA YOUTH CORRECTIONAL FACILITY FOLOW-UP

In the Eighteenth Report of the Special Master, the Special Master detailed a chronology of events that demonstrated a failure to meet several *Farrell* mandated requirements at Ventura. The most significant of these included Defendantôs inability to provide:

- An effective behavioral treatment unit (BTP) at Ventura
- Mandated education services to youth in restricted programs
- Adequate education, recreation and program space in the BTP
- Timely access to non-urgent medical appointments, and
- The full continuum of services to youth requiring special education services

While problems have existed to varying degrees with some of these issues at other DJJ institutions, the severity and consistency of these problems at Ventura rose to the level that the Special Master believes more consistent observation and monitoring of this institution is needed until such time that DJJ has demonstrated that Ventura leadership can adequately address these issues. As such, the Special Master will report on progress, or the lack thereof, on this issue in each of her quarterly reports until she has adequate documentation from either direct observation or from Court appointed experts that the problems discussed in OSM 18 have been addressed.

A. Implementing a Behavioral Treatment Program

Upon examination, it was readily apparent that many of the problems at the Ventura BTP result from an implementation failure. The Ventura BTP staff had not been trained in the protocols and procedures of a BTP. If one could say there was a model underpinning Venturaôs version of a BTP, it would be akin to a segregation unit that was designed not to treat youth but to deprive youth of privileges. In short, the problems at the BTP stemmed from a failure to implement the actual BTP model.[69] Staff was being asked to run a BTP without having been trained in the purpose or the structure of a BTP.[70] DJJ senior administrators sent a team of Central Office staff to Ventura on April 7-8 and 14-15, 2011 to identify program deficiencies and to assist institution managers in developing corrective action plans.[71] On June 21-23, 2011, training was provided to BTP unit staff, educators and managers about the purpose, structure and strategies of administering a BTP.[72]

Training staff in the concept that behaviorally challenging youth require more, not less treatment, and that treatment is not a one-time event, is central to the success of the BTP. This is particularly difficult for DJJ because the Integrated Behavioral Treatment Model is only in its pilot stage and is, therefore, not universally understood. Staff need not just ñordersò telling them what to do but time to observe the use of appropriate behavioral management techniques in various situations.

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[69] For a full discussion of this issue, see OSM 18, pp. 9-11.

[70] BTP training was provided at years before at Ventura but none of the staff currently on the BTP were involved in that training. Further the program protocols were not on the unit so staff could attempt to understand the program design.

[71] *See* Memo from Associate Director Nylund to Special Master Campbell, July 29, 2011. DJJ senior managers kept the Special Master apprised of site visit progress during several phone calls and in-person meetings.

[72] Special Master Campbell observed the first day of the training and found the trainers to be highly capable and skilled. Most institution staff participated and demonstrated interest in the concepts and activities.

The Central Office administrative team visited Ventura on July 25-26, 2011 and continued to find issues that indicate the BTP unit staff need additional support.[73] The training team was scheduled to return August 17-18th to provide further assistance with areas of concern.

B. Out-of-Cell Time

A critical issue that Defendant is attempting to address is the lack of appropriate recreation and program space for youth in the BTP units. DJJ recognized that in some cases, it was not meeting its own minimum standard of a minimum of three hours of out-of-cell time for a youth.[74] To remedy this situation Defendant is working to create more recreation and program space and to closely monitor the out-of-cell time to ensure compliance with the minimum standards.

One DJJ Program Administrator and the Prison Industry Association (PIA) construction managers were at Ventura on July 21, 2011 to begin the development of construction plans for group recreation space that will be added to the BTPs. This space is in addition to the current recreation space and provides a higher level of security. The space that measures 32 x 40 and has a partial cover for inclement weather is large enough for group or individual activity. The projected completion date is September 30, 2011.[75] Defendant plans to remedy the program space deficit for the BTPs by adding modular multi-purpose buildings. The date for installation and completion of the modular units

[73] For example, staff does not yet fully understand which youth need to be in a BTP and the transition process out of a BTP. These issues will be addressed when Dr. Jim Telander and Henry Lum return to Ventura to assist with program implementation.

[74] This standard is contested by Plaintiff as inadequate and a violation of the Safety & Welfare Remedial Plan. The Court will hear arguments in the matter in January, pursuant to Plaintiffôs motion to hold Defendant in contempt for failing to provide adequate out-of-cell time for youth.

[75] *See* e-mail from Mark Blaser, Program Administrator, August 8, 2011. Administrator Blaser also verbally briefed the Special Master about progress of both the recreation and program spaces.

remains January 2012.[76] Defendant is demonstrating commitment to creating remedies to resolve the physical impediments to out-of-cell problems.

Other issues Defendant is addressing include ensuring staff understand the out-of-cell policy, documentation of youth in a restricted status and consequences that ensue if a youth fails to receive the minimum out-of-cell time. Confusion existed among staff regarding the minimum criteria of three hours of out-of-cell time. Defendant believes that an instructional memo from the institution superintendent that clarifies the policy has eliminated the confusion. A review of the record that documents ñmandated time out of cellò indicates that staff at Ventura has been ensuring the youth are out of their cells a minimum of three hours per day. ñSince May 1, 2011, Ventura has continued to demonstrate compliance with the delivery and documentation of time out of room services to youth. A review of TD/TIP time out of room documentation in WIN shows Ventura in 100% compliance from May 1, 2011 to July 16, 2011ò.[77] Review by Central Office staff of out-of-cell data has increased from monthly to weekly. Institution and Central Office staff are also monitoring to ensure that staff accurately enters data regarding restricted movement into the electronic record.

While more stringent supervision of this issue is definitely warranted and has resulted in immediate behavior change by staff, long-term change must include training staff in alternative behavior management strategies. This includes the creation of a continuum of interventions and rewards that staff understand how to use with youth. Without new skills and a broader resource tool kit, staff will quickly find themselves

[76] Recognizing that construction schedules can and do change, the current construction schedule shows an occupancy date of January 31, 2011.

[77] *See* Memo from Associate Director Nylund to Special Master Campbell, July 29, 2011. The Special Master also reviewed the data that delineates how out-of-cell time is spent.

once again resorting to inappropriate strategies when responding to youth misbehavior. Staff, like youth, respond better to positive incentives, rather than increased monitoring and loss of freedom. Developing new skills and behaviors is the best way to bring about change in staff or youth. How managers respond to problems with staff is an opportunity to model the behaviors they are trying to teach staff to engage in with youth.

As noted above in Section V (Use of Force), Ventura has experienced high vacancy rates in its supervisory classifications, which could compromise its effort in this regard. For example, four of seven (57%) Senior Youth Correctional Counselor (SYCC) positions were vacant as of May 25, 2011 that resulted in one SYCC being assigned to provide day-to-day supervision of two BTP units despite myriad of problems confronting those units. The Special Master urges the Defendant to closely monitor staffing issues at Ventura and intervene or provide support and assistance when necessary and appropriate.

On August 4, 2011, the Honorable Jon S. Tigar issued an order to show cause as to why Defendant should not be held in contempt for violation of Court orders in this area. The hearing is set for January 26, 2012. Order Granting Motion to Enforce Court-Ordered Remedial Plans and to Show Cause Why Defendant Should Not Be Held in Contempt of Court, August 4, 2011 (August 2011 Order), at 5.

C. Provision of Education Services

As noted above in Section II, Defendant is making significant strides in hiring needed credentialed education staff to ensure adequate education services for youth. The Education Experts have indicated a willingness to help Defendant understand how to address education services for youth in TD, TIP or a BTP. TD and TIP create serious challenges in the provision of education services and the Special Master believes that

with a full staff complement and the needed technology services, the Principal of Mary B. Perry High School can and will address this issue. The Special Master requests follow-up regarding what is being done to remedy the technology challenges raised in OSM 18.

On August 4, 2011, the Honorable Jon S. Tigar issued an order to hire adequate teaching staff within 90 days and to ensure adequate classroom space within 150 days. August 2011 Order at 5.[78]

D. Integration of Youth

One of the disturbing findings of the investigation of problems with the BTP Ventura is that some youth have not integrated into the general population for several years. ñStaff reported that some youth refuse to integrate and they have not been integrated since 2005 or 2006ò. [79] Attention in the reform effort regarding integration has been focused largely on gang issues and yet it appears that race issues are equally important. The idea that some youth have not integrated into the general population for so many years raises concerns and questions.

Defendant has been investigating these issues. The Safety and Welfare Expert has requested data based on risk and need, not just disciplinary history regarding these youth and the youth viewed as having the most problematic behavior issues at Ventura. Defendant is considering contracting with someone to work with these youth. Defendant is advised to consider whether the proposed contractor has an evidence-based program with proven outcomes that is consistent with the Integrated Behavioral Treatment Model (IBTM). One of the goals of the IBTM is to focus limited resources on a smaller number of proven strategies and to not use resources on programs that do not use evidence-based

[78] *See* 08.04.2011 Order Granting Motion to Enforce (3).pdf.
[79] *Id*. at p.6.

strategies. The Special Master requests that the data requested by the Safety and Welfare Expert is provided as soon as possible and that the IBTM implementation committee and the IBTM consulting group review any proposed new program.

VII. CLOSURE OF SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

On June 13, 2011, Acting Director Rachel Rios announced the closure of SYCRCC to facility staff. The closure is an effort to further reduce service delivery costs. On June 14, 2011, the announcement was codified in writing and sent to all DJJ staff. Youth, families, experts and the Special Master were notified of the closure on the same day. As with the recent closure of the Preston Youth Correctional Facility, the Defendant is soliciting the expertsô input and feedback.[80]

The closure is scheduled for December 2011. Defendant has developed a transition plan and projects all youth will be transferred by November 2011.[81] The Defendant anticipates that the closure will not result in a violation of the *Farrell* living unit caps.[82] Defendant has been conscientious in efforts to inform and engage both the Plaintiff and experts about the closure.[83] The Special Master will organize conference calls between the experts and Defendant to ensure that Defendant and experts have opportunities to discuss and explore the best way to ensure a smooth transition.

Plaintiff is concerned about the transfer of any additional youth to Ventura. Plaintiff believes that any new youth at the institution would exacerbate the violence and racial tensions already present.

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[80] *See* Southern Youth Correctional Reception Center and Clinic Closure Update, July 27, 2011.
[81] *See* Proposed Transition Plan ï SYCRCC, July 26, 2011.
[82] Statement made by Acting Director Rios at the August 2, 2011 OSM/Expert Meeting.
[83] *See* Letter, Acting Director Rachel Rios to Plaintiff Counsel Sara Norman, June 17, 2011 and Norman's response letter, June 23, 2011. regarding SYCRCC Closure.

VIII. CONCLUSION

Five of the Farrell experts have begun to transfer different aspects of monitoring to Defendant. In two of the areas, education and disabilities, it is clear that not only is Defendant capable of performing the monitoring functions, there has been no notable loss of progress and, in many areas, compliance ratings have improved for items monitored by Defendant. The transfer of monitoring functions is important not just because it provides Defendant an opportunity to develop necessary compliance and quality assurance systems but because it allows the experts to focus their energy and resources on the remaining issues that require resolution to achieve substantial compliance in the entire remedial plan. The Education and Disabilities Remedial Plans have only a few remaining issues that require attention to achieve substantial compliance. The Special Master hopes the experts can now focus on these items and work with Defendant to develop an exit strategy from the case that demonstrates systemic and lasting solutions to the issues raised in the remedial plans.

The Dental, Medical and Safety and Welfare Experts are all in various stages of transferring monitoring functions. Each expert is working with Defendant to determine training strategies, what items to transfer and how to assess outcomes. These efforts will be discussed in future reports of the Special Master.

The most challenging issues that remain in the case reflect the failure of DJJ to have an Integrated Behavioral Treatment Model (IBTM). Issues such as use of force and implementing effective BTPs are ultimately resolved not by piece meal responses but when the IBTM is a way of life for all DJJ staff. When there is one unified case plan that is shared by staff who have clearly defined roles, understand that each person must

reinforce the case plan goals, and that the goals are driven explicitly from a credible and properly implemented risk and need assessment process that focuses on factors that are proven to reduce recidivism, issues like use of force will diminish significantly and staff will understand what a BTP is and how to run it. To do this will require breaking down the silos that currently exist between mental health treatment and daily behavior management.

To make significant progress in implementing the IBTM will require a narrowing of focus for Defendant. Defendant is building constitutional education and health care systems. This has required significant time and energy. Now it is time to refocus the limited time and energy of Defendant to focus primarily on the IBTM. One of the most important reasons to achieve substantial compliance in education, disabilities, dental and medical is to ensure that the full attention of Defendant can focus on making the mental health systems and sex behavior treatment program integrate with an effective daily management and behavioral system that supports desired change in the youth.

It is unfortunate that years were lost in this case defining the behavioral treatment model but now the parties have agreed on a model that is showing great promise. The system is small enough now that full implementation while challenging can and must be done. Significant change occurs with consistent focus. The focus in this case must now shift from doing many things to integrating the many things into one unified approach.

The Special Master respectfully submits this report.

Dated: September 9, 2011

_____

Nancy M. Campbell
Special Master

California Division of Juvenile Justice Summary Education Program Report For School Year 2010-2011

Section I. Introduction

Background

During December 2002, Mr. Stephen Acquisto, Deputy Attorney General, California Department of Justice contacted Dr. Tom O'Rourke and Dr. Robert Gordon to conduct a review of the California Youth Authority educational program with two objectives: 1) to evaluate the CYA general and special education programs based on thirteen areas of inquiry; and 2) to provide specific comments and recommendations regarding the current status of the educational program in each of the areas of review.

The DJJ Education Branch used the findings of this review and other information to develop the education section of the Consent Decree Remediation Plan (dated March 1, 2005). There were six major sections in the Education Services Remedial Plan:

I. Overview, Philosophy, and Program Policy
II. Staffing
III. Student Access and Attendance
IV. Curriculum
V. Special Education / Record Keeping
VI. Access to State Mandated Assessments

Review Process:

The Consent Decree required that a specific monitoring process for the Education Services Remedial Plan be established and implemented that directly monitored and measured compliance with and progress towards meeting implementation of decree requirements by the Department of Juvenile Justice. Dr. O'Rourke and Dr. Gordon were asked to develop standards for monitoring and to conduct site visits using a standardized monitoring instrument.

The education experts have conducted site visits during six monitoring cycles, from September 2005 through March 2006, from September 2006 through April 2007, from October 2007 through March 2008, from October 2008 through May 2009, from October 2009 through May 2010 and from February 2011 through April 2011 at the following DJJ operated schools:

DJJ High School	DJJ Youth Correctional Facility
****James A. Wieden High School	Preston Youth Correctional Facility
Johanna Boss High School	O. H. Close Youth Correctional Facility
**DeWitt Nelson High School	DeWitt Nelson Training Center
N. A. Chaderjian High School	N. A. Chaderjian Youth Correctional Facility
*Marie C. Romero High School	El Paso de Robles Youth Correctional Facility
Mary B. Perry High School	Ventura Youth Correctional Facility
***Lyle Egan High School	Heman G. Stark Youth Correctional Facility
Jack B. Clarke High School	Southern Youth Correctional Reception and Center Clinic

* This facility was closed before completion of the 2008 cycle.
** This facility was closed before completion of the 2009 cycle.
*** This facility was closed before completion of the 2010 cycle.
**** This facility was closed before completion of the 2011 cycle.

- Initial visits were announced and communicated to the Education Services branch and the sites being visited.

- Each of the facilities was provided with copies of the Education Services Remedial Plan and copies of the monitoring instrument that was based on the six (6) major areas of the plan.

- In July 2006, July 2007, June 2008, June 2009, and August 2010 training was provided to the DJJ Office of Education personnel, central office personnel and site-based administrators in order to provide a framework for audit preparation prior to the site reviews.

- As a part of the 2006-2007, 2007-2008, 2008-2009, 2009-2010 and 2010-2011 review cycles, all sites were notified to send specific written reports and other relevant documentation to the education experts two weeks prior to their site visit.

- Each high school was visited and reviewed for compliance with the specific items noted in the Education Remedial Plan using the standardized monitoring instrument.

- A four-part approach was used to obtain information in order to monitor progress toward compliance with the Consent Decree:

  1) Review of system level written materials (e.g., WASC reports, DJJ policies, annual reports, school improvement plans, school site plans, course standards, course guides, lesson plans, course syllabi, Special Education Manual, and other supporting documents).

  2) Review of site generated data, including special education records, Individual Education Plans (IEP's), attendance data, school closing data, special management unit documents, class rolls, school schedules, high school graduation plans, psychological evaluations and other educational reports and documents.

  3) Interviews with central office administrators, site based administrators, counselors, teachers, other support staff and students.

  4) Observations of classroom activities, student movement, and special management programs, including mental health and other restricted programs.

- The written materials provided data collected since the beginning of the school year. Interviews with educational personnel provided staff perceptions of the strengths and needs of the education program. Analysis of this information, together with direct observations, resulted in a series of findings regarding compliance with the requirements of the consent decree in the areas of general and special education.

Findings

At the conclusion of each review, an exit conference was conducted. The experts met with the site administrators and provided verbal feedback regarding the general findings of the audit. No written documentation or report was provided to the site at the exit conference.

A detailed Remedial Plan Site Compliance Report was prepared for each site. These reports were provided by the experts to the Special Master's office within 30 calendar days of the site visit. After review, the Special Master's office submitted copies of the reports to representatives of the Plaintiff and the Defendant.

On the Remedial Plan Site Compliance Reports, findings on each item reviewed consisted of a compliance rating and specific written comments supporting the rating. The report used the following compliance ratings:

> **Substantial Compliance** (as defined in Consent Decree) - if any violations of the relevant remedial plan are minor or occasional and are neither systemic nor have been addressed to resolve or repair the issue
>
> **Partial Compliance -** elements of the remedial plan compliance are evident, but not to a sufficient degree to meet the standard of substantial compliance
>
> **Non-compliance**-compliance is not evident and/or the level of compliance does not meet minimal requirements of the remedial plan
>
> **Not Applicable** – item was not monitored at the site because the specific standard did not apply
>
> **Not Audited** – item was found in substantial compliance system wide for two consecutive audits and was not reviewed in this audit cycle

Because of the relatively brief time involved in the actual site reviews, the reports are limited in their ability to provide ongoing descriptions and should be utilized as only one source of information for indicating progress by the DJJ facilities towards meeting consent decree requirements.

Content of the Summary Education Program Report:

The content of this report is presented in three parts:

I. Introduction- background on the development of the Education Services Remedial Plan, its inclusion in the Consent Decree and the methodology of the Remedial Plan review process

II. Summary Report – report indicating the compliance ratings on specific items in the Remedial Plan for each school program reviewed

III. Major Commendations and Recommendations – statements regarding areas of progress during the current audit cycle as well as areas needing improvement in order to achieve full compliance with the requirements of the Educational Remedial Plan.

Section II. Summary Report

The summaries of the experts' findings are found in the attached tables:

Attachment A California Remedial Plan Site Compliance Report

I. Overview, Philosophy, and Program Policy
II. Staffing
III. Student Access and Attendance,
IV. Curriculum,
V. Special Education,
VI. California High School Exit Exam

On this table, the name of each site and the date of the experts' review are indicated at the top of the column. The items reviewed are listed by each of the six (6) areas and the compliance rating for each item (substantial, partial, non compliance, or non applicable) is shown.

The report is color coded. Items that are non compliant are highlighted in red. Items that are partially compliant are highlighted in yellow. Items that have maintained substantial compliance for 2 consecutive audits are highlighted in blue. Items that are substantially compliant for one year or non-applicable have been left white

Attachment B Comparison of the Office of Audit and Core Compliance Report and the Experts Audit Reports.

On this table, the name of each site and the date of the experts' review are indicated at the top of the column. The items reviewed are listed by each of the six (6) areas and the compliance rating for each item (substantial, partial, non compliance, or non applicable) is shown. Comparisons are shown between the OACC audit ratings and the experts' ratings.

Ratings which reflect no change between the OACC and the expert's audits are noted in blue. Ratings where the experts raised the OACC rating are noted in yellow. Ratings where the experts lowered the OACC rating are noted in red. Non applicable ratings are noted in green.

Section III. Major Commendations and Recommendations

The following comments are made by the experts to assist the Division of Juvenile Justice (DJJ) in attaining full compliance with the Consent Decree requirements. The commendations and recommendations are organized according to the six areas in the Education Services Remedial Plan.

I. Overview, Philosophy and Program Policy

Commendations:

- The DJJ continues to make progress towards meeting the requirements of the Consent Decree Remediation Plan.
- All of the schools continue to be accredited by the Western Association of Colleges and Schools.
- All schools provide a core curriculum that meets the Content Standards for the California Public Schools.
- All students are screened and provided English language services by teachers who are appropriately credentialed and certified.
- All schools have documented offering transition planning to students 90 days prior to students release.

Recommendations:

- The downsizing of the DJJ facilities and the reduction of the student population including the current recommendation to close the Southern Youth Correctional Reception Center makes it necessary to update and revise the Educational Central Office Organizational Chart. It is also necessary to provide written job descriptions for each position noted on the chart that reflect current needs.
- Planning for the student's return to the community begins at the time of admission. There is an ongoing need to develop a re-entry model designed to focus on a consistent approach to transitioning of youth from confinement back to the community. This model requires collaboration between institution staff, families, youth, community aftercare, and community service providers. A structured transition phase and careful re-entry planning along with guided follow up increases the likelihood of successful re-entry to the community. The model should involve a feedback loop which informs the site of whether the youth has found meaningful employment, entered school and/or become a productive member of the community.

II. Staffing

Commendations:

- Each school has an adequate pool of substitute teachers to meet the 15% minimum requirement.
- Each high school with a restricted program has a minimum of two school psychologists.

Recommendations:

- With the downsizing and closing of facilities, there is a need to balance staffing and teacher allocations at all locations. The DJJ must remove hiring freezes for essential teachers in order to provide services needed for the delivery of the educational program.
- The DJJ must review the current system used to provide substitute teachers to prevent class cancellations due to teacher absences at all sites. The pool of substitute teachers at Mary B. Perry high school is depleted due to their assignments to teacher vacancies caused by the current hiring freeze. Chaderijan and Johanna Boss High Schools fail to share a joint pool of substitute teachers despite being located on the same campus. Essentially they are competing for the same resources. These two schools should combine their pool of substitute teachers to provide a larger pool of substitute teachers available at each site.
- The DJJ must provide credentialed teachers and related service providers at all sites. It is necessary to immediately address and eliminate extended delays that occur in filling teacher vacancies.
- Special education assessments at the Johanna Boss High School failed to meet California Department of Education (CDOE) and Individual with Disabilities Education Act (IDEA) standards. Staff must conduct all assessments including those required for related services such as speech, language, hearing, within the prescribed timelines established by DJJ policy and federal law.
- Individual Educational Program (IEP) mandated service hours, including those provided by related service providers, must be offered to students housed at Chaderjian and Johanna Boss High Schools.

III. Student Access and Attendance

Commendations:

- DJJ is commended for increasing the enrollment in the vocational classes. Students should be provided with counseling and better access to these programs to enable them to gain the necessary employment skills to prepare them as they re-enter the community.

- The security staff at all facilities are commended for their efforts to promote safety and security on the school campus. Efforts are being made to get students to school on time and provide support to teachers in their efforts to provide an atmosphere in the classrooms conducive to teaching and learning.

- The principals are commended for their efforts to keep classes open.

- The Alternative Behavior Learning Environment program is working well at all sites. This program provides opportunities for students to continue learning when alternative education is needed due to classroom behavior issues.

Recommendations:

- The "Program Service Day" was developed to allow time for all treatment programs, (educational mental health and medical) to meet work day/week without loss of the mandatory 240 minute school day. Consistent implementation of the "Program Service Day" is necessary at all sites to provide students with an uninterrupted 240 minute instructional day. School refusals, without consistent disciplinary consequences, school pull outs for non emergency medical, mental health and/or safety and security reasons continues to negatively impact the establishment of school program.

- Chaderjian, Johanna Boss, and Mary B. Perry High Schools fail to provide IEP mandated related services due to related service provider vacancies. Students are not receiving services within federally mandated time lines.

- Teacher vacancies must be filled immediately before the staff at Mary Perry High School can be stabilized.

- The restricted setting at Mary B. Perry High School must be fully staffed with teachers, security and other support personnel to insure safe and successful implementation of program goals and objectives. Once this stability is established, every effort should be made to insure that all students assigned to the restricted programs are provided access to 240 minutes of daily education instruction as required by the remedial plan.

- The DJJ must develop a system that identifies unexcused and excused student absences which are education or non-education related. Program administrators at the central office and at each site must continue to address student absences. The practice of classifying non emergency absences or pull outs as excused absences should be discontinued.

- Extended denial of access to the school program involving students placed on Temporary Intervention Plan (TIP) should be examined by DJJ administrative staff at both the school and central office level. Deviations from established DJJ timelines must be documented and considered to be exceptions to acceptable disciplinary practice.

IV. Curriculum

Commendations:

- It is noted that all ratings on item IV Curriculum, with the exception of one PC rating on audit item 4.12 at Jack B.Clarke High School, are substantially compliant. The DJJ has done a very good job of developing and providing curriculum, instructional services and educational supplies and materials which meet state and federal standards.

- Principals are conducting classroom observations to monitor teaching and to ensure that teachers are teaching the curriculum and are being responsive to the needs of the student population.

- Distance learning, aligned with content standards, has been implemented to supplement the academic curriculum.

Recommendations:

- The Central Office staff of the Education Services Branch of the Department of Juvenile Justice must continue to update all educational policies and see that they are available online to all educational staff. Additional training will be necessary to assure that the DJJ remains compliant in this area.

- School administrators must continue to provide leadership in monitoring the mini-libraries on the living units. School librarians should be held responsible for the oversight and maintenance of these mini-library sites.

- Distance learning technology must be provided to all students including those on the restricted units. Technology must be used to increase educational service hours without compromising security for students segregated from the general population.

- Efforts to monitor yearly progress on the 5-year Strategic Plan must be formally documented by DJJ Central Office staff.

V. Special Education

Commendations:

- Chaderjian, Johann Boss, Mary B Perry and Jack B. Clarke High Schools are commended for maintaining substantial compliance ratings on 15 of 25 special education audit areas measured by the California Remedial Plan Site Compliance Report.

- Teachers at all facilities were well versed in the identification and referral requirements for special education eligible students.

- The DJJ has provided extensive training to special education and regular education staff on topics including student limitations, lesson modifications, adaption of instruction, IEP development and IEP referral requirements and procedures.

  Recommendations

  - The DJJ does not provide a full continuum of services to the special education students at Chaderjian, Johanna Boss, and Mary B. Perry High Schools. The DJJ Central Office administration must develop procedures including contracting with outside agencies and eliminate hiring freezes to immediately address the provision of mandated services when key service provider positions are vacant.

  - Chaderjian, Johanna Boss, and Mary B. Perry High Schools fail to provide all instructional segments and related services identified in new or existing IEP's. The monitoring of service provider logs and the implementation of a system of administrative and teacher accountability must be implemented at both the Central Office and school sites.

  - Chaderjian, Johanna Boss and Mary B. Perry High Schools fail to provide all IEP mandated related service hours in a timely manner. This problem was previously identified during the 2009-20010 education audits. Central Office and site level administrative staff must develop and implement a system to monitor the provision of service hours.

  - N.A. Chaderijan and Mary B. Perry High Schools fail to provide special education students placed in the restricted units with a full continuum of placement options including all segments and services listed in the student's IEP. Eligible students must be provided access to the GED and vocational programming when such services are identified as service needs in the IEP.

  - Chaderjian, Johanna Boss and Mary B. Perry High Schools failed to maintain a standardized system for tracking and providing compensatory services for special education students. Documentation of the provision of compensatory services must be addressed.

  - Program Specialists who have conducted special education site reviews at each high school have failed to provide documented feedback to teachers who have submitted corrected IEP's.

VI. California High School Exit Exam

Commendations:

- It is noted that the experts found that all ratings in this area to be substantially compliant. Documentation of adherence to the statewide testing schedule has been established. DJJ has done a very good job of allowing all eligible students access to mandated educational assessments with appropriate accommodations, modifications or variations as a part of testing procedures in accord with DJJ guidelines.

Recommendations:

- DJJ should continue to monitor this area to assure compliance is maintained.

Additional Comments and Recommendations

High Schools continue to make progress towards meeting the mandates of the remedial plan as noted in the California Education Remedial Plan Site Compliance Reports 2010–2011.

Recommendations

During the 2010-2011 education monitoring cycle, the Office of Audits and Core Compliance (OACC) audited each site 45 days prior to the education experts' audit. These internal audits were instrumental in ensuring that each high school monitored its compliance items in each area noted in the *Farrell v. Cate* Education Remedial Plan..Through this process, several areas which were identified by the OACC audit team as partial or non-compliant, were remedied by school personnel prior to the experts audit.

The OACC audit team review at the four high schools identified 41 non or partially compliant items that the DJJ was able to address prior to the education experts site audit. The Principal at Jack B. Clarke is commended for her efforts to address the deficiencies noted in the OACC audit report. She corrected 13 of 14 areas found to be partially or non compliant. Similar improvements to a lesser degree were noted at the other high schools.

The OACC compliance ratings for 16 items rated as substantially or partially compliant regressed during the 45 day period between audits. It is noted however, that approximately half of the items have been addressed by the DJJ and corrective action plans are in place.

The high degree of rater agreement between the OACC and the education experts as documented in Appendix B (Comparison of OACC and the Experts Audit Ratings), strongly supports the validity of the OACC findings. The experts feel that the OACC internal auditing system will allow monitoring responsibilities to be shifted from the court appointed experts to this independent audit team. This process demonstrates DJJ's ability to meet the mandates of the Education Consent Decree Remedial Plan and continue to maintain ongoing reform efforts.

California Remedial Plan Site Compliance Report

Area : EDUCATION **Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon** **From January 2011 through April 2011**

Ratings:	**SC Substantial compliance**	**PC Partial Compliance**		**NC Non compliance**		
Ratings:	**Substantial Compliance**	**Partial Compliance**		**Non Compliance**		**ALL SITES**
	Site	**Chaderjian**	**Boss**	**MBPHS**	**Clark**	**2010 / 2011**
	Date of Review	**1/31/2011**	**2/3/2011**	**4/5/2011**	**4/8/2011**	
	Items Reviewed					
I. Overview						
1.1	Schools meet WASC accreditation standards	**SC**	**SC**	**SC**	**SC**	
1.2	Curriculum meets CA state standards	**SC**	**SC**	**SC**	**SC**	
1.3	High School Graduation Plans in records	**SC**	**SC**	**SC**	**SC**	
1.4	Semi-annual reviews of High School Graduation Plans	**PC**	**NC**	**NC**	**SC**	
1.6	Progress being made toward high school diplomas	**SC**	**SC**	**PC**	**SC**	
1.7	English Language Learner screening & services	**SC**	**SC**	**SC**	**SC**	
1.8	Transition planning (90 days prior to release)	**SC**	**SC**	**PC**	**SC**	
II. Staffing						
2.1	Teachers hold valid CA credentials and teach in-field	**PC**	**SC**	**SC**	**SC**	
2.2	Adequate credentialed staff in content areas for gradua	**SC**	**SC**	**SC**	**SC**	
2.3	Recruitment plan for education staff and 2 recruiters	**SC**	**SC**	**SC**	**SC**	
2.4	Time between education vacancy and hiring	**NC**	**NC**	**NC**	**SC**	
2.5	Pool of substitute teachers = 15% of teaching staff	**SC**	**SC**	**SC**	**SC**	
2.6	Class cancelled due to teacher absence/lack of subs	**SC**	**SC**	**NC**	**SC**	
2.7	In-field teacher used for teacher vacancy of 45 days	**SC**	**NC**	**NC**	**SC**	
2.8	Psychologist and related service providers available	**NC**	**NC**	**NC**	**SC**	
2.9	Time from referral for testing and report completed	**SC**	**NC**	**SC**	**SC**	
2.10	Time from referral for related services to service delive	**NC**	**NC**	**SC**	**SC**	
2.11	2 school psychologists for each restricted program	**SC**	**SC**	**SC**	**SC**	
III. Student Access & Attendance						

	Date of Review	1/31/2011	2/3/2011	4/5/2011	4/8/2011	
3.1	Standardized Academic Calendar meets CA requireme	**SC**	**SC**	**SC**	**SC**	
3.2	Standardized Academic Calendar-basis of student serv	**SC**	**SC**	**SC**	**SC**	
3.3	Policy & practice-all students enrolled within 4 days	**SC**	**SC**	**SC**	**SC**	
3.4	Registrars request records on new students within 4 da	**SC**	**SC**	**SC**	**SC**	
3.5	Students meeting GED criteria have GED opportunity	**PC**	**SC**	**SC**	**SC**	
3.6	SCT services for students with academic/ behavioral pr	**SC**	**PC**	**SC**	**SC**	
3.7	SCT records of interventions and referrals	**SC**	**PC**	**SC**	**SC**	
3.8	Students not making academic progress referred to SC	**PC**	**PC**	**NC**	**SC**	
3.9	Development of SCT tracking system	**SC**	**SC**	**SC**	**SC**	
3.10	Documentation of progress reviews of SCT plans	**SC**	**PC**	**NC**	**SC**	
3.11	SCT logs show follow-through on eligibility testing	**SC**	**NC**	**SC**	**SC**	
3.12	Students referred from SCT receive special education t	**SC**	**SC**	**SC**	**SC**	
3.13	SCT training (procedures, roles & responsibilities, form	**SC**	**SC**	**SC**	**SC**	
3.14	Teachers informed of missing student's whereabouts	**SC**	**SC**	**SC**	**SC**	
3.15	Document school attendance for previous 30 days	**NC**	**NC**	**NC**	**NC**	
3.16	Cooperative Agreements to ensure students' attendan	**SC**	**NC**	**SC**	**SC**	
3.17	Quarterly reviews of school attendance by Exec.Team	**SC**	**SC**	**SC**	**SC**	
3.18	Plans (due 4/05) to remediate deficient attendance	**SC**	**SC**	**SC**	**SC**	
3.19	Quarterly corrective action plans for high absence rates	**SC**	**SC**	**SC**	**NC**	
3.20	Policy & procedure to eliminate class cancellations	**SC**	**SC**	**NC**	**SC**	
3.21	Teacher records indicate missing students	**SC**	**SC**	**SC**	**SC**	
3.22	Exclusion from school forms have complete data	**SC**	**SC**	**SC**	**SC**	
3.23	Observation of students not being sent to school	**NC**	**PC**	**NC**	**SC**	
3.24	Accurate attendance data in WIN database	**SC**	**SC**	**SC**	**SC**	
3.25	Mgmt team monthly review of attendance data	**SC**	**NC**	**SC**	**SC**	
3.26	Performance expectations on attendance (due 7/05)	**SC**	**SC**	**SC**	**SC**	
3.27	Training on attendance expectations	**SC**	**SC**	**SC**	**SC**	
3.28	Implementation of attendance policy & procedures (due	**SC**	**SC**	**SC**	**SC**	
3.29	Incentives developed for increased school attendance	**SC**	**NC**	**SC**	**SC**	
3.30	Annual state school calendar implemented	**SC**	**SC**	**SC**	**SC**	
3.31	Yearly calendar w/44 student advising/case conference	**SC**	**SC**	**SC**	**SC**	
3.32	Adequate instructional space	**SC**	**SC**	**SC**	**SC**	
3.33	Structured classroom behavior management system	**SC**	**NC**	**SC**	**SC**	
3.34	Alternative behavior management classroom at each si	**SC**	**SC**	**SC**	**SC**	
3.35	Staff training on behavior management system	**SC**	**SC**	**SC**	**SC**	
3.36	Behavioral goals for spec. ed. students-restricted progr	**SC**	**SC**	**SC**	**SC**	
3.37	Use of small classrooms (adequate size) in restricted s	**SC**	**SC**	**SC**	**SC**	
3.38	Staff ratio & credentialed teachers in restricted settings	**SC**	**SC**	**SC**	**SC**	
3.39	Instructional program in restricted placements	**SC**	**SC**	**SC**	**SC**	
3.40	Training provided to staff in restricted settings	**SC**	**SC**	**SC**	**SC**	

Date of Review		1/31/2011	2/3/2011	4/5/2011	4/8/2011	
IV. Curriculum						
4.1	Curriculum Guides & policies aligned with CA Educatio	**SC**	**SC**	**SC**	**SC**	
4.2	Process to develop and revise curriculum on cyclical ba	**SC**	**SC**	**SC**	**SC**	
4.3	Curriculum guides for all core & vocational classes	**SC**	**SC**	**SC**	**SC**	
4.4	Core Curriculum Guides available in electronic form (du	**SC**	**SC**	**SC**	**SC**	
4.5	Schools meet CA & WASC standards for books & mate	**SC**	**SC**	**SC**	**SC**	
4.6	Annual inventory & needs assessment of books & equi	**SC**	**SC**	**SC**	**SC**	
4.7	Textbooks & library books available in classrooms	**SC**	**SC**	**SC**	**SC**	
4.8	Books available in mini-libraries on living units	**NC**	**SC**	**SC**	**SC**	
4.9	Professional development for school leadership person	**SC**	**SC**	**SC**	**SC**	
4.10	Training schedule on new procedures-educ & custody s	**SC**	**SC**	**SC**	**SC**	
4.11	Training attendance-new procedures-educ & custody s	**SC**	**SC**	**SC**	**SC**	
4.12	Formation of Trade Advisory Committees & quarterly m	**SC**	**SC**	**PC**	**PC**	
4.13	Annual surveys for vocational course planning (due 7/0	**SC**	**SC**	**SC**	**SC**	
4.14	Annual Career Technical job studies to evaluate CTE p	**SC**	**SC**	**SC**	**SC**	
4.15	Use of technology at each site (due 6/05)	**SC**	**SC**	**SC**	**SC**	
4.16	Distance learning courses meet CA Content Standards	**SC**	**SC**	**SC**	**SC**	
4.17	Use of Global Classrooms distance learning (due 6/06)	**SC**	**SC**	**SC**	**SC**	
4.18	Distance learning provided in restricted units	**SC**	**SC**	**SC**	**SC**	
4.19	Automated library system at each HS (due 6/06)	**SC**	**SC**	**SC**	**SC**	
4.20	Teachers use course syllabi & lesson plans	**SC**	**SC**	**SC**	**SC**	
4.21	Quarterly teacher observations using revised rubric	**SC**	**SC**	**SC**	**SC**	
4.22	5 year strategic plan & reading initiative implemented	**SC**	**SC**	**SC**	**SC**	
4.23	Policies revised to reflect operational changes	**SC**	**SC**	**SC**	**SC**	
4.24	Education policies available electronically (due 6/06)	**NC**	**SC**	**SC**	**SC**	
V. Special Education						

	Date of Review	1/31/2011	2/3/2011	4/5/2011	4/8/2011	
5.1	Special Education Policy Manual revised & available (d	SC	SC	SC	SC	
5.2	Files transferred & services implemented in 4 days	SC	SC	SC	SC	
5.3	Screening provided and referrals for psychological testi	SC	SC	SC	SC	
5.4	Teachers identify special ed students in classrooms	SC	SC	SC	SC	
5.5	Referral for testing-update eligibility; reports complete &	NC	PC	SC	SC	
5.6	Site has full continuum of placement options	NC	NC	NC	SC	
5.7	Continuum of services available in restricted settings	SC	NC	NC	SC	
5.8	Segments & services listed in IEPs are provided	NC	NC	NC	SC	
5.9	Accuracy & completeness of special education data sy	SC	SC	SC	SC	
5.10	Assessment procedures updated & standardized	SC	SC	SC	SC	
5.11	Training and reports of assessment completion rates	SC	SC	SC	SC	
5.12	Procedures standardized, including county intake (due	SC	SC	SC	SC	
5.13	Clinics-agreements with Intake & CS on providing IEPs	SC	SC	SC	SC	
5.14	Procedures for Intake & CS on providing IEPs	SC	SC	SC	SC	
5.15	Pre-existing valid IEPs implemented	NC	NC	NC	PC	
5.16	Changes in IEPs documented w/rationale	SC	SC	SC	NC	
5.17	Eligibility determined prior to IEP meeting	SC	SC	SC	SC	
5.18	IEP eligibility meetings held timely & with notices, parti	PC	SC	SC	SC	
5.19	IEPs include consideration of related svc/transition plan	NC	NC	NC	SC	
5.20	Training on specific topics for special ed teachers	SC	SC	SC	SC	
5.21	System of IEP progress reviews implemented	SC	SC	SC	SC	
5.22	Compensatory special education svc provided when ne	NC		NC	SC	
5.23	Education Stakeholders' Committee w/quarterly meetin	SC	SC	SC	SC	
5.24	Training to education and custody staff on Spec Educ	SC	SC	SC	SC	
5.25	Regional Prog Specialist site reviews of spec ed compl	NC	NC	NC	NC	
VI. California High School Exit Exam						
6.1	CA assessment program provided to eligible students	SC	SC	SC	SC	
6.2	CYA curriculum in LA & math related to Graduation Tes	SC	SC	SC	SC	
6.3	Students have multiple opportunities to pass state exar	SC	SC	SC	SC	
6.4	Students have appropriate test accommodations /modi	SC	SC	SC	SC	
6.5	Students with equivalent passing scores- waivers requ	SC	SC	SC	SC	
6.6	Students failing test receive remediation	SC	SC	SC	SC	
6.7	Test data is monitored & basis of school improvement	SC	SC	SC	SC	
6.8	Students have range of alternatives to complete educa	SC	SC	SC	SC	

Comparison of OACC and Education Experts Audit ratings

Area : EDUCATION **Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon** **From January 2011 through April 2011**

Ratings:	No Change in Audit Rating	Ed. Experts raised OACC Rating		Ed. Experts lower / OACC Rating		NA / No BTP
	Site	Chaderjian	Boss	MBPHS	Clark	
	Date of Review	1/31/2011	2/3/2011	4/5/2011	4/8/2011	
	Items Reviewed					
I. Overview						
1.1	Schools meet WASC accreditation standards	SC-SC	SC-SC	SC-SC	SC-SC	100%
1.2	Curriculum meets CA state standards	SC-SC	SC-SC	SC-SC	SC-SC	100%
1.3	High School Graduation Plans in records	SC-SC	SC-SC	SC-SC	SC-SC	100%
1.4	Semi-annual reviews of High School Graduation Plans	PC-PC	SC TO NC	PC TO NC	SC-SC	50%
1.6	Progress being made toward high school diplomas	SC-SC	SC-SC	PC-PC	PC TO SC	75%
1.7	English Language Learner screening & services	SC-SC	NC-NC	NC TO SC	SC-SC	75%
1.8	Transition planning (90 days prior to release)	SC-SC	SC	PC TO SC	SC-SC	75%
II. Staffing						
2.1	Teachers hold valid CA credentials and teach in-field	PC-PC	SC-SC	SC-SC	SC-SC	100%
2.2	Adequate credentialed staff in content areas for gradua	SC-SC	SC-SC	SC TO NC	SC-SC	75%
2.3	Recruitment plan for education staff and 2 recruiters	SC-SC	SC-SC	SC-SC	SC-SC	100%
2.4	Time between education vacancy and hiring	NC-NC	SC-SC	NC-NC	PC TO SC	75%
2.5	Pool of substitute teachers = 15% of teaching staff	SC-SC	SC-SC	SC-SC	SC-SC	100%
2.6	Class cancelled due to teacher absence/lack of subs	SC-SC	SC-SC	NC-NC	SC-SC	100%
2.7	In-field teacher used for teacher vacancy of 45 days	SC-SC	NC-NC	NC TO PC	PC TO SC	50%
2.8	Psychologist and related service providers available	NC-NC	NC-NC	NC-NC	SC-SC	100%
2.9	Time from referral for testing and report completed	SC-SC	NC-NC	SC-SC	SC-SC	100%
2.10	Time from referral for related services to service delive	SC TO NC	NC-NC	SC-SC	SC-SC	75%
2.11	2 school psychologists for each restricted program	SC-SC	NO BTP	SC-SC	SC-SC	75%
III. Student Access & Attendance						

	Date of Review	1/31/2011	2/3/2011	4/5/2011	4/8/2011	
3.1	Standardized Academic Calendar meets CA requireme	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.2	Standardized Academic Calendar-basis of student serv	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.3	Policy & practice-all students enrolled within 4 days	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.4	Registrars request records on new students within 4 da	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.5	Students meeting GED criteria have GED opportunity	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.6	SCT services for students with academic/ behavioral pr	SC-SC	NC TO PC	PC TO SC	PC TO SC	25%
3.7	SCT records of interventions and referrals	SC-SC	NC TO PC	SC-SC	SC-SC	75%
3.8	Students not making academic progress referred to SC	SC-SC	NC TO PC	NC-NC	NC TO SC	50%
3.9	Development of SCT tracking system	SC-SC	PC TO SC	SC-SC	SC-SC	75%
3.10	Documentation of progress reviews of SCT plans	SC-SC	NC TO PC	NC TO SC	NC TO SC	25%
3.11	SCT logs show follow-through on eligibility testing	SC-SC	NC-NC	SC-SC	SC-SC	100%
3.12	Students referred from SCT receive special education t	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.13	SCT training (procedures, roles & responsibilities, form	SC-SC	PC TO SC	SC-SC	SC-SC	75%
3.14	Teachers informed of missing student's whereabouts	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.15	Document school attendance for previous 30 days	NC-NC	PC TO NC	NC-NC	PC TO NC	50%
3.16	Cooperative Agreements to ensure students' attendan	SC-SC	SC TO NC	SC-SC	SC-SC	75%
3.17	Quarterly reviews of school attendance by Exec.Team	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.18	Plans (due 4/05) to remediate deficient attendance	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.19	Quarterly corrective action plans for high absence rates	SC-SC	SC-SC	SC-SC	NC-NC	100%
3.20	Policy & procedure to eliminate class cancellations	SC-SC	SC-SC	SC TO NC	SC-SC	75%
3.21	Teacher records indicate missing students	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.22	Exclusion from school forms have complete data	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.23	Observation of students not being sent to school	SC TO NC	PC-PC	SC TO NC	SC-SC	50%
3.24	Accurate attendance data in WIN database	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.25	Mgmt team monthly review of attendance data	SC-SC	NC-NC	SC-SC	SC-SC	100%
3.26	Performance expectations on attendance (due 7/05)	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.27	Training on attendance expectations	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.28	Implementation of attendance policy & procedures (due	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.29	Incentives developed for increased school attendance	SC-SC	SC TO NC	SC-SC	SC-SC	75%
3.30	Annual state school calendar implemented	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.31	Yearly calendar w/44 student advising/case conference	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.32	Adequate instructional space	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.33	Structured classroom behavior management system	SC-SC	SC TO NC	SC-SC	SC-SC	75%
3.34	Alternative behavior management classroom at each si	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.35	Staff training on behavior management system	SC-SC	SC-SC	SC-SC	SC-SC	100%
3.36	Behavioral goals for spec. ed. students-restricted progr	SC-SC	NO BTP	SC-SC	PC TO SC	75%
3.37	Use of small classrooms (adequate size) in restricted s	SC-SC	NO BTP	NC-NC	SC-SC	100%
3.38	Staff ratio & credentialed teachers in restricted settings	SC-SC	NO BTP	SC-SC	PC TO SC	75%
3.39	Instructional program in restricted placements	SC-SC	NO BTP	NC TO PC	SC-SC	75%
3.40	Training provided to staff in restricted settings	SC-SC	NO BTP	SC-SC	SC-SC	100%

Date of Review		1/31/2011	2/3/2011	4/5/2011	4/8/2011	
IV. Curriculum						
4.1	Curriculum Guides & policies aligned with CA Educatio	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.2	Process to develop and revise curriculum on cyclical ba	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.3	Curriculum guides for all core & vocational classes	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.4	Core Curriculum Guides available in electronic form (du	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.5	Schools meet CA & WASC standards for books & mate	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.6	Annual inventory & needs assessment of books & equi	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.7	Textbooks & library books available in classrooms	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.8	Books available in mini-libraries on living units	PC TO NC	SC-SC	SC-SC	SC-SC	75%
4.9	Professional development for school leadership person	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.10	Training schedule on new procedures-educ & custody s	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.11	Training attendance-new procedures-educ & custody s	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.12	Formation of Trade Advisory Committees & quarterly m	SC-SC	PC TO SC	PC TO SC	PC-PC	50%
4.13	Annual surveys for vocational course planning (due 7/0	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.14	Annual Career Technical job studies to evaluate CTE p	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.15	Use of technology at each site (due 6/05)	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.16	Distance learning courses meet CA Content Standards	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.17	Use of Global Classrooms distance learning (due 6/06)	SC-SC	NC TO SC	SC-SC	SC-SC	75%
4.18	Distance learning provided in restricted units	SC-SC	NO BTP	NC TO SC	SC-SC	75%
4.19	Automated library system at each HS (due 6/06)	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.20	Teachers use course syllabi & lesson plans	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.21	Quarterly teacher observations using revised rubric	PC TO SC	SC-SC	SC-SC	SC-SC	75%
4.22	5 year strategic plan & reading initiative implemented	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.23	Policies revised to reflect operational changes	SC-SC	SC-SC	SC-SC	SC-SC	100%
4.24	Education policies available electronically (due 6/06)	SC-SC	SC-SC	SC-SC	SC-SC	100%
V. Special Education						

	Date of Review	1/31/2011	2/3/2011	4/5/2011	4/8/2011	
5.1	Special Education Policy Manual revised & available (d	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.2	Files transferred & services implemented in 4 days	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.3	Screening provided and referrals for psychological testi	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.4	Teachers identify special ed students in classrooms	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.5	Referral for testing-update eligibility; reports complete &	PC TO NC	PC-PC	SC-SC	SC-SC	75%
5.6	Site has full continuum of placement options	NC-NC	NC-NC	NC-NC	PC TO SC	75%
5.7	Continuum of services available in restricted settings	NC-NC	NC-NC	NC-NC	SC-SC	100%
5.8	Segments & services listed in IEPs are provided	NC-NC	NC-NC	NC-NC	PC TO SC	75%
5.9	Accuracy & completeness of special education data sy	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.10	Assessment procedures updated & standardized	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.11	Training and reports of assessment completion rates	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.12	Procedures standardized, including county intake (due	NA	SC-SC	SC-SC	SC-SC	100%
5.13	Clinics-agreements with Intake & CS on providing IEPs	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.14	Procedures for Intake & CS on providing IEPs	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.15	Pre-existing valid IEPs implemented	NC-NC	NC-NC	SC-SC	SC TO PC	75%
5.16	Changes in IEPs documented w/rationale	SC-SC	SC-SC	SC-SC	NC-NC	100%
5.17	Eligibility determined prior to IEP meeting	PC TO SC	SC-SC	SC-SC	PC TO SC	50%
5.18	IEP eligibility meetings held timely & with notices, parti	PC-PC	SC-SC	SC-SC	NC TO SC	75%
5.19	IEPs include consideration of related svc/transition plar	NC-NC	NC-NC	SC-SC	SC-SC	100%
5.20	Training on specific topics for special ed teachers	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.21	System of IEP progress reviews implemented	SC-SC	SC-SC	SC-SC	NC TO PC	75%
5.22	Compensatory special education svc provided when ne	NC-NC	NC-NC	NC-NC	SC-SC	75%
5.23	Education Stakeholders' Committee w/quarterly meetin	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.24	Training to education and custody staff on Spec Educ	SC-SC	SC-SC	SC-SC	SC-SC	100%
5.25	Regional Prog Specialist site reviews of spec ed compl	SC TO NC	SC TO NC	NC-NC	NC-NC	50%
VI. California High School Exit Exam						
6.1	CA assessment program provided to eligible students	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.2	CYA curriculum in LA & math related to Graduation Tes	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.3	Students have multiple opportunities to pass state exar	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.4	Students have appropriate test accommodations /modi	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.5	Students with equivalent passing scores- waivers requ	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.6	Students failing test receive remediation	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.7	Test data is monitored & basis of school improvement	SC-SC	SC-SC	SC-SC	SC-SC	100%
6.8	Students have range of alternatives to complete educa	SC-SC	SC-SC	SC-SC	SC-SC	100%

Introduction

This report represents the sixth annual auditing report by the Disabilities Expert and Auditor, Logan Hopper, in response to the Consent Decree entered in the matter of *Farrell v. Cate.* The Consent Decree requires that the Disabilities Expert visit each Division of Juvenile Justice (DJJ) correctional facility and Headquarters during each fiscal year, and report on the progress DJJ is making in implementing the Wards with Disabilities Program (WDP) Remedial Plan, filed with the Court on May 31, 2005.

During the fiscal year 2010-11, the Disabilities Auditor visited the following facilities (listed in the order of the visits):

N. A. Chaderjian Youth Correctional Facility
Ventura Youth Correctional Facility
Southern Youth Correctional Reception Center and Clinic (SYCRCC)
O.H. Close Youth Correctional Facility
Division of Juvenile Justice Headquarters

For the fiscal year 2010-11, the Disabilities Auditor scheduled one two-day site visit to each correctional facility. At the end of each facility visit, a summary report giving findings and compliance ratings was submitted to the Office of the Special Master and subsequently to the parties for review and comment, and a final report was then issued.

This comprehensive annual report attempts to determine a general level of compliance for all applicable items from the Wards with Disabilities Program (WDP) Remedial Plan and the Disabilities Audit Instrument, using the following codes:

SC = Substantial Compliance; PC = Partial Compliance; BC = Beginning Compliance; NC = Non-Compliance; NA = Not Applicable.

A system of "+" or "–" associated with compliance ratings was instituted last fiscal year, and used occasionally as a way of acknowledging either an improvement or a decline from a past rating. While these notations were not popular with all parties, it is felt that they are of value, since the "grades" are not as important to the Auditor as the progress made and the realization that continuing compliance is dependent on an understanding of what the WDP Remedial Plan intends to accomplish. If a reader has objections to these notations, the symbols may be disregarded. It is the Auditor's intent that these "+" or "–" symbols should not be used in any statistics generated, but used to gauge an improvement or decline.

During this audit cycle, a number of audit line items were transferred for auditing by CDCR's Office of Audits and Court Compliance, subject to random sampling by the Disabilities Expert, in mutual agreement by the parties, the Office of the Special Master, and the Disabilities Expert. OACC's ratings from their audit conducted prior to the Disabilities Expert's audit are provided for reference in this report, but do not necessarily represent auditing or concurrence by the Disabilities Expert. The compliance ratings for these items are marked by an "*".

Item numbers have been added to this report to assist in referring to the various audit items, but it should be noted that the Court-approved Disabilities Audit Instrument does not contain item numbers, and numbers provided by others in similar report formats may be different from those contained herein.

Executive Summary

For the most basic summary of the year's activities and current status, it is clear that the Wards with Disabilities Program has made strides and reached substantial compliance in a number of areas, but there still are areas where compliance has not been reached and further efforts are needed to effectively provide wards with disabilities equal access to programs and services. The main purpose of this report is to provide guidance as to where DJJ should continue with established procedures, and where further development is needed to achieve substantial compliance with the WDP Remedial Plan.

During the fiscal year, management of the Wards with Disabilities Program was again provided by Sandi Becker, Departmental WDP Manager, who has continued to work diligently to perform the duties required by the WDP Remedial Plan. During the three years of her tenure, Ms. Becker has gained an understanding of the program's requirements as well as disability policy in general, and has proven to be very capable and dedicated to the task. At three of the four facilities currently in operation, the facility WDP coordinators have been in their positions for some time and have gained valuable experience, and their daily activities represent one of the strongest aspects of the Wards with Disabilities Program. At Ventura, two temporary WDP coordinators also performed a valuable service in filling in for the permanent position, but their tenure was short, and it is hoped that a new, full-time coordinator will be in place at the time this report is approved. The WDP departmental and facility coordinators and staff members go about their tasks in different ways, but they have all demonstrated remarkable patience and skill in setting up processes and undertaking the necessary tasks. As a result of the combined efforts of these coordinators, the WDP program has progressed as an entity at all facilities. The execution of basic WDP tasks by these coordinators, such as overseeing the Staff Assistant teams, providing individualized assistance to wards with disabilities, and monitoring the disciplinary and grievance systems, continues to meet basic goals established by the plan, although some areas still require guidance and additional policy development from Headquarters.

The annual auditor's report for the last few years has cited a need for better coordination of required WDP Remedial Plan elements into the day-to-day operations by facility staff, particularly those in supervisory positions, as well as a need for more meaningful acceptance of the program's goals by all correctional staff. The WDP Remedial Plan is a complex and comprehensive document that touches upon all operations of DJJ, since the overriding goal is for wards with disabilities to be integrated with and receive equal treatment and services consistent with those provided to all wards. Generally, Superintendents continue to be knowledgeable about and cooperative with the goals of the remedial plan. In addition, many supervisors at the facilities, usually Program Administrators or Treatment Team Supervisors, assist the WDP facility coordinators in procedural and operational matters, and many of these staff should also be commended for their commitment toward making the implementation of the plan filter into the various disciplines and departments. However, beyond these staff members, the level of understanding and commitment to WDP Remedial Plan goals and objectives is still sporadic, although gains have been shown in the last few years in a number of areas. Yet full cooperation and coordination from all staff has been the major impediment to more significant progress.

The sections that follow summarize the successful implementation actions taken by the DJJ in some areas, as well as document some areas where progress is still needed to meet the WDP Remedial Plan's requirements.

Self-auditing by CDCR's Office of Audits and Court Compliance (OACC) and WDP Coordinators

At the request of the Special Master and DJJ, a process was implemented during this fiscal year to transfer a significant amount of WDP auditing to DJJ. The audit line items assigned to DJJ were determined by negotiation among all parties; it should be noted that these assignments were based in part on previous satisfactory ratings (although in keeping with the Court's ruling, not necessarily that two "SC" ratings would automatically transfer line items to DJJ's auditing, since the Consent Decree was intended to refer to larger issues) and upon DJJ's anticipated ability to effectively monitor the specific audit item. CDCR's Office of Audits and Court Compliance was assigned the primary auditing responsibility for about 60 of the audit items contained in the WDP audit instrument, and that office prepared compliance reviews at all four facilities and Headquarters. While these appeared to have been reasonably objective and well-prepared, they are considered a separate process from the Disabilities Expert's audit tasks, and in some cases, the Disabilities Expert has arrived at differing results and compliance ratings. From the beginning of this new audit process, there were several procedures that were not fully defined as to how the process should work, and it is clear that the transfer of auditing to DJJ is still a "work-in-progress". Recent discussions between the Disabilities Expert and OACC representatives brought agreement that the auditing process should continue next year with the same items and processes as this past year. It is felt that the overall process was a positive one that increased knowledge and awareness of the main issues involved with the WDP Remedial Plan by all parties. In addition, the Departmental WDP Coordinator has also been proactive in auditing sites prior to the OACC audits, and she has prepared "Quarterly Audit Checklists" for use by facility coordinators to monitor compliance on a quarterly basis. See item number 10 for detailed information.

Items and Issues Representing Gains in WDP Compliance

There were several items where improvements were made during the past fiscal year. These include the following:

(1) This year's review of a random sampling of intake files indicated that Intake and Court Services Unit was consistently able to identify known disabilities, or to question their presence for future assessment. The Intake and Court Services Unit staff still have to wade through the inadequate documentation received from the committing courts; records from the courts and county jails are poorly prepared, and while DJJ maintains that this is beyond its control, it may be necessary to require better documentation from these parties. See item numbers 29 & 31.

(2) The departmental WDP manager previously prepared a new "Board Information Report", available for printing from WIN, to replace the outdated and unused "Case Report Transmittal" form. The new form is now in common use, and it appears to contain all of the necessary information for the Board (YAB) to understand a ward's disabilities and the required accommodations. These are now routinely provided to the Board, as well as put into the ward's field file. See item numbers 35 & 65.

(3) Overall educational programs and educational accommodations for wards with disabilities at N.A. Chaderjian reached a substantial compliance level, only the second time a facility has met the applicable requirements (previously, Preston, no longer an active facility for auditing, had reached this level). Major reasons for improvements included: (1) consistency in personnel, and knowledge and acceptance of the WDP program requirements by administrative education staff, (2) improvements in the SCT process and documentation of disability referrals, and (3) improvements in the IEP process, including "pre-IEP" advocacy meetings with youth.

(4) The Disabilities Expert attended a training for surrogate parents for Chaderjian and Close in August, 2010. This was the first actual training session the Expert has been able to attend, and the curriculum and presentation were well-prepared and executed. Attendance was high, and the surrogate parent's interactions were robust and candid. Trainings for SYCRCC and Ventura trainings were also held during 2010-11, meeting the remedial plan's requirement for this annual training.

Use of Force Actions and Accommodations for Wards with Disabilities

One of the most critical issues still remaining, and a subject of much activity by both DJJ and the Disabilities Expert during the last year, was to undertake a study to evaluate and make recommendations to reduce the degree of violence and related use of force (UOF) on youth with mental health and other disabilities within the four remaining correctional facilities. The eight months' activities of DJJ's UOF Committee and Subcommittee were complex and somewhat controversial, as neither the Safety & Welfare Expert nor the Disabilities Expert were able to fully endorse the report or all of the committee's recommendations. While both experts generally agreed with the findings and observations of the subcommittee undertaking the extensive qualitative reviews of use of force incidents, both experts felt that the committee's recommendations regarding prohibitions on the use of chemical agents were not restrictive enough, and that the other recommendations would not effectively resolve the problems of disproportionate use of use of force on youth with mental health and other disabilities. The Disabilities Expert felt strongly that chemical agents should not be used under any circumstances during single-youth incidents involving youth with disabilities or other identified mental health youth assigned to the specialized mental health living units; this recommendation was based largely on the subcommittee's findings that in almost all such cases where chemical agents were used, such use was unnecessary and ineffective in resolving the specific issues that led to the use of force. Likewise, the Disabilities Expert felt strongly that the current system of immediate vs. controlled force being the only two options available was unrealistic, and adherence to these policies for youth with disabilities or other identified mental health youth actually deterred the ability of correctional officers and counselors from being able to use the types alternative de-escalation techniques required by the WDP Remedial Plan; a broader system allowing for a greater range of force options and interventions should be instituted, as also recommended in the UOF Committee's report. See item number 53, as well as the Joint Experts' Original UOF Report and the Experts' Supplemental "Report on UOF in DJJ and Mental Health Youth", dated May 10, 2011, issued as an attachment to the OSM's Quarterly Report No. 18.

Wards with Disabilities Identification and Accommodation

During the most recent facility audits visits, the various facilities still used different methods and achieved differing results in attempts to identify, classify, and assign appropriate accommodations to wards with disabilities. During this fiscal year, there was still a lack of clear direction from Headquarters on these processes, although WDP staff at all facilities used their best efforts to prepare appropriate documentation of wards with disabilities and their reasonable accommodations. The Special Master's Office has suggested that the Disabilities Expert should be more involved in this issue and prepare a draft report on the subject. The Disabilities Expert would gladly undertake such a task, but would want agreement from DJJ that this is desired before beginning such a task. See item number 41.

ADA Staff Training

One of the major implementation activities of the WDP Remedial Plan is the provision for on-going, annual staff training in the areas of WDP policies and procedures and disability awareness, sensitivity, and harassment training. WDP facility coordinators have completed Training for Trainers sessions and are actively involved in the training activities at their facilities. The Disabilities Auditor has been provided with training attendance lists for all facilities and was previously present at one of the training sessions. To date, while the exact figures vary between facilities, current data shows that approximately 60% of all staff were given the training during the last calendar year. This still falls short of the training goals, and an increased effort is necessary to determine why some staff are not attending and to assure their participation. See item number 25.

Educational Issues for Wards with Disabilities

There is overlap between the requirements of the WDP Remedial Plan and Educational Services, particularly in the area of services for wards with disabilities enrolled in special education programs. Since many wards with disabilities are housed in special treatment or restrictive programs, the difficulties of providing complete services at these units tends to negatively affect educational services for these youth. It is recommended that remedial strategies developed by the educational experts continue to be implemented to improve the number of hours of direct and integrated instruction for these wards, as well as the provision of compensatory services. Monitoring activities still indicated some problems in the formulation of individualized education programs (IEP's). It is recommended that particular attention to the requirements of the WDP Remedial Plan, such as the use of staff advocates prior to and during IEP meetings, would help to resolve these issues.

Self and Staff Referrals for Wards with Disabilities

These referrals underwent major changes two years ago, with all facilities transitioning from the previous Request for Sick Call (YA 8.229) form to the new "Disability Referral / Evaluation Form" (DJJ 8.288). It is now relatively common for the DJJ 8.288 form to be used by both staff for staff-referrals and wards for self-referrals. WDP coordinators and Headquarters staff members have spent a considerable amount of time in attempts to complete remedial plan items related to the ward self-referral and staff-referral process, and their efforts are commendable. Yet there is still need for improvements to reach substantial compliance in all referral areas. The use of the DJJ 8.288 form for Education referrals and adherence to the remedial plan requirement to use the SCT process to refer and assess wards for this purpose (including the subsequent use of the Referral to the School Consultation Team (DJJ 7.464 for full review and assessment by the SCT) has improved, but still needs special attention at some facilities. See audit items numbers 12, 46, 88-90 & 99.

Report respectfully submitted,

Logan Hopper, Disabilities Expert and Auditor

Facility Compliance Chart

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	A. Headquarters								
	I. Directorate								
1	Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director's office.	Verify current copy is retained.	NA	NA	NA	NA	SC*	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
	B. Departmental Ward Disability Coordinator & Functions								
2	By October 2005, establish and maintain a full-time Departmental Wards with Disabilities Program (WDP) Coordinator and analytical staff to develop, support, lead and manage a quality program.	Verify positions are in place and filled.	NA	NA	NA	NA	SC	Sandi Becker is entering her fourth year as the full-time Departmental WDP Coordinator. Other staff members within the Farrell Compliance Unit have been made available as needed.	While it is understood that the State is in serious financial and staffing difficulties, and it is true that other staff at Headquarters are available to assist with clerical and analytical tasks, it is felt that an assistant (not necessarily full-time), dedicated to and very knowledgeable about the program's goals, is preferable to effectively carry out the variety of tasks required.
3	Ensure duty statement encompasses all Departmental WDP Coordinator duties defined in the WDP Remedial Plan.	Review duty statement.	NA	NA	NA	NA	SC	A signed duty statement for the current Departmental WDP Coordinator was presented at the most recent Headquarters' audit.	
4	The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the Dept. WDP Coordinator.	NA	NA	NA	NA	SC	Sandi Becker is believed to be performing the required oversight functions in an effective and commendable manner.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
5	Establish and maintain full-time WDP Coordinators at each facility by Feb., 2006.	Verify positions are in place and filled.	NA	NA	NA	NA	SC-	Each facility currently has an assigned WDP Coordinator(s) in place, although the current WDP Coordinator(s) at Ventura are working on a temporary basis. See items 36-38.	Headquarters and Personnel should develop improved procedures for the interviewing and hiring process for new coordinators when needed.
6	The Departmental WDP Coordinator will develop a standardized emergency announce-ment protocol by December, 2005.	Review emergency announcement procedures to ensure procedures are in place to provide the needed assistance for wards with disabilities. Determine timeliness of announcement.	NA	NA	NA	NA	SC-	An emergency announcement protocol, Section 6158.3 of the I&C Manual, dated Nov. 27, 2007, was previously prepared. It is unclear if this document expired on Nov. 27, 2009, and the reference and date on the document provided at the Headquarters audit is marked as CN 361 and dated Sept. 19, 2010. In response to comments and recommendations by the disabilities expert in previous reports, the WDP Manager and Director of Facilities developed a supplemental document entitled "Evacuation Plans for People with Disabilities". The substance of these documents is acceptable for compliance with this audit item's literal requirements (thus the "SC" rating), but as was discussed with senior management during the Headquarters audit, it is unclear if the applicable documents are official department policy and what their approval / revision status actually is. In addition, the supplemental document is supposed to be included in each facility's "Multi-hazard Emergency Plan", yet little documentation has been provided to show that has been accomplished. There were some limited efforts made to document this during facility audits, but the results were not definitive (although admittedly, there was little time allocated for this task).	Provide additional information on how all applicable documents have been approved as official department policy, and how the information has been disseminated to the facilities. During next year's facility audits, provide documentation that the "Evacuation Plans for People with Disabilities" document is included in the facility's "Multi-hazard Emergency Plan", and is being used by living unit staff.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
7	The Departmental WDP Coordinator shall ensure that a WDP report is completed monthly, quarterly and annually for each site.	Review monthly, quarterly and annual reports for completeness.	NA	NA	NA	NA	SC	Monthly reports were typically provided by the facilities throughout the fiscal year (except for the period of time when Ventura was without a WDP coordinator). Facilities generally use the basic "population" report, as well as charts on wards' with disabilities grievances, disciplinary actions, and placements into restrictive settings. DJJ's formal quarterly and annual reports include a section on WDP activities.	It has been suggested in the past that the monthly reports should include a narrative on WDP activities during the month; the current reports are largely statistical with little qualitative value.
8	In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, prepare an "action plan" for wards with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis.	Audit to determine implemen-tation and review documentation to ensure compliance.	NA	NA	NA	NA	SC-	An "action plan" statement was previously approved by the Disabilities Expert. It still appears that the OHU Policy (Section 6246.5 of the I&C Manual) contains no reference to the issues described in the "action plan". Due to time constraints, it was not possible to visit all the OHU's, and it is still unclear how the facilities are going to "determine the most physically accessible locations available and make the barrier removal improvements required on a timely basis".	Include the OHU action plan statement in the new OHU Policy (Section 6246.5 of the I&C Manual). Improve the implemen-tation procedures by expanding the policy at the specific facilities to develop procedures for determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
9	In conjunction with the Health Care Transition Team, the Mental Health and Medical Experts, and Disabilities Expert, ensure systems are in place to monitor the use of psychotropic prescriptions and medications including SSRI's for wards under the age of 20.	Audit to determine implementation and review documentation to ensure compliance.	NA	NA	NA	NA	PC	It should be noted that the "Item" and "Method" columns state that the monitoring of psychotropic prescriptions must be ensured, meaning that detailed procedures for not only carrying out the monitoring tasks but also for providing an effective and conclusive documentation process must occur. During either the facility audits or the Headquarters audit, no definitive documentation that effective systems are in place was provided by Mental Health. It was reported by Mental Health that follow-up documentation could be obtained from mental health chronological records in WIN, but a check of a number of records of mental health youth taking psychotropic during the audit yielded little if any documentation of effective monitoring of these prescription. Although time did not allow for detailed reviews of UHR's, such a review was undertaken during the Close audit (where many youth under 20 are housed), and time limits for medication reviews were exceeded for all such youth. At all facilities, interviews with youth taking psychotropic medications indicated that some degree of follow-up was occurring, but not a consistent and comprehensive monitoring. In addition, previous WDP reports contained comments on the Psychopharmacological Policy draft sent to the Disabilities Expert as PoP #206 on 8/8/08. The Disabilities Expert did not approve or endorse the draft (and it is unclear that it was approved by the Mental health Expert) and sent comments and suggested revisions to that draft on 10/3/08, but has never received any response to the issues raised. Many of these concerns still remain.	(1) Provide documentation of the implementation of the required monitoring activities, including use of the forms related to the tiered administration system, and adherence to the timelines for reviewing and monitoring prescriptions with wards and parents. (2) Consider revisions to the psychopharmacology guidelines to improve ward interaction, advocacy, and monitoring. (3) Complete the training component (if not already completed per the policy's 60-day requirement) and provide documentation of who attended the trainings and when.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
10	The CYA shall conduct annual compliance reviews of the court-approved Disabilities Program Remedial Plans in all CYA facilities to monitor compliance with the Remedial Plan, to ensure that wards with disabilities are being effectively identified, to ensure that the needs of those wards are being met and to reassess and re-evaluate the level of staffing and training needed to comply with the Remedial Plan, commencing in the 2006 calendar year.	Verify completion of annual compliance reviews.	NA	NA	NA	NA	SC	As discussed in the introduction and executive summary, CDCR's Office of Audits and Court Compliance has been assigned the primary auditing responsibility for about 60 of the audit items contained in the WDP audit instrument and has prepared compliance reviews at all four facilities throughout the last fiscal year. While these have been reasonably objective and well-prepared, they are considered a separate process from the Disabilities Expert's audit tasks, and in some cases the Disabilities Expert has arrived at differing results and compliance ratings. These have typically led to Corrective Action Plans (CAP's) prepared by the DJJ Farrell Compliance Unit; however, the CAP's are not usually shared with or approved by the Disabilities Auditor, and while they certainly initiate some corrective actions, it is not clear that they effect comprehensive improve-ments. The Departmental WDP Coordinator has also been proactive in auditing sites prior to the audits, and she has prepared "Quarterly Audit Checklists" for use by facility coordinators to monitor compliance on a quarterly basis.	The annual compliance reviews, while not necessarily endorsed or approved by the Disabilities Expert, comply with the literal requirements of the audit instrument, although they do not actually re-evaluate the level of staffing and training needed to comply with the Remedial Plan, as listed in the "Item" description.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
11	Within six months of the court approval and adoption of this plan, the Department's Ward Disability Program Coordinator will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review the outside consultants training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedule to ensure all individuals complete the reqd. training.	NA	NA	NA	NA	SC	Sandi Becker previously attended several training sessions, both in-house and from a national ADA coordinator's association, and also in conjunction with an outside disability advocacy consultant.	While these trainings have been helpful in meeting the training goals, I would still recommend additional, on-going training resources that would not put a strain on the severe State budgetary constraints, such as additional training from the State's Department of Rehabilitation or Department of Developmental Services training units.
12	Develop the Disability Health Services Referral Form.	Monitor for completion by December, 2005.	NA	NA	NA	NA	SC	A "Disability Referral/ Evaluation Form" (DJJ 8.288) was completed and distributed on February 25, 2008. The form is now in use at facilities. The form has many excellent features, yet it is still felt that clarifications are needed on how Education uses the form, since the remedial plan requires that the SCT process refer and assess wards for this purpose (although this does not affect the way Health Services uses the form). Also, the form required by this item was intended to serve as a basic "sick call" form, but it is still not clear that the form is readily available on living units.	It is recommended that the form remain in use with no revisions throughout the next fiscal year, and its usage and effectiveness monitored by the Auditor and WDP staff. Renew efforts to assure that youth have ready access to the form (some youth are hesitant to ask staff for such a form, for obvious reasons).

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	C. Headquarters Policies								
13	The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006.	Review purchase orders (PO) (STD 65) to confirm purchase within established timeline.	NA	NA	NA	NA	SC*	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Accessible vans have been purchased and are in use.
14	By July 2006, the Department shall develop and maintain system that documents the mental & physical impairments of wards with disabilities and any reasonable accommodations.	Audit to determine implementation within the given timeframe and review documentation to ensure compliance.	NA	NA	NA	NA	SC	The monthly reports document mental and physical impairments of wards at an aggregate, although not at an individual level. Reasonable accommodations are usually documented by the facility WDP coordinators. DJJ has developed a documentation system through the WIN system upgrades and has presented several report formats that can be printed from WIN. Despite the "SC" ratings, it should be noted that this is still an on-going process that requires further development and fine tuning.	
15	The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all levels of care within the youth correctional system.	Review 10% of placements and all level of care for wards with disabilities.	NA	NA	NA	NA	SC-	Reviews of random files did not indicate any specific lack of equal access.	It has been previously recommended that the Department prepare a documentation form to aid in assurances of equal access, but this recommendation has not been accepted.
16	All wards under the jurisdiction of the CYA shall be given equal access to all programs, services and activities offered by the Department. Programs, services, and activities shall be offered in the least restrictive environment, with or without accommodations.	Review 10% of place-ments & access to special programs for wards with dis-abilities.	NA	NA	NA	NA	SC	Reviews of random files did not indicate lack of equal access to special programs.	It has been recommended that the Department prepare a documentation form to evaluate the least restrictive environment requirement, but this recommendation has not been accepted.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
17	Establish policies to assure that placement of wards with disabilities into restrictive programs is not based either directly or indirectly on a ward's physical or mental disability, or on manifestations of that disability.	On-going audit.	NA	NA	NA	NA	PC	It is believed that the policy CN 18 "Youth with Disabilities - Equal Access", while comprehensive in many areas, does not contain the degree of specificity necessary to assure that disability is not a factor in assigning a ward to a restrictive program. Statistics provided during the Headquarters and facility audits showed that youth with disabilities still comprise a higher percentage of those placed in restrictive programs than others youth, according to the following statistics: Percent of WDP youth placed on alternative program from 2/10 – 1/11: 34.1% (a total of 1659 placements into alternative programming, with no explanations of what efforts were made to identify root causes of reasons for placements). Percentages / Total of WDP youth: Chad: 39.5% WDP; Ventura: 24.8% WDP; SYC: 35.8% WDP; Close: 25.6% WDP; All facilities: 30.4%.	It has been recommended that specific policies and procedures be documented in writing to evaluate a ward's (with or without a disability) placement into a restrictive program.
18	By December 2005, the Education Branch shall establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of Special Education to study and make recommendations to improve the adult ward's and parents' meaningful participation during IEP meetings, to encourage more active participation, and to provide informational materials for parents and/or surrogates.	Review recommen-dations & develop appro-priate imple-mentation plans.	NA	NA	NA	NA	SC*	*Item previously completed and removed from future audits (may be audited by CDCR Office of Audits and Court Compliance, if desired by DJJ).	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
19	The Education Branch working committee shall also study the need for and evaluate the ability of the various public or private groups or agencies to assist with the means of attending IEP meetings for parents. (This is not be interpreted as requiring the Dept. to provide such means.)	Review recommen-dations and provide support if applicable.	NA	NA	NA	NA	SC*	*Item previously completed and removed from future audits (may be audited by CDCR Office of Audits and Court Compliance, if desired by DJJ).	
20	The Education Branch working committee shall also study the need to include a wider variety of individualized accom-modations in IEP's.	Review recommen-dation and develop appropriate implementa-tion plans.	NA	NA	NA	NA	SC*	*Item previously completed and removed from future audits (may be audited by CDCR Office of Audits and Court Compliance, if desired by DJJ).	
21	In consultation with the disabilities expert, the CYA will conduct a study regarding the need for a residential program for wards with certain developmental disabilities. The study will commence within 6 months from the date that the Disabilities Remedial Plan is filed with the court.	Review documented study for meeting timeline and evaluate recommen-dations.	NA	NA	NA	NA	PC	Previous meetings with a DJJ ad-hoc committee studying this topic were productive and had active participation from a number of DJJ staff. A draft report entitled "Residential Treatment Program for Youth with Developmental Disabilities", dated 8/24/10, was submitted to the Disabilities Expert, and response comments were returned to DJJ on 9/24/10. While the draft report included a number of positive aspects regarding potential programs and courses of action, it was determined that a realistic evaluation of the number of youth determined to need such supportive services would be necessary before any further action could be taken. See also items 24, 86, & 115.	Continue with assessment tasks to determining the number of affected youth. Schedule a follow-up meeting with thee DD study committee.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
22	The visiting facility at Ventura is currently under construction & will be fully operational by 1/06. The new facility at Preston will be fully operational and safe for all wards, visitors and staff by July '06. The CYA will confer with the Disability Expert to explore and implement interim solutions to address architectural barriers at the existing Preston visiting area.	Visit locations to determine completion /level of operation.	NA	NA	NA	NA	SC*	*Item previously completed and removed from future audits (may be audited by CDCR Office of Audits and Court Compliance, if desired by DJJ).	
23	The CYA shall conduct a needs assessment and prepare Department wide disability training materials, with the assistance of an outside disability advocacy organization or consultant, in consultation with the Disability Expert, by June, 2006.	Review needs assessment and training materials.	NA	NA	NA	NA	SC	The needs assessment, while believed to be cursory and non-specific, has nevertheless been completed. A course curriculum for the sensitivity & awareness portions of the training has been developed by an outside disability consultant and reviewed by the Disabilities expert, with some pending recommendations, and it is now in use.	It is still recommended that development of the final curriculum for all training modules be on-going and improved according to details as recommended by the Disabilities Expert.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
24	The CYA shall develop a screening tool to assess the current ward population in order to identify any develop-mentally disabled wards who may not have been previously identified. The CYA shall complete this assessment by December, 2006.	Review screening tool to ensure validation. Ensure that the assessment is completed within the given timeframe.	NA	NA	NA	NA	SC-	A new screening tool for youth with developmental disabilities was prepared in May, 2010, and reviewed and approved by the Disabilities Expert. It is in use by clinical psychologists at the facilities, although some still do not use the screening form consistently or correctly. See also item no. 86.	
25	Within 12 months of the court approval of the plan, all staff will receive training, prepared with the assistance of an outside disability advocacy organization or consultant, and in consultation with the Disability Expert in sensitivity, awareness & harassment. This training will be provided to all staff on an annual basis. Until such time as this training is incorporated in the basic training academy curriculum, this training will be provided to all new hires within 90 days of placement in the facility.	Review the outside consultant training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedules and document attendance to ensure all staff and new hires are provided training.	NA	NA	NA	NA	PC	A course curriculum for the sensitivity, awareness, and harassment portion of the training has been developed, and training sessions for current staff have proceeded at all facilities. Last year's auditor's report estimated the percentage of completion by all staff to be about 80%, based on the available data. For this year, more definitive data (including the names of all staff completing the training and the range of total staff at each facility during the year) was provided. The results were: HQ: 89%; Stockton complex: 62%; Ventura: 42%; SYC: 48%; Preston: 55%. It appears that a greater effort needs to be made to provide the required training to all staff within the calendar year. It has been verbally reported that the training academy has instituted training sessions for new hires, but no attendance records have been provided to the Auditor.	It is our understanding that new record-keeping in WIN will eventually keep an accurate track of the exact training participation of all current staff and new hires. It may be that some staff are not attending annual training because they have received the exact same training in the past and feel that they do not need a "refresher"; therefore, it may be necessary to revise the training to include new categories each year.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
26	The Department shall ensure that a ward is not precluded from assignments to a work or a camp program based solely upon the nature of a disability.	Review departmental list of wards with disabilities; conduct interviews. Audit work / camp program rosters to determine placement of wards with disabilities.	NA	NA	NA	NA	PC	Reviews of random files and interviews with wards still indicated several problems in this area at the facilities during the last fiscal year, and no specific documentation has been provided. It was previously recommended that the Department prepare a documentation form to aid in assurances of equal access, but none has been presented. See also item 98	It was previously recommended that the Department prepare and implement a documentation form to aid in assurances of equal access.
27	The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by Aug., 2005.	Review form for completion.	NA	NA	NA	NA	SC*	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
	D. Headquarters Programs/Screening								
28	Maintain a contract for sign language interpreter services, as well as a record of use of this service.	Review contracts (STD 213/210) for sign language interpreter's services.	NA	NA	NA	NA	SC*	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
29	The Intake and Court Services Unit staff shall review incoming documentation from the committing courts and counties of all wards for indicators of impairments that may limit a major life activity and require accommodations or program modifications.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	NA	NA	NA	NA	SC	The Intake and Court Services Unit staff still have to wade through the poor documenttation received from the committing courts. There were no specific indications that incoming documentation from the courts and counties was not adequately reviewed. It should be noted that records from the courts and county jails are poorly prepared, and while DJJ maintains that this is beyond its control, it may be necessary to require better documentation from these parties.	I would again recommend additional documentation verifying the extent of review within the Intake and Court Services Unit.
30	The CYA will revise the Referral Document, YA 1.411 by replacing the term "handicap" with "disability" within 30 days of the filing date of this plan.	Review form for completion.	NA	NA	NA	NA	SC*	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
31	When indicators of impairment exist, the Intake and Court Services Unit staff shall complete the disability section on the Referral Document and forward to the designated Reception Center and Clinic.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	NA	NA	NA	NA	SC	See also Item 29 above, as all of those comments also apply here. This year's review of a random sampling of intake files indicated that Intake and Court Services Unit was consistently able to adequately identify known disabilities, or question their presence for future assessment. As with the item above, the fact that records from the courts and county jails are poorly prepared is a contributing factor to difficulties, but the Referral Document should still used as an important resource by the clinics, and complete information on this form is important.	See also Item 29 above, as all of those recommend-dations also apply here.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	Facility Administration								
	A. Superintendent								
32	Maintain a current copy of the Wards With Disabilities Program Remedial Plan retained in Superintendent's office.	Verify current copy is retained.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
33	Superintendents shall ensure wards with disabilities are informed, during orientation, of the existence of electronic equipment in libraries, what equipment is available, how and when equipment can be accessed, and where the equipment is located.	Review orientation program for inclusion of information.	PC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Headquarters should provide detailed procedures (consistent among all reception centers) for providing an effective orientation at the three reception centers, including a coordinated package of information on the types of electronic equipment available and effective usage by wards with disabilities.
34	The Superintendent shall report to the Deputy Director, within twenty-four hours, when a ward with a disability that requires accommodation is placed in a restrictive setting, i.e., TD or lockdown.	Interview wards & SAs. Audit TD forms for compliance. Review Special Incident Reports related to Adminis-trative Lockdowns.	SC	SC	SC	SC	NA	A system of reporting by e-mail is in place at each facility. Some facilities may consider a Temporary Intervention Program (T.I.P.) to be temporary detention, but the Auditor determined that the T.I.P. was in effect the same as a T.D., and that the notification and reporting process should occur.	Since changes in unit titles and programs have been subject to recent changes, this item should be subject to continuing future auditing and verification.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
35	The Superintendent shall be responsible for ensuring that due process and equal access occurs for wards with disabilities who require accommo-dations during institutional Youth Authority Board (YAB) hearings.	Audit Case Report Transmittal Form.	SC	SC	SC	SC	NA	Board Information Reports available from WIN and put to use last year were present in Board packets, and staff assistants were provided to the extent necessary to achieve an SC rating, although not always provided.	
	B. Facility WDP Coordinator								
36	Maintain WDP Coordinators at each facility.	Verify positions are in place and filled.	SC	PC	SC	PC	NA	Each facility had active WDP coordinator(s) at the audit. At Ventura, two AGPA's from the facility (one the Pbs/Comstat coordinator, and one the wards' rights coordinator) were assigned to perform various WDP duties and tasks on an interim basis. While the efforts of these two staff members were laudable in many ways, filling the position full-time is a definitive requirement of the WDP Remedial Plan, and their ability to perform all of the necessary tasks and represent the program fell short of what is required (see also item no. 38 below). At Close, the coordinator was splitting time with the grievance coordinator position, a practice not allowed by the full-time WDP Coordinator requirement contained in the WDP Remedial Plan.	Headquarters and personnel should develop improved procedures for the interviewing and hiring of new coordinators when needed. At Ventura, appoint a full-time WDP coordinator. At Close, the full-time WDP coordinator position needs to be reinstated.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
37	Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	Review duty statement.	SC*	PC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. However, all rating given by CDCR Office of Audits and Court Compliance are subject to random audit or specific review (based on situations encountered at the facility). In this case for Ventura, the Disabilities Expert disagrees with the "C" rating given by OACC. It is clear that the intent of the WDP Remedial Plan is that the WDP coordinator must agree to and sign the duty statement, not that there just be a blank form available. During the audit, the two "interim" coordinators stated that (1) their actual positions as coordinators for other programs did not allow for them to state that they had other duties, & (2) they did not feel they had been assigned the duties sufficient for either to agree to and sign the duty statement.	At Ventura, see item 36. At Close, it is unclear if the previous duty statement currently applies, since it is based on full-time duties.
38	The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the facility WDP Coordinator.	SC	PC	SC-	SC	NA	At Ventura, while the work of the two "interim" WDP coordinators was admirable, there were a number of normal duties that they could not fulfill on an interim basis. At the other three facilities, each current facility WDP Coordinator was believed to be performing the required oversight functions.	At Ventura, see item 36.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
39	Within six months of the court approval and adoption of this plan, the facility Ward Disability Program Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review outside consultants training material to determine compliance with requirements in the WDP Remedial Plan. Review & confirm training schedule to ensure individuals complete the required training.	SC*	PC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. However, all rating given by CDCR Office of Audits and Court Compliance are subject to random audit or specific review (based on situations encountered at the facility). In this case at Ventura, while the work of the two "interim" WDP coordinators was admirable, they did not attend the WDP coordinator training that I gave (along with the outside consultant), and the lack of detailed knowledge that they would have gained from such a training was evident. At the other three facilities, each current facility WDP Coordinator attended the higher level of training provided.	At Ventura, see item 36.
40	The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	Review monthly reports.	SC	SC	SC	SC	NA	Basic, simplified monthly reports printed from WIN were submitted monthly to the departmental coordinator by facility coordinators.	These consist of only quantitative data (list of qualified wards, and grievances filed and DDMS actions against these wards). More qualitative information would be helpful.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	Facility's Policies								
41	Efforts to identify wards with disabilities within youth correctional facilities shall be continuous, and shall include self-referrals, staff-referrals, facility ADA screening and assessment, and special case conferences.	On-going audit.	PC	PC	PC	PC	NA	There were some improvements in most of the facilities' identification efforts during the last fiscal year. In general, the various disciplines are using their best efforts to identify affected wards, but Headquarters has not disseminated comprehensive guidelines appropriate for proper identifications, screenings, and assessments of medical and mental health disabilities, although there have been some basic memos (including a new one from the CMO in May, 2010) regarding some specific impairments. Better coordination among departments is also needed. The developmental disability identification process was not in full effect at any facility except Ventura; for this aspect, see also item numbers 99 & 115. At all facilities except Chad, educational identifications are still lacking the compre-hensive approach described in the WDP Remedial Plan due to systematic failures in the SCT process – see items 91 & 93.	More detailed clarifications from Headquarters are needed to make the proper determinations of disability, particularly in the areas of medical and mental health. New clarifications as included in the ADA Amendments Act of 2008 (not just a copy of the legislative content of the law, as has been provided in the past, since these changes are complex and need guidance on implementation) also need to be incorporated into identification procedures. These practices and procedures should be reviewed by the Disabilities Expert prior to implementation (this has been recommended and requested for the past two years, but the Disabilities Expert has received no significant information to review). The Special Master's Office has suggested that the Disabilities Expert should be more involved in this issue and prepare a draft report on the subject. The Disabilities Expert would gladly undertake such a task, but would want agreement from DJJ that this is desired before beginning such a task.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
42	Assistive devices may be taken away from a ward only to ensure the safety of persons, the security of the facility, to assist in an investigation, or when a Department physician or dentist determines that the assistive device is no longer medically necessary or appropriate.	Interview wards and review supporting documen-tation.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
43	Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	Interview wards and WDP coordinators to verify presence of operational TDD.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
44	Wards with hearing impairments shall have access to at least one facility television located in their assigned living unit that utilizes the closed captioning function at all times while the television is used.	Interview wards and WDP coordinators to verify presence of operation closed captioning function TV.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
45	Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities.	Conduct site visits to verify presence of accessible posted materials.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
46	A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her assigned PA, Casework Specialist or by completing the Referral for Sick Call (RSC) form. A ward may make a self-referral for an accommodation for a documented or perceived impairment through an Education Advisor by completing the Self-Referral to the School Consultation Team form.	Review submitted RSC (YA 8.229) and SRSCT (YA 7.464) forms and determine appropriate-ness of disposition. Observe random interviews at intake.	SC-	SC-	SC	PC	NA	This item generally continued to improve with the transition from the previous RSC (YA 8.229) form to the new "Health Care Services Request Form" and the "Disability Referral/Evaluation Form" (DJJ 8.288), with both being available to wards for self-referrals. It is clear that a complying process is in effect and that wards are not precluded from self-referring. However, there were only a few documented instances where a ward used the self-referral process. At SYCRCC, documentation of typical usage to the degree that would be expected was sporadic, and those forms that were provided were often not handled correctly. A distinction should be made between the disparate ratings for this item and item no. 41 - it is the Auditor's feeling that this item refers primarily to a ward's ability to access the self-referral process, and item no. 41 pertains primarily to the facility's handling of the self-referral and subsequent identification and implementation.	
47	The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	Interview wards and Principal for proof of practice.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
48	Students who take the CAHSEE with a modification and receive the equivalent of a passing score are eligible for the waiver request process. Students who are eligible will be granted waivers based on the SBE process and policy.	Verify by records review of students taking state-mandated exams that waivers were requested for students with modifications who receive equivalent passing scores (in accord with CDE guidelines.)	NA	NA	NA	NA	NA	Since the requirement for passing the CAHSEE has been recently removed for special education students, this item is not currently applicable and should be re-written. Nevertheless, it appears that the school was ready to use the waiver request process if necessary, and that the waiver would be granted.	
49	Each ward with a disability shall have a High School Graduation Plan.	Review randomly 10 or 10%; whichever is greater, of students with IEP's graduation plans.	SC	SC	SC	SC	NA	Of the student files reviewed, a sufficient number of wards with a disability had a current and reasonably accurate High School Graduation Plan at the "SC" facilities.	
50	Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan.	Review randomly 10 or 10%; which-ever is greater, of students with IEP's graduation rates and uses of the exception to the graduation requirements.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
51	The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities.	Review randomly 10 or 10%; whichever is greater, of access for students with IEP's.	SC-	PC	PC	PC	NA	Based upon the student files reviewed and interviews, there were still indications that some wards with disabilities, particularly those at restricted and special purpose / treatment units, had limited access to full-day educational programs, vocational programs, and other special educational activities. In general, students with disabilities still do not have the equal range of placement options available to other students. At Chad, the diligence of the school principal and senior education staff, as well as an improved SCT process, have brought about significant improvements in providing equal access to wards with disabilities, based upon the eight-part criteria prepared by the Auditor to assess compliance.	Emphasis should be placed on (1) improving the level of compensatory services provided to special education students unable to attend classes, (2) improving SCT referral and IEP tracking logs to assure that time lines for assessments and IEP's are met, (3) completing implementation of the Program Service Day model and other policies designed to improve attendance, & (4) improving both attendance and facilities at the "satellite" classrooms being used by restrictive / special purpose units, (5) increase staffing to prescribed levels to provide a broader range of placement and instructional options at special purpose / treatment units.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
52	Non-emergency verbal announcements, in living units where wards with hearing & other impairments reside, shall be done on the public address system and by flicking the lights on and off several times to notify wards with disabilities of impending information. Verbal announcements may be effectively communicated in writing, on a chalkboard, or by personal notification.	Review operational procedures. Interview wards to determine effective non-emer-gency communi-cations.	SC	SC	SC	SC	NA	Standardized written operational procedures were provided to the Auditor at all facilities. Since only two wards with hearing disabilities were present (at Chad and Close), it was not possible to determine if any significant problems in this area might exist. The flicking of lights is not currently a common occurrence at the living units	It is recommended that this item be continued in the auditing process until the non-emergency and emergency protocols are fully implemented, and until wards with hearing impairments are present to the extent necessary to evaluate the procedures.
53	CYA staff shall be aware of accommodations afforded to wards with disabilities in developing and implementing security procedures including use of force, count, searches, transportation, visiting and property.	Interview 10 security personnel and wards yearly for specific inquiry regarding security issues.	PC	PC	PC	PC	NA	A detailed review of UOF reports and other documents provided indicated continuing problems in this area. While alternative conflict and violence resolution techniques were described by DJJ as being utilized by custody staff, there was little documentation provided to show how these procedures were actually being utilized. The Joint Experts' Original and Supplemental Reports on UOF, issued as an attachment to the OSM's Quarterly Report No. 18, provide additional comments on these issues.	Recommendations for documenting the procedures contained in the WDP Remedial Plan (pages 40-44) were discussed with some security staff during the audits. These included documentation in behavior, use of force, and serious incident reports, and expanding the force reduction reports. Implementing the recommendations contained in the Joint Experts' Supplemental Report would solve most of the issues encountered.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
54	Prior to placing a ward with a disability into a restricted setting, the Superintendent shall review the referral form and ensure that any accommodation required by a ward has been documented.	Review records of 10 or 10%, whichever is greater, of wards placed in restrictive settings.	SC*	PC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	See also item no. 34.
55	Each Education Specialist that is assigned as a case carrier, or alternate, will discuss the tenets of advocacy with the ward and surrogates prior to the IEP meeting to encourage active participation. During the IEP meeting, the specialist or alternate, will serve as the advocate of the student.	Attend pre-meetings and IEP meetings to determine degree of participation and advocacy roles.	SC-	PC	PC	PC	NA	Each facility was aware of the requirements, but documentation was sporadic, and it believed additional training and improved methods of documentation are needed. The procedure for Education staff simply signing a name in the Special Education file log does not really work as effective documentation, since there is no way to be assured that the person involved is actually providing the type of information described in the WDP Remedial Plan (or for that matter, is even talking to the ward). At Chad, the policy appeared to be mainly implemented, since teachers and some youth stated that the pre-meeting was occurring. At Ventura, the Principal issued a recent memorandum to staff regarding the procedures for a “pre-meeting” with the student (thus allowing for a “PC” rating, despite the low percentage of documentation), but a review of 10 special education files showed that 6 failed to document that such a meeting occurred. At SYC, special education binders usually contained a notation “pre-IEP meeting” on the faculty sign-in sheet, although some failed to document that such a meeting occurred. There was no documentation that these included the student, and in two cases, the “pre-IEP meeting” was held on the same day as the actual meeting, giving no time for review or reflection.	Standardize departmental-approved form for documenting the dates, times, and participants in IEP "pre-meetings". Investigate procedures to assure that wards in restricted or special purpose living units are better served in this area.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
56	All individuals who serve as surrogate parents will receive annual training in the role and responsibilities of a surrogate as identified by the State Dept. of Education. Student advocacy will be addressed as part of the training and the training will also encourage active participation.	Review training curriculum to ensure compliance with the State Dept. of Education criteria. Attend training sessions provided to surrogate parents.	SC	SC	SC	SC	NA	The Disabilities Expert attended a training for surrogate parents for Chad and Close in August, 2010. Attendance roster for SYC and Ventura trainings during 2010-11 were provided at the audits.	Provide the surrogate training annually, and assure that all surrogate parents to be used attend.
57	Reasonable accommodation shall be afforded wards with disabilities to ensure equally effective communication with staff, other wards, and the public. Assistive devices that are reasonable, effective, and appropriate to the needs of a ward shall be provided when simple written or oral communication is not effective or as necessary to ensure equal access to the programs and services. (A list of potential devices omitted for brevity)	Interview wards and WDP Coordi-nators to determine level of availability & access-ibility of assistive devices.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Better assistance and transfer of necessary information from other departments, as well as specific guidance from Head-quarters, is needed to assure continuing compliance in this area.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
58	The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards. Accommodations shall be made to afford equal access to the court, to legal representation, and to health care services for wards with disabilities.	Interview wards with disabilities and WDP Coordinators to confirm accom-modations.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Procedures for providing the required variety of reasonable accommodations or modifications should be developed more fully, and department-wide documentation procedures should be implemented for continuing compliance.
59	Qualified sign language interpreters shall be provided as necessary to ensure effective communication; at a min., for all due process functions, medical consultations, video-conferencing and special programs.	Review record of use logs for qualified interpreters.	*SC*	SC	SC	SC	NA	There were only two deaf wards present at the facilities (Chad and Close) during the audit. Both wards presented distinct challenges, but it is felt DJJ responded to the best of its ability, considering contractual issues beyond its control.	Continue to fine tune contracting procedures for providing interpreting services.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
60	Reasonable accommodations may only be denied if the accommodation 1) poses a direct threat to the Health and Safety of others, 2) constitutes an undue burden, or 3) if there is equally effective means of providing access to a program, service, or activity through an alternative method that is less costly or intrusive. Alternative methods may be used to provide reasonable access in lieu of modifications requested by the ward as long as those methods are equally effective. All denials of specific requests shall be in writing.	Review (written) denied requests for accommodation to determine if alternate method provided reasonable access.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
61	The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings.	Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	While Casework Specialists are doing a good job in assuring the presence of Staff Assistants, it should be realized that other accommodations may be necessary for certain disabilities, to allow wards with disabilities to represent themselves independently. Procedures for these should be prepared.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
62	Departmental staff shall ensure wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans & the completion of required forms.	Interview wards with disabilities and Staff Assistants to ensure com-pliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
63	Institutional parole staff will provide detailed information regarding the ward's needs and make recommendations to field parole staff regarding referrals to key community agencies and service providers.	Review sample of Parole Consideration reports for identified wards with disabilities. Interview inst. parole agents / Casework Specialists to ensure compliance.	PC	PC	PC	PC	NA	While a general degree of information about wards' with disabilities needs was usually included in the parole reports provided in the documentation binder, specific guidelines have not been developed in this area, nor were there any specific indications that specific community agencies and service providers were referred, based upon a specific ward's disability. A new form to be used as "cover sheets" to the more detailed parole reports was provided at the audit. While the form provides an "Other" category to list the information required by this item, there is no specific area to provide this information, signaling a continuing lack of attention to this requirement.	There has been confusion about this item since the beginning of auditing. This may be moot, since it is our understanding that parole is to be discontinued. Nevertheless, it is unclear if this item should be continued or removed from the audit instrument. It is our understanding that in the future, youth would still be released to County probation, and the same type of information transfer would be advantageous to these probation officers. Resolution by the parties is required.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
64	Institutional parole staff shall work collaboratively with field parole staff and Regional Center personnel to coordinate services, as forth in the remedial plan, for individuals with developmental disabilities and their families upon release.	Review sample of parole plans for identified wards with developmental disabilities. Interview institutional Parole Agents/ Casework Specialist to ensure compliance.	NA	NA	NA	NA	NA	No wards with developmental disabilities were identified as recently paroled.	
65	The IIPA/Casework Specialist shall complete & forward the Case Report Transmittal Form, along with all supporting documents on the issue of a disability, to the PA III or Supervising Casework Specialist II, when scheduling a YAB hearing. PA I/C.S. shall be responsible for requesting accommodations for wards with disabilities during YAB hearing when a ward requests an accom-modation, or when the PA I/C.S. is aware of a disability or should have been aware of a disability.	Review copies of Case Report Transmittal Forms. Interview wards with disabilities and IPA's, Casework Specialists to ensure com-pliance.	SC	SC	SC	SC	NA	The new Board Information report available from WIN appears to contain all of the necessary information for the YAB to understand the ward's disabilities and the required accommodations. These are typically provided to the Board as well as being put into the ward's field file.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
66	The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings.	Interview wards with disabilities and SA's to ensure compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
	1. Disciplinary Decision Making System								
67	To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct), all wards with disabilities who re-quire an accommodation shall be assigned a Staff Assistant from the facility SA team.	Review DDMS documents on wards with disabilities to ensure SA assistance.	SC*	SC*	SC*	NC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
68	Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education.	Review composition of SA teams.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
69	Disposition chairperson shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of disposition chairperson for compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Since the "disposition chairperson" may change frequently, it is recommended that this item not be removed from future audits. There has been some confusion about who the "disposition chair-person" is intended to be. The Auditor's interpretation is that this is the DDMS Coordinator, who should review dispositions regularly to determine if effective communication is provided.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
70	The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive/ emotional disabilities & present an overview of the DDMS process.	Audit training module; review training records for compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Since SA team members may change frequently, it is recommended that this item not be removed from future audits.
71	The facility WDP Coordinators shall review all DDMS/ grievance forms at least monthly to identify any patterns of misbehavior that may be related to cognitive and emotional disabilities.	Review monthly audit documents to confirm compliance.	SC-	PC	SC-	SC	NA	Current facility WDP coordinators were generally aware of the requirement and usually reviewed DDMS forms and dispositions. One instance at Chad demonstrated that the coordinator made such referrals to mental health staff. While mental health staff may have undertaken a general degree of review, there was no documentation that patterns of misbehavior were monitored to the extent necessary to determine if these played a role in the behavior. At Ventura, there was no documentation provided to show that patterns of misbehavior were monitored to the extent necessary to determine if these played a role in the behavior (either by the two "interim" facility WDP coordinators or by others).	Further review and refinement of procedures by Headquarters is needed, and further auditing is appropriate. Headquarters has indicated that mental health staff should undertake the detailed review of the patterns, but there was no indication that this was occurring as described by DJJ. Such additional policy is acceptable to the Disabilities Expert; however, this should not totally remove the facility WDP coordinator's general periodic review.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	2. Grievance Procedures								
72	The SA shall be assigned to each grievance (from filing to resolution) involving a ward with a mental or physical disability who currently requires an accommodation.	Review completed grievance documents (Griev Form-YA8.450, Appeal Form-YA 8.451) for wards with disabilities to ensure SA assistance through confirmed signature.	PC	SC	PC	PC	NA	There were actually very few documented grievances filed by WDP youth, as reported by either the WDP or grievance coordinator at each facility. As a typical example, at SYC, of the total of ten reported grievances filed by WDP youth within the previous two months, two youth were not provided with staff assistants where such was indicated. While this number would not appear to be that significant, a detailed review of the grievance process and the provision of a staff assistant or other accommodation for youth with a disability indicated several problems, also confirmed by interviews with youth. While there is usually (but not always) a sign placed over the grievance boxes at the living units stating that a staff assistant may be requested, the grievance forms are very confusing, and use of the term "representative" as opposed to "staff assistant" is an entirely different connotation even to those (many) youth who are clearly confused by the entire, new grievance process. In addition, five of the ten grievances described above were eventually dismissed, "withdrawn" or deemed to be "mistaken" for purely (allegedly) procedural reasons, none of which furthered a fair disposition of the issue at hand. The process of requiring an informal review (without access to a staff assistant) appeared to sometimes intimidate youth from proceeding, due to fears of staff retribution or retaliation (whether or not such fears were justified).	There were very few documented grievances filed by WDP youth, as reported by the grievance coordinator, and as confirmed by the records and interviews with youth. Without being overly specific in order to protect the anonymity of wards, the vast majority of wards interviewed expressed a lack of confidence in the fairness of the current grievance system as a cause for this phenomenon. The new grievance process needs a detailed review of effectiveness and fairness, particularly as it involves youth with disabilities, but unfortunately, such a detailed review is beyond the scope of this single facility report.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
73	All grievance respondents shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of grievance respondent for compliance.	PC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Completed staff training at the departmental level would be needed to comply with this requirement.
74	The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental / physical disabilities and present an overview of the grievance process.	Audit training module and review training record of SA for compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
75	The WDP Coordinator shall review all grievance forms at least monthly to identify any patterns of repetitive involvement that may be related to mental and physical disabilities and refer such cases to the appropriate supervisory staff.	Review monthly audit documents to confirm com-pliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
76	Completed grievance forms should be randomly monitored by the facility WDP Coordinator to determine if indeed disability is an issue, even though the ward filing the grievance may not have specifically cited it.	Included in meetings with WDP Coordi-nators.	SC	PC	SC-	SC	NA	The facility WDP coordinator was generally aware of the requirement and usually reviews grievance forms and dispositions. There were actually very few documented grievances filed WDP youth, as reported by the WDP coordinators, although some youth filed a number of grievances. There was no documentation provided to show that patterns of excessive grievances were being monitored to the extent necessary to determine if disability played a role in these grievances (either by the two "interim" facility WDP coordinators or by others). At Ventura, even though one of the two "interim" facility WDP coordinators was also the grievance coordinator, there were there specific procedures cited regarding what actions to take or how such issues would be referred to others.	Further review and refinement of procedures is needed, and further documentation of this activity is appropriate. It is unclear why there are so few grievances being submitted, a subject in need of further study, but beyond the specific purview of the Disabilities Expert. See also item 72.
77	The grievance screening process for accommodations, including the medical verification process for accommodations, should be completed in a timely manner and interim accommodations shall be provided to the extent necessary.	Review randomly 10 or 10%, whichever is greater, of accommo-dation related grievances.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
78	The Wards Rights Coordinator, within 24 hours of receipt, shall review grievances, with attached documentation, that request accommodations or allege discrimination to determine whether the grievance meets one or more of the following criteria for review and response: allegation of non-compliance w/ dept. WDP policy; allegation of discrimination based on a disability under WDP; denial of access to a program, service, or activity based on disability.	Sample of 10 or 10%, whichever is greater, of grievances filed during the last quarter.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	It is recommended that detailed procedures to facilitate the Wards Rights Coordinator's review of grievances related to accommodations and discrimination (including DJJ Document CN-18, "Youth with Disabilities - Equal Access") be reviewed with the Wards Rights Coordinator and fully implemented.
79	The Wards Rights Coordinator shall forward to the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 48 hours of receipt.	Audit grievances from ward with disabilities (Grievance Form YA 8.450) that request accommodations or allege discrimination to confirm meeting timelines.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
80	Grievances referred to the CMO when medical verification of a disability or identification of an associated limitation is required and returned to the Wards Rights Coordinator are handled within timeframes as defined within the remedial plan.	Audit grievances from wards with disabilities (Grievance Form YA 8.450) that request accom-modations or allege discri-ination to determine compliance of protocol within time constraints.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	It is recommended that detailed procedures to facilitate the Wards Rights Coordinator's review of medical verifications (including DJJ Document CN-18, "Youth with Disabilities - Equal Access") be reviewed with the Wards Rights Coordinator and fully implemented.
81	If medical verification is not available in the UHR, and medical staff determines that a referral to an expert consultant, external to the department, is required, an appt. shall be scheduled within ten working days to determine whether a disability or any limitations exist. The medical staff, upon receipt of report from an expert consultant, shall note verification of a disability and any limitations that exist on grievance form, and in the UHR of a ward.	Review grievances from wards with disabilities (Grievance Form YA 8.450) that request accommodatio ns or allege discrim-ination and their UHR to determine compliance of protocol within given time constraints.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
82	After consultant verification of a disability, medical staff shall return the grievance, with all reqd. documentation, to the Wards Rights Coor-dinator. The Wards Rights Coordinator shall forward to the Office of the Supt. all grievances that meet the criteria for review and response within 48 hours of receipt from Health Care staff.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accom-modations or allege discrim-ination to deter-mine compliance of protocol within stated time constraints.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
83	The Wards Rights Coordinator shall refer a grievance to the facility WDP Coordinator when verification of a non-medical disability is required and ensure it is handled as defined within the remedial plan and within timeframes.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accom-modations / allege discrimination.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
84	Wards may use the WDP Grievance process to file a grievance based on the denial of a request for a reasonable accommodation during YAB proceedings.	Interview wards with disabilities. Review grievances to determine compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
85	Wards with disabilities shall be granted reasonable accommodations with respect to timeframes, consistent with the Safety and Welfare Plan, for processing of grievances.	Interview wards with disabilities. Review grievances to determine compliance.	SC	SC	SC	SC	NA	There were no instances where a ward had an unresolved grievance relating to this item during the auditing period.	
	D. Programs								
	1. Reception Center & Clinic Functions								

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
86	As part of the clinic screening and assessment process, all wards shall be screened at the reception centers, and as indicated, throughout their stay in the Department, to determine whether they have a developmental disability which may make them eligible under criteria set forth in the ADA and/or may make them eligible to receive services from a Regional Center.	Review screening documents in ward field files.	NA	SC	PC+	NA	NA	At Ventura, Dr. Freeland, the Chief Psychologist, and her staff should be commended for their excellent work in completing the appropriate developmental testing and evaluation process for all youth at the facility. At SYC, the "PC" rating should not be construed as a slight to the efforts of Dr. Dubow, Dr. Jones-Bunn, or Dr. Bostwick (psychologists primarily responsible for the DD testing and evaluations), who worked diligently over the few months before the audit to try to bring this item into compliance. Indeed, the SYC staff provided KBIT tests to a large number of youth, although a precise list of all youth currently at the facility, citing whether or not each had been tested and their initial KBIT or TONI scores, was not initially provided as requested, and, clear documentation of follow-up evaluations using the department-approved form was not readily available for a sufficient number of youth. Supplemental data demonstrated appropriate procedures that are on-going and close to bringing the item into substantial compliance, but a number of youth are still in need of the final, follow-up evaluations. At both reception centers, a few wards were specifically identified as being develop-mentally disabled, yet all were not listed as such in WIN records or WDP lists.	Use the department-approved assessment process to complete the evaluation of all wards currently at the facility, and provide the required follow-up evaluations to those youth who score below the prescribed limit or refuse KBIT testing. Provide better documentation to the Disabilities Auditor, listing all wards and their KBIT scores, if tested; and a written evaluation by a clinical psychologist regarding the results of the KBIT score or other criteria used to make an appropriate assessment and placement. Formally include all identified youth in WIN and include in the WDP program.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
87	During the initial wards interviews, advise wards of their rights under the ADA and section 504, and receive formal documentation that they have received and understood this.	Observe random interviews at intake facilities.	NA	SC*	SC*	NA	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
88	Assigned Casework Specialists shall refer a ward to a mental health professional on a Mental Health Referral Form when indicators of a mental impairment exist that may limit a major life activity.	Review copies of Mental Health Referral Form for completeness.	NA	SC	SC	NA	NA	At SYC, Casework Specialists routinely and correctly use the "Disability Referral / Evaluation Form" (DJJ 8.288) form to refer wards to a mental health professional during intake. At Ventura, Casework Specialists could use various forms, including a "Disability Referral/ Evaluation Form" (DJJ 8.288), "Mental Health Services Referral" form (as required by the remedial plan), a "Ward's Request for Reasonable Accommodation" form, or a "Critical Factors Assessment for Determining Need for Mental Health Evaluation" form, to refer wards to a mental health professional during intake, but it was not documented that they do so. Nevertheless, since only a few girls are now received at intake, there was no indication that the current informal methods of referral were ineffective.	Standardization of forms used by all reception centers and guidance from Headquarters is needed to assure long-term compliance.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
89	Assigned Casework Specialists shall refer a ward to a medical professional on a Disability Health Services Referral form when indicators of a physical impairment exist that may limit a major life activity.	Review copies of Disability Health Services Referral Form for completeness.	NA	SC	SC	NA	NA	Casework Specialists routinely and correctly use the "Disability Referral / Evaluation Form" (DJJ 8.288) form to refer wards to a medical professional during intake.	Standardization of forms used by the three reception centers and guidance from Headquarters is needed to assure long-term compliance.
90	Assigned Casework Specialists shall use a Referral to School Consultation Team (SCT) form to refer a ward to an educational professional to verify the existence of a learning impairment that may limit a major life activity.	Review copies of Referral to School Consultation Team (YA 7.464) for completeness.	NA	PC	SC	NA	NA	At SYC, Casework Specialists routinely use the "Disability Referral / Evaluation Form" (DJJ 8.288) form to refer wards to an educational professional, in lieu of the RSCT form YA 7.464 form. At Ventura, Casework Specialists still use other methods to refer wards with learning disabilities to educational services during intake and at other times. The RSCT form YA 7.464 form is not used for this purpose, and it was not evident that the School Consultation Team (SCT) is routinely utilized to document a learning impairment referred during intake. Better documentation by Education staff is critical for improvement. See also items 92 and 94.	Standardization of forms used by the three reception centers and guidance from Headquarters is needed to assure long-term compliance.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
91	Licensed mental health professionals and medical personnel shall complete the screening process on a ward within 10 working days of a referral from an assigned Casework Specialist.	Review screening forms for completeness and timeliness: MH – SPAN/ YA 8.216; Med – Medical HX/YA 8.260.	NA	SC*	SC*	NA	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
92	Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for completeness and timeliness: Ed – CASAS, CELDT, High Point Testing, HX in file	NA	PC	PC	NA	NA	At both reception centers, the initial intake interview includes a review of educational needs, but educational records and interviews indicated that initial assessment plans were not often developed within 15 calendar days. There were several records of formal staff or self-referrals for evaluating wards with disabilities, and for these, the time periods allowed by the WDP Remedial Plan were exceeded in most cases. Better documentation by Education staff is critical for improvement.	
93	Within 10 working days of completing the disability screening process, department staff members who are licensed mental health professionals and medical personnel shall use standardized psycho-logical test instruments, medical, dental practices to assess wards.	Review appropriate docume-ntation for completeness and timeliness.	NA	SC*	SC*	NA	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
94	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documenta-tion for completeness and timeliness.	NA	PC+	PC	NA	NA	For standard initial educational assessments (as opposed to referrals, see also items 90 and 92), records indicated that a wide variety of educational assessments are either utilized or developed. In some cases, recent assessments from other sources are used to provide interim placement or schedule the IEP. However, there were several records found where youth were not fully assessed and placed appropriately within the 50 day time period. At Ventura, pressures on school population and lowered staffing have inhibited the ability to complete educational assessments within prescribed time limits.	
95	If it is determined prior to or during the ICR that a ward is in need of an accommodation in order to allow for effective participation, the Supervising Casework Specialist II shall ensure that such accommodations are provided.	Review random ICR reports for wards with dis-abilities.	NA	SC*	SC*	NA	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Since much of this procedure relies on the diligence of the Supervising Casework Specialist II, I would recommend that these procedures be written for future documentation.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
96	All wards shall complete the orientation process at a reception center that contains a standardized Disability module which shall include: 1) a summary of the main points of the Disability law under Title II of the ADA and IDEA and their relevance to wards, 2) a summary of the main points of the Department Disability Policy as it relates to wards, 3) an explanation of the Disability self-referral process, and 4) the Ward's Rights Handbook section on Disability.	Review orientation program for required components and audit ward-signed orientation forms to confirm participation.	NA	SC	PC	NA	NA	The only real orientation process monitored during this year was at SYC. Interviews with the Supervising Parole Agent and the Parole Agent who provides the overall youth orientation meeting indicated that the Parole Agent usually provides a group of 3 to 4 youth with a general orientation to the facility and the WDP program. It is evident that most wards receive a packet of information regarding the Wards with Disabilities Program as they arrive (in combination with as many as 37 other orientation packets related to various programs), but no formal computerized, standardized "orientation process", as described in the WDP Remedial Plan (Section III.J., page 10), is currently provided, and the effectiveness of the current orientation, when combined with so much other information and given in an informal format, is questionable. In addition, the document provided fails to document that that the Disability self-referral process or the Ward's Rights Handbook section on Disability are adequately discussed. While interviews with youth are not specifically listed as a method for audit, it is clear from these interviews that youth can be confused by such an exhaustive orientation program, and may not be able to grasp the complexities of the WDP program in such a short period allotted for this purpose. At Ventura, since only a few girls are now received at intake, there was no indication that informal orientation methods of orientation are ineffective.	This item will become more important when the new reception center at Chad becomes fully active. The interview with the Parole Agent at SYC who provides the overall youth orientation meeting showed that she does a very good job in relating to the youth and making the overall orientation process as effective as possible, given the large amount of material that has to be covered. Nevertheless, it is not clear that her past training exceeds any more than the one-hour WDP training given to all staff, and these disability issues can be complex. The facility WDP Coordinators should be involved in presenting the orientations. As recommended in previous years, Headquarters should develop and coordinate the WDP orientation process, and the Disabilities Expert should be consulted early in this process to assure future compliance Orientation should be formalized into a group setting, utilizing the "standardized Disability module" in the manner that was intended in its preparation.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
97	Presenters of ward orientation program shall make the reasonable accommodations or modifications necessary for wards with disabilities who require accommodations during the orientation.	Review ward-signed orientation forms for documented information regarding provided accom-modations.	NA	SC	PC	NA	NA	Procedures for providing and documenting accommodations were not adequately documented. Informal methods of providing accommodations *may* be effective, but more formal methods need to be utilized. Youth-signed attendance forms provided at the audit had a line where a staff assistant could sign, but there was no indication given on how a staff assistant or other accommodation would be determined and provided. Of the 60+ forms provided for SYC, no youth had a staff assistant, and subsequently, a number of these youth were eventually listed as requiring a staff assistant for various activities. At Ventura, since only a few girls are now received at intake, there was no indication that informal methods of providing accommodations during orientation are ineffective.	Written procedures for providing accommodations at orientation (usually held prior to the initial determination of accommodation need) need to be developed.
	Residential Programs								
98	For each special program or activity, evaluate eligibility criteria to assure that wards with disabilities are not excluded when they can perform the essential functions of the activity.	On-going audit, based on detailed factors listed in the plan. Visit special program locations yearly.	SC-	SC-	SC-	SC-	NA	This item should most likely be given an "NA" rating, but DJJ has objected in the past when the item was not applicable, since it would be impos-sible to ever achieve compliance. However, it was reported by facility staff that there were no special programs or activities at any facility that have specific eligibility criteria (this does not include educational programs). It was impossible to examine all activities present at the facility to verify this situation. In general, there were no specific policies or procedures to assure that wards with disabilities were included on an equal basis in such programs, if indeed they were to exist. While it is understood that participation in many programs is appropriately behavior-based, it is unclear how wards in special management or counseling programs would be able to participate in such programs.	Written procedures for assuring equal access to all special programs need to be developed. This item is in need of further study as to why the facility offers no special programs whatsoever, but such a detailed analysis is beyond the purview of the Disabilities Expert and the audit item involved.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
99	Staff shall refer wards to Health Care Services and the Education Department for screening when information is observed or received that indicates the presence of a physical or mental impairment that has not been documented and verified.	Review submitted SRSC (YA 7.464) and SCT Referral (YA 8.229) forms and determines appropriate-ness of disposition.	SC-	SC-	SC-	SC-	NA	Some improvements were demonstrated in this area at some facilities, but not at others. Staff generally use various forms and methods to refer wards to Health Care Services, including common but not consistent use of the new "Disability Referral/ Evaluation Form" (DJJ 8.288). Staff do not generally use the SCT Referral Form (YA 7.464) to refer wards to the Education Department for screening.	Guidance and training is needed from Headquarters to demonstrate appropriate use of the appropriate referral forms, consistent with the WDP Remedial Plan.
100	Within five days of receipt, the MTA or RN shall forward RSC referrals to the appropriate licensed mental health professionals or medical personnel for screening.	Review RSC (YA 8.229) for timeliness of submission.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
101	Within five days of receipt, the SCT Coordinator shall forward SCT referrals to the appropriate credentialed education staff for screening.	Review SCT (YA 7/464) referrals for timeliness of submission.	PC	PC	PC	PC	NA	While procedures are improving, there was no documentation provided indicating that this time line (admittedly a difficult one, and one which would be given some leniency) was being met.	See item 99 above.
102	Licensed mental health professionals and medical personnel shall complete the screening process on a ward within 10 working days of a referral from an assigned Casework Specialist.	Review screening forms for completeness and timeliness. MH – SPAN /YA 8.216; Med – Medical HX/YA 8.260	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
103	Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for completeness and timeliness. Educ.-CASAS, CELDT, High Point Testing, HX in file	PC	PC	PC	PC	NA	While procedures are improving, there was no documentation provided indicating that this time line (admittedly a difficult one, and one which would be given some leniency) was being met.	See item 99 above.
104	Within 10 working days of completing the disability screening process, Department staff members who are licensed mental health professionals and medical personnel shall use standardized psychological test instruments and medical and dental practices to assess wards.	Review appro-priate documen-tation for complete-ness and timeliness	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
105	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
106	The Treatment Team Supervisor/ Supervising Casework Specialist shall ensure that within five days of receipt of WDP Assessment reports, from licensed mental health professionals, medical personnel, or credentialed education staff, that the assigned PA /Casework Specialist conducts a special case conference.	Audit case conference forms (ICP) for wards with disabilities to ensure implementation and timeliness.	PC	SC	SC	PC	NA	There were few (at some facilities, none) documented records that any special case conferences related to WDP assessments were held at any facility during the last year. Documentation of periodic case conferences and reviews was provided, but these did not concentrate on providing disability accommodations, as this item intends to address. However, the process is in place (thus allowing for a PC rating instead of a NC).	The reasons for no special case conferences for newly-identified youth is unclear, but needs further study, perhaps by the facility WDP coordinator at each site. Audit time did not allow for a detailed study of these reasons.
107	The PA/Casework Specialist shall document on the Individual Change Plan (ICP) form the following information: Impairment, Accommodations, Current level of care, Classification code.	Review the ICP for documentation of information.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
108	The PA or Casework Specialist shall ensure that copies of the changes in the status of a ward with a disability documented on the ICP form are forwarded to the following: Education Services for inclusion in the School Records File, Health Care Services for inclusion in the UHR, Casework Services for inclusion in the Field File	Review the School Records File form, the UHR and the Field File for documentation of information	SC*	SC*	SC*	PC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
109	The Department shall ensure that staff reviews the level of care placement and any reasonable accommodations for wards with disabilities at regularly scheduled case conferences.	Audit ICP forms for wards with disabilities to determine level of review.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
110	The Superintendent shall ensure that the following data is documented for all wards with a disability: (1) Name, age, YA number; (2) Location by facility, living unit, or parole office; (3) Specific impairment; (4) Impairments that substantially limit a major life activity: (5) Impairments that substantially limit a major life activity and require accommodations; (6) Specific accommodations; (7) Need for a Staff Assistant; (8) Level of care designation; (9) Classification code.	Review documentation for completeness of information.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	Continue to improve data entry and report techniques. Additional training on how to generate detailed reports is still needed.
111	The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities.	Review modified materials	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
112	The Program Manager shall ensure that a Staff Assistant (SA) is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions.	Review list of SA and assignments. Conduct interviews with SA & wards with disabilities to determine effectiveness.	PC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	The Disabilities Expert remains uncomfortable with the concept prevalent at some facilities that all staff can work as Staff Assistants. This is a task that should be reserved for those that have been specially trained and have shown acumen for effectively providing this service.
113	The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities.	Interview wards with disabilities to determine access and participation.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
	3. Developmental Disabilities								
114	No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	Tour facilities to ensure compliance.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
115	Services will be provided to all wards identified as being developmentally disabled or who have been determined to need supportive services similar to wards with developmental disabilities, irrespective of age of onset.	Review departmental list of DD wards, program placement (YA 1.503) and ICP.	BC	PC	PC	PC	NA	These ratings should not be construed as a slight to the exceptional work of many clinical psychologists, who worked diligently over the last few months to try to bring this item into compliance. Indeed, staff provided KBIT tests to a large number of youth. However, the fact remains that since the last round of WDP audits, testing and follow-up evaluations were virtually non-existent until December, 2010 at most facilities, despite detailed conversations about how the process should proceed with the Chief and Senior Psychologists during the last audit, and despite a clear memo from Headquarters in March outlining the process (whether the facilities ever received that memo is unclear). Lists of potential DD wards from the facility that were provided were conflicting and incomplete. Some wards were specifically identified by WIN as being developmentally disabled, yet no special programs, treatment options, or activities for these wards with developmental disabilities currently exist at any facility.	Use the department-approved assessment process to evaluate wards that have not been previously KBIT-tested at a reception center, and provide the required follow-up evaluations to those youth who score below the prescribed limit or refuse KBIT testing. Provide better documentation to the Disabilities Auditor, listing all wards and their KBIT scores, if tested; and a written evaluation by a clinical psychologist regarding the results of the KBIT score or other criteria used to make an appropriate assessment and placement. Formally include all identified youth in WIN and include in the WDP program. Prior to completion of the departmental planning study to determine types of programs and supportive services needed to serve these youth, use the special case conference process (see item no. 106) to determine the supportive services necessary for these youth.

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
	4. Removal of Architectural Barriers								
116	The Department committed to the renovation of one room at each facility, as a minimum, to ensure the provision of accessible housing for wards with disabilities. The total completion of this project is scheduled for June 30, 2006.	Monitor the project completion timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
117	The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006.	Monitor the project timeline and visit each facility area upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
118	The Department committed to the removal of critical disability related structural barrier projects that will be completed each year from FY 2005/06 to FY 2008/09. These projects are part of the barriers that were identified by the survey completed by Access Unlimited and are identified in Appendix B to the Disability Remedial Plan.	Monitor the project timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
119	The Department committed to analyze 3000 additional barriers identified in the report prepared by Access Unlimited and provides a report that would categorize the barriers into three distinct areas. This report is due July 15, 2005, and will be filed at Appendix C to the Disability Remedial Plan.	Review, approve and submit required report.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	
120	Construction of the first category of projects, which involves projects that can be fixed in a short period of time with minimum costs, shall be completed by September 30, 2006.	Audit first category projects for compliance of completion within defined timeline.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

No	Item	Method	Cha	Ven	SYC	Clo	HQ	Comments	Recommendations
121	The second category of projects, which involve projects that will require substantial funding, will be completed by Sept. 30, 2008.	Audit second category projects for compliance of completion within defined timeline.	SC*	SC*	SC*	SC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ for this audit cycle. Rating given by CDCR Office of Audits and Court Compliance.	

Education Audit Ratings Analysis

Facility / Numbers	Chad	OH Close	Ventura	SYCRCC
Number of Items Audited	**115**	**115**	**115**	**115**
Number of Items that Received a Different Rating from the Expert	**7 of 115 (6%)** Of 7, 2 were rated higher and 5 lower	**14 of 115 (12%)** Of 14, 8 were rated higher and 5 lower	**12 of 115 (10%)** Of 12, 7 were rated higher and 5 lower	**15 of 115 (13%)** Of 15, 13 were rated higher and 2 lower.

Audit Areas Where Different Ratings Occurred

Facility / Audit Areas	Chad	OH Close	Ventura	SYCRCC	Total
Overview (1.4, 1.6, 1.7, 1.8)	**0**	**1** (lower)	**3** (1 lower 2 higher)	**1** (higher)	**5** Of 5, 3 were rated higher and 2 lower
Staffing (2.2, 2.4, 2.7, 2.10, 3.6, 3.7, 3.8, 3.9, 3.10, 3.13, 3.15, 3.16, 3.20, 3.23, 3.29, 3.33, 3.36, 3.38, 3.39)	**2** (both lower)	**10** (6 higher, 4 lower)	**7** (4 higher, 3 lower)	**8** 7 higher, 1 lower)	**27** Of 27, 17 were rated higher and 10 lower
Curriculum (4.8, 4.12, 4.17, 4.l8, 4.21)	**2** (1 higher, 1 lower)	**2** (both higher)	**2** (both higher)	**0**	**6** Of 6, 5 were rated higher and 1 lower
Special Education (5.5, 5.6, 5.8, 5.12, 5.15, 5.17, 5.18, 5.21, 5.22, 5.25)	**3** (2 lower, 1 higher)	**1** (lower)	**0**	**6** (5 higher, 1 lower)	**10** Of 10, 6 were rated higher and 4 lower

WDP Audit Ratings Analysis

Facility / Numbers	Chad	OH Close	Ventura	SYCRCC	Central Office
Number of Items Audited	**78**	**78**	**90**	**90**	24
Number of Items that Received a Different Rating from the Expert	12 of 78 (15%) Of 12, 6 were rated higher, 3 lower and 3 in other category	12 of 78 (15%) Of 12, 10 were rated lower and 2 in other category	16 of 90 (18%)) Of 16, 2 were rated higher, 13 lower and 1 in other category	13 of 90 (14%) Of 13, 11 were rated lower and 2 in other category	3 of 24 (12%) All 3 lower
Number of DJJ Self-Rated Items **(Expert rated only a few of these items on a random basis)**	**50 of 78 (64%)**	**50 of 78 (64%)**	**55 of 90 (61%)**	**54 of 90 (60%)**	**2 of 24 (8%)**

Audit Areas Where Different Ratings Occurred

Facility / Audit Areas	Chad	OH Close	Ventura	SYCRCC	Central Office	Total
Superintendent (#34)	**1** (higher)	**0**	**0**	**0**	Not Applicable	**1** 1 higher
Facility WDP Coordinator (#36, 37, 38, 39)	**1** (higher)	**1** (lower)	**3** (all lower)	**0**	"	**5** 1 higher 4 lower
Facility Policies (#41, 46, 48, 51, 53, 55, 56, 63, 64, 71, 72)	**7** (2 higher, 2 lower & 3 in other)	**7** (5 lower & 2 in other)	**5** (2 lower & 3 in other)	**7** (5 lower & 2 in other)	"	**26** 2 higher 14 lower 10 other
Grievance Procedures (#72, 76)	**1** (other)	**1** (lower)	**1** (lower)	**1** (lower)	"	**4** 3 lower 1 other
Residential Programs (#101, 103, 106)	**1** (lower)	**3** (all lower)	**2** (1 higher & 1 lower)	**1** (lower)	"	**7** 1 higher 6 lower
Developmental Disabilities (# 115, 145)	**1** (higher)	**0**	**1** (higher)	**1** (lower)	"	**3** 2 higher 1 lower
Reception Center & Clinic Functions (#86, 90, 92, 94)	N/A	N/A	**3** (all lower)	**3** (all lower)	"	**6** All 6 lower
DDMS (#71)	**0**	**0**	**1** (lower)	**0**	"	**1** 1 lower

Safety & Welfare Audit Ratings Analysis

Facility / Numbers	Ventura	OH Close Audited July 18-19, 2011 (report not yet available)	Chad Audit scheduled for August 15-16, 2011	SYCRCC Audit scheduled for October 17-19, 2011
Number of Items Audited	**82**			
Number of Items that Received a Different Rating from the Expert & OSM	**15 of 82 (18%)** Of 15, 2 were rated higher, 11 lower and 2 in other category.			

Audit Areas Where Different Ratings Occurred

Facility / Audit Areas	Ventura				Total
Clarify lines of authority/create system for auditing and corrective action 2.2.2 and 2.2.3	**2** (1 higher and 1 lower)				**2** (1 higher and 1 lower)
Revise Use of Force Policy 3.2, 3.3a, 3.3b and 3.4b	**4** (all lower)				**4** (all lower)
Convert Facilities to Rehabilitative Model 6.1a, 6.1c, 6.2b, 6.4d, 6.5a and 6.5b	**6** (3 lower and 3 in other category)				**6** (3 lower and 2 in other category)
Complete Training 6.7f	**1** (1 higher)				**1** (1 higher)
Grievance System 8.5.7b and 8.6.2c	**2** (both lower)				**2** (both lower)

Memorandum

DATE: July 6, 2011

TO: Associate Directors
Superintendents
Assistant Superintendents

FROM: Rachel R. Rios
Director (A)

SUBJECT: DIVISION OF JUVENILE JUSTICE
USE OF FORCE IMPLEMENTATION PLAN

The Division of Juvenile Justice (DJJ) is committed to providing a safe and healthy environment for the facilitation of youth programs and staff development in program service delivery with a minimal reliance on the use of force. To that end a Use of Force Implementation Committee was established to review various reports on the use of force in DJJ. The Implementation Committee consulted the Office of the Special Master, Safety and Welfare expert, Wards with Disabilities expert, Prison Law Office representatives and internal stakeholders to develop an implementation plan. The overriding goal of the Use of Force implementation plan is to identify ways to reduce the Use of Force in Division of Juvenile Facilities by evaluating and developing recommendations to current policies, procedures and practices.

The attached documents provide an outline to address areas identified to enhance DJJ's overall management of the Crisis Prevention and Management – Use of Force policy and an operational plan. A team to guide these efforts is being established and details will be forthcoming.

This is a critical issue for DJJ and the Implementation Committee is to be commended for their quick and concise work. I look forward to our combined support of this project which will assist us in accomplishing our goal of reducing force within DJJ.

cc: D. Nylund
J. Aguas
F. Gomes

Attachments

Use of Force Implementation Recommendations

June 26, 2011

USE OF FORCE IMPLEMENTATION RECOMMENDATIONS COMMITTEE

Gina Pallotta, Ph.D
Senior Psychologist, Supervisor
N.A. Chaderjian Youth Correctional Facility

Elaine Stenoski, M.S.W.
Program Administrator
N.A. Chaderjian Youth Correctional Facility

Bob McCollum
Captain, Preston Youth Correctional Facility

Frank Gomes
Assistant to Deputy Director of Parole

Jeff Plunkett
Major, Juvenile Facilities

Use of Force Implementation Committee Review

June 21, 2011

Executive Summary

The Division of Juvenile Justice recognizes that the current use of chemical and physical restraints is elevated and disproportionate with mental health and disabled youth. The Division of Juvenile Justice is committed to making substantial changes to policies, procedures and practices to reduce the situations where use of force becomes necessary in our juvenile facilities. The Division of Juvenile Justice has agreed to set a goal to reduce incidents of Use of Force by 20% within the next twelve months by providing policy changes, programmatic changes and staff training within our facilities.

Under the direction of Rachel Rios, Director (A), a multidisciplinary Use of Force Implementation Committee was formed to review previous reports and recommendations on the Use of Force within the Division of Juvenile Justice and formulate one overall Recommendation and Implementation Plan. The overriding goal of the Use of Force Implementation Committee was to find ways to reduce the Use of Force in Division of Juvenile Justice facilities by evaluating and developing recommendations to current policies, procedures and practices.

The Use of Force Implementation Committee reviewed twelve different documents and reports, read relevant Division of Juvenile Justice Policies and consulted with the following groups and individuals: Don Spector, Prison Law Office; John Chen, Office of Special Master; Barry Krisberg, Safety and Welfare Court Expert; Logan Hopper, Wards With Disabilities Court Expert; the Policy Unit; Labor Relations; Health Care and Mental Health Services, Research and Integrated Behavior Treatment Model staff. The Division of Juvenile Justice is in agreement with the majority of these recommendations. More specifically, 86% of the recommendations from the Use of Force Sub-Committee report dated March 17, 2011 are supported. The recommendations from these documents were consolidated and categorized into six overall areas, as outlined in the Use of Force Implementation Committee's Recommendation section.

The Division of Juvenile Justice also supports the majority of recommendations in the Use of Force in DJJ and Mental Health Youth, Supplemental Report dated May 10, 2011 by Barry Krisberg and Logan Hopper as indicated below.

The supported recommendations to be implemented are: **(See attached Implementation Plan for additional details)**

- Staff training on de-escalation techniques
- Staff training and policy changes on discriminating the difference between immediate vs. controlled Use of Force
- Define imminent danger and provide staff training
- Staff training on effective interventions with mental health youth
- Crisis Prevention Support Plan will be developed for every youth
- Staff training on behavioral analysis focusing on antecedents, behaviors and consequences
- Modify the working hours of Psychologists to include evening coverage and enhance their documentation of de-escalation interventions and involvement in Use of Force incidents
- Modify the Use of Force policy and forms
- Revision of Force Review Committee and Division of Force Review Committee to create a solution focused process
- Encourage the use of physical strengths and holds to reduce the use of Chemical Agents

Recommendations that can be partially implemented from the Supplemental Report dated May 10, 2011 by Barry Krisberg and Logan Hopper: **(See attached Implementation Plan for additional details)**

Use of Force in DJJ Mental Health Youth, Supplemental Report Recommendations:

- "Chemical agents shall not be used on single youth, without qualifications"
- "Chemical agents to be eliminated with females"

DJJ recommendation:

- DJJ will issues a policy directive which prohibits the use of chemical agents for single youth incidents, single female youth incidents and incidents involving youth on mental health living units, unless staff or youth are in imminent danger (serious bodily harm to youth or staff) or with a security supervisor's approval. If chemical agents are used, a Facility Force Review and Department Force Review Committee will conduct an in-depth review that will take into account the totality of the situation to determine if alternative approaches could have been utilized and implement any needed training or corrective staff action.

Use of Force in DJJ Mental Health Youth, Supplemental Report Recommendations:

- "Conduct a pilot program that removes the use of chemical agents on a mental health living unit"

DJJ recommendation:

- While DJJ agrees to implement a new program approach with the goal to reduce the use of chemical agents/force, peace officer staff assigned to these units will continue to maintain the safety equipment agreed upon with the current labor contract. The Division of Juvenile Justice will work closely with the Court Experts to evaluate the program design. DJJ will identify two living units (one in the north and one in the south) that have the highest level of force. The Superintendent and Senior Psychologist will assist in selecting staff and ensure that training and programming focuses on reducing the use of force utilizing evidence based behavioral interventions.

Use of Force in DJJ Mental Health Youth, Supplemental Report Recommendations:

- "Modify the transitions, transfer and movement policies"

DJJ recommendation:

- DJJ agrees to conduct training to all direct care staff on assisting youth with transitions, transfers and movements. We will continue to utilize case staffing and large group structure to assist youth during these times.

In summary, the Division of Juvenile Justice supports the majority of recommendations regarding use of force. The focus of our efforts to reduce the use of force will be to provide meaningful training in evidence based interventions, monitoring and skills training to provide staff with effective alternatives to the use of force. However, due to safety and security concerns DJJ maintains that Chemical Agents remain as an option in cases of imminent danger.

Introduction

The majority of reports reviewed indicate that a large and disproportionate number of Mental Health Youth are involved in Use of Force incidents. Although the Use of Force Implementation Committee agrees with this overall finding there appears to be conflicting information. The Use of Force Implementation Committee met with the Office of Research Juvenile Branch's research staff to further clarify the methodology used for selecting the 245 Use of Force incidents for their research. The Office of Research reported that the Use of Force incidents selected for review were not a randomly selected representative sample and thus all results should be interpreted with due caution.

The Use of Force Implementation Committee recommends that the Office of Research Juvenile Branch conduct a new statistical examination of Use of Force incidents. This examination should utilize a random representative sample of all Use of Force incidents within Division of Juvenile Justice. The cases should be selected by the Office of Research Juvenile Branch to ensure the reliability and validity of the results.

The process for determining if a youth meets the criteria for Mental Health may need to be revised to increase its accuracy. After consulting with Dr. Morales, Chief Psychiatrist, he reported that the criteria for mental health designation will be evaluated and modified and institutional application of these modifications will be implemented.

Recommendations

The consistent recommendations from the Special Master, Safety and Welfare expert and previous Mental Health and Wards with Disability Program experts are to eliminate the use of chemical agents for mental health youth in the Division of Juvenile Justice. The Use of Force Implementation Committee's recommendation is that chemical agents should remain as an option if staff or youth are in imminent danger (serious bodily harm to youth or staff).

The following recommendations were developed to reduce the Use of Force within the Division of Juvenile Justice. These recommendations also support the Use of Force recommendations in the Eighteenth Report of the Special Master, June, 2011 with the exception of the total removal of Chemical Agents. **(Please refer to the attached Implementation Plan for more specific details).**

1. Training

- Evidence-based intervention training that supports the Integrated Behavior Treatment Model to effectively manage and de-escalate aggressive and/or mentally ill youth.
- Sergeants and Lieutenants training to focus on tactical responses in Controlled Use of Force incidents with an emphasis on de-escalation techniques prior to Use of Force on non-compliant youth.
- Use of Force Policy changes for all direct care staff to include defining imminent danger, clarify controlled versus immediate force and necessary versus reasonable force.
- Crisis Prevention Support Plan policy changes to indicate every youth will have a Crisis Prevention Support Plan that is updated during each case conference and copies placed on the living unit allowing for easy access during a crisis.
- Training for direct care staff on assisting youth with transitions, transfers and movements.

2. Youth Programming

- A behaviorally-based incentive program to supplement the current Youth Incentive Program focusing on reinforcing youth's appropriate behavior (absence of Use of Force). There will be individual daily reinforcement and group weekly reinforcements available for appropriate behavior.
- Develop protocol for Crisis Intervention sessions to occur progressively over several days. Youth will be provided individual counseling with the psychologist and living unit staff, and treatment assignments will focus on conflict resolution.

3. Documentation

- Modify the Use of Force form in the Ward Information Network system to include a list of all necessary components. The user will have to check off each listed item before the Ward Information Network system will allow them to print the necessary document.
- Statewide database to track all Use of Force incidents at each facility. Data will be used to monitor the overall Use of Force and identify trends or patterns that can then be used as a teaching tool to help reduce the Use of Force.

4. Force Review Committee and Team Meetings

- Force Review Committee changes will allow the Superintendent the discretion to identify and separate Use of Force incidents based on the presence of six critical factors and any incident deemed necessary for review. The Force Review Committee will complete an in-depth analysis of problematic cases. This will allow for timely and accurate feedback to staff, participants and witnesses in Use of Force incidents. All Use of Force cases will be submitted for review to the Division Force Review Committee.
- Multi-disciplinary Team Meetings will be required on all living units to facilitate training and communication. These team meetings will be used to problem solve ways to reduce the Use of Force and for a variety of other teaching opportunities.

5. Staffing Changes

- One Psychologist per facility will work until 9 PM on Monday through Friday to be available to respond to emergencies, potential Use of Force and Controlled Use of Force incidents. Also, psychologists, who are already on-call during weekends and holidays, will be contacted and required to consult and/or respond to Controlled Use of Force incidents.

6. Program Recommendations

- Implement programmatic changes on two living units (one in the North and one in the South) that have the highest level of Use of Force. Highly motivated staff will be selected by the Superintendent's office in consultation with the Program Managers and Senior Psychologist. Weekly multi-disciplinary team meetings will focus on problem solving and increasing the effectiveness of interventions to reduce the Use of Force. Intervention training will focus on behavior analysis, including a token economy that is consistent with the Integrated Behavior Treatment Model. The unit will then use used as a model living unit to train staff.

Conclusion

The Use of Force Implementation Committee believes that this plan will result in a significant reduction of the Use of Force incidents and create a more therapeutic environment that is safer for both youth and staff. The next step in implementing this plan is the identification of qualified staff that can further develop the training material and implement the changes. All aspects of this plan are executable within a 12-month time frame.

USE OF FORCE OPERATIONAL IMPLEMENTATION PLAN

1. Program Recommendations	
Task	**Deliverable**
Months 0-3	
• Identify committee to develop program guide • Identify two programs, one northern and one southern with the highest level of force	• Memorandum appointing staff to Program Development Guide committee • Memorandum identifying the two programs
Months 3-9	
• Develop program guide • Identify and train staff • Implementation of program recommendations	• Completed Program Guide • Memorandum directing implementation on identified units • Copy of training sign-in sheets
2. Documentation Recommendations	
Months 0-3	
• Every youth will have a Crisis Support Plan	• Memorandum directing development of Crisis Support Plan for every youth • Visual inspection of Crisis Support Plan in binder on each living unit
Months 0-6	
• Identify committee and make modifications to the Use of Force Policy to include data base, form changes and timelines	• Memorandum appointing staff to committee • Modified Use of Force Policy, forms, and data base
3. Meeting/Committee Recommendations	
Months 0-3	
• All living units will have weekly multidisciplinary meetings	• Memorandum to explain expectations of weekly multidisciplinary meetings • Copies of weekly meeting minutes
4. Staffing Changes Recommendations	
Months 0-3	
• Clarify Psychologist on-call duties to include responding to Use of Force incidents	• Memorandum to clarify on-call policy
Months 0-12	
• Change Psychologist work hours to include one Psychologist working evenings until 9 PM on Monday-Friday	• Copies of documents determining union issues and notices, as appropriate • Copy of Psychologist rotational schedule

5. Youth Programming Recommendation	
Task	**Deliverable**
Months 0-6	
• To collaborate with IBTM workgroup to develop progressive Crisis Intervention procedures	• Memorandum to direct staff to create and implement Progressive Crisis Intervention • Copy of training manual • Copy of training sign-in sheet
Months 0-12	
• To collaborate with IBTM workgroup to develop behavioral management tool for Youth Incentive Program	• Memorandum to direct Staff to create and implement Youth Incentive Program • Copy of completed behavioral management tool • Copy of training sign-in sheet
6. Training Recommendations	
Months 0-3	
• Development of OJT on Psychotropic Medication	• Memorandum to identify staff to create and implement Psychotropic Medication OJT • Copy of OJT module • Copy of training sign-in sheet
Months 0-9	
• Train staff on Use of Force Policy Changes	• Memorandum to identify staff to develop training curriculum • Copy of training material • Copy of training sign-in sheet
Months 0-12	
• To collaborate with IBTM workgroup to develop evidence based intervention training	• Memorandum to direct staff to create and implement evidence based intervention training • Copy of completed training manual • Copy of training sign-in sheet

UOF IMPLEMENTATION TEAM RESPONSE TO UOF REPORT

I. PREVENTION		
1.1 Crisis Prevention Support Plans were not required for every Youth, easily accessed, routinely updated, or relied upon before, during, or following incidents.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, develop a *Crisis Prevention Support Plan* for every Youth with a *Mental Health Designation* or an identified disability; at a minimum, review and update plan every 30 days.		• Every youth should have Crisis Prevention Support Plan • See Crisis Prevention Support Implementation Recommendations
2. Within 60 days, develop a *Crisis Prevention Support Plan* for every Youth; at a minimum, review and update plan every 30 days.	5. All staff in mental health units should work as treatment team and be familiar with each youth's individual vulnerabilities and trained in a variety of individualized responses to youth misconduct.	• Every youth will have a Crisis Prevention Support Plan • See Crisis Prevention Support Implementation Recommendations
3. Within 6 months, implement a standardized *Crisis Prevention Support Plan Policy* state-wide. At a minimum, ensure the policy includes provisions for the following: • Expected content and format for each plan. • Development of a plan for every Youth. • Review during each *Case Conference* and after each force incident. • Involvement of the Youth in drafting and updating the plan. • Description of any required accommodations for a Youth with a *Mental Health Designation* or an identified disability. • Stated concerns regarding specific types of force for individual Youth, including prohibition of chemical agents with pregnant females. • Review and approval of the plan by the Senior Psychologist. • Easy accessibility to each plan on every living unit and in designated areas. • Formulation of a dissemination and communication strategy.	11. More staff training on the use of alternative dispute resolution with mentally disabled youths, and staff must be required to document their use of these alternative methods in UOF situations. DJJ should enhance staff training on behavior analysis and youth skills training, with an emphasis on how to de-escalate conflict situations. This training should be part of the IBTM approach but must be adapted to the special needs of mentally disabled youth. The reviews must address potential behavioral interventions that might have obviated the UOF. The UOF incident and review needs to be incorporated into the youth's treatment plan.	• Continual refresher training in Aggressive Replacement Therapy, Counterpoint, Motivational Interviewing, Cognitive Behavioral Primer, and Alternative Dispute Resolutions to address Expert recommendation • Already done • Agree- see Crisis Prevention Support Implementation Recommendations • Agree- at each Case Conference and after significant behavioral change- not at every Use of Force • Agree- youth participation at Case Conference and during intake process • Make changes to Crisis Prevention Support Plan to include Wards With Disabilities identifying section • Agree-policy change recommendation • Senior Psychologist does not need to review- treatment team approval appropriate • Each living unit will create a binder with each youths current/updated Crisis Prevention Support Plan • Discussion of youths Crisis Prevention Support Plan at weekly staff meeting.

4. Regardless of whether the techniques actually de-escalate the conflict, reinforce and reward staff members for attempting to use effective strategies identified in the *Crisis Prevention Support Plan* developed for a Youth.		• We have current expectations for supervisors to recognize positive job performance by use of verbal and written reinforcements
1.2 Staff members did not consistently identify warning signs and intervene when Youth behavior was escalating.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, implement specific procedures for identifying warning signs and employing de-escalation techniques among Youth with a *Mental Health Designation* or an identified disability. At a minimum, ensure the procedures include: • Training and coaching for staff members. • Consultation with a Mental Health Clinician. • Recognition of effects of trauma, including possible triggers. • Extended time periods for interventions.		• Current Mental Health Remedial plan supports weekly treatment team meetings on Mental Health units. These weekly meetings provide an avenue for training and discussion • Integrated Behavior Treatment Model supports training, coaching, de-escalation techniques, mentoring • Refer to training recommendations • Refer to Program Recommendations
2. Identify employees effective in identifying warning signs and employing de-escalation techniques; use designated staff members as role models and mentors.		We are currently providing training to all staff that involves: • Aggressive Replacement Training • Counterpoint • Motivational Interviewing • Cognitive Behavioral Primer • Refer to Training Recommendations • Refer to Program Recommendations
3. Train and coach staff members on identifying warning signs, events that precipitate force and how to effectively intervene.		See Above
4. Train and coach staff members on crisis intervention, with priority given to those staff members assigned to living units that target Youth with behavior challenges.		See Above

1.3 Female Youth hid behind vertical shelves in rooms which precluded visual observation.		
UOF Report Policy, Practice and Training Recommendation	Expert Recommendations	UOF Implementation Team Recommendation
1. Within 30 days, issue an official statement requiring that any Youth who is at risk of suicidal or self-injurious behavior and who has a documented or demonstrated history of hiding behind vertical shelving is placed in a room without any visual obstruction.		• Conduct an evaluation to determine if additional shelving should be removed

II. INTER-DISCIPLINARY TREATMENT TEAM		
2.1 Mental Health Clinicians and custody staff members did not partner effectively to de-escalate and manage Youth conflicts.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, implement procedures to increase the presence and intervention of Mental Health Clinicians in force incidents; require that Mental Health Clinicians intervene when a Youth with a *Mental Health Designation* or an identified disability is involved.	3. UOF policies should specifically review the circumstances in which more patience with mentally ill youth or not responding to less serious misconduct is the preferred staff response. The role of mental health staff to be engaged in the situations should be defined in DJJ policy and training.	• Already in current Use of Force policy for Controlled Use of Force incidents • See recommendation for extending clinical staff coverage
2. Within 6 months, conduct pilot project on a *Mental Health Unit* in which there are not any Youth Correctional Counselors and Mental Health Clinicians are the living unit staff members; if effective at reducing force incidents, then expand to all *Mental Health Units*.		• Not a safe practice • Refer to Program Recommendations
3. Integrate Mental Health Clinicians into the rehabilitative process on living units through cultural change, enhanced communication and teamwork across disciplines.		• Implement weekly Treatment Team meetings on all core and specialized units
4. Promote *Inter-disciplinary Treatment Teams* where members are equally valued and respected; reward collaboration.		• Implement weekly Treatment Team meetings on all core and specialized units
5. Re-establish mandatory *Inter-disciplinary Treatment Team* meetings		• Implement weekly Treatment Team meetings on all core and specialized units
6. Encourage Mental Health Clinicians to act as role models and mentors for Correctional Peace Officers.		• Implement weekly Treatment Team meetings on all core and specialized units
7. Evaluate cost-effectiveness of expanding the role of the Mental Health Clinician to include Licensed Clinical Social Workers and/or Licensed Marriage and Family Therapists.		• Consult with Labor to determine if appropriate or viable
8. Incorporate cross training between Mental Health Clinicians and Correctional Peace Officers.		• Refer to Training Recommendations

III. INTERVENTION		
3.1 Before, during and after conflicts between two Youth, staff members did not intervene effectively to prevent incidents from escalating.		
UOF Report Policy, Practice and Training Recommendation	Expert Recommendations	UOF Implementation Team Recommendation
1. Within 90 days, implement an Incentive Program for reducing force incidents; reward staff members for using effective conflict resolution skills with their colleagues and for encouraging their use among the Youth.		• We have current expectations for supervisors to recognize positive job performance by use of verbal and written reinforcements
2. Revise current practices around *Conflict Resolution Sessions* to reflect effective, evidence based practices. Consider factors such as: • Environment: Where *Conflict Resolution Sessions* are conducted, who is present, and if other Youth are around. • Proximity: The distance between the Youth during *Conflict Resolution Sessions* and whether a staff member should sit between the Youth. • Commitment: Contracts do not guarantee commitment to non-violence; the Youth should demonstrate a commitment to nonviolence in other ways, such as identifying and meeting specific behavioral goals. • Youth Participation: The role of the Youth in identifying goals and expectations; as well as how the other Youth on the living unit might support or hinder conflict resolution. • Consequences: How violence can be extinguished and non-violence can be reinforced.		• Develop training curriculum for all direct care staff on basic conflict resolution • Implement Multistage Crisis Intervention to include assignments and interventions (to be developed) • See Youth Incentive Program Recommendations
3. Facilitate a peer culture of non-violence that identifies group goals and rewards peaceful interaction.		• Currently addressed in the Violence Reduction Committee • See Youth Incentive Program Recommendations
4. For two Youth who have had conflict and committed to non-violence, structure participation in a joint activity that both can enjoy.		• See progressive crisis intervention recommendations

5. Role model effective conflict resolution skills for the Youth; resolve conflicts in front of the Youth and identify skills used.		• Refer to Training Recommendations
6. Train and coach staff members on effective conflict resolution techniques. **[Consider the existing LETRA training curriculum.]**		• Refer to Training Recommendations
3.2 Staff members did not de-escalate conflicts using alternative interventions other than unstructured dialogue.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, implement an *Incentive Program* for reducing force incidents; reward staff members for using alternative interventions.		• We have current expectations for supervisors to recognize positive job performance by use of verbal and written reinforcements • See recommendations for Youth Incentive Program
2. Discourage the use of the generic term "dialogue" in reports; require staff members to document the specific interventions used, whether the techniques used are *Motivational Interviewing*, praise, clarification of consequences, forced choice, etc.		• Refer to Documentation Recommendations
3. Use proximity when intervening; for example, when safe to do so, staff members should move to a position between Youth in conflict and/or remove Youth from the line of violence.		• Refer to Training Recommendations
4. Train and coach staff members on how to use alternative interventions to manage conflicts.		• Refer to Training Recommendations
5. Train and coach staff members on basic behavioral principles like praise, reinforcement and extinction.		• Already completed in Motivational Interviewing training
3.3 Staff members did not intervene effectively to de-escalate conflicts among gang involved Youth.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Review the *Gang Charter* within the *Division of Juvenile Justice* and implement an effective, evidenced-based *Gang Intervention* strategy. ***[Look to literature and research on integrating segregated groups.]***		• Waiting for University of California, Irvine workgroup recommendations
2. Work with gang involved Youth to develop aspects of their identity other than gang affiliation; help gang involved Youth explore alternative, pro-social ways to get their needs met.		• Currently addressed in Project IMPACT

3.4 Staff members did not modify intervention strategies consistently to meet the individual needs of Youth with Disabilities and Mental Health issues.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, issue an official statement that when intervening with a Youth with a *Mental Health Designation* or an identified disability, chemical agents should not be used as a daily management tool; provide training and coaching.	9. Chemical restraints should not be used on youth with mental health disabilities in MH units unless the staff or other youth are in imminent danger of serious physical injury. "Imminent danger of serious physical injury" should be properly defined to include only those rare occasions where it truly applies. Chemical restraints should not be used on youth mental health disabilities in MH units who are involved in "single-youth incidents" (i.e., incidents that do not directly involve another youth) under any circumstances.	• Not a safe practice to eliminate chemical agents • Chemical Agents will not be used for single youth incidents, female youth incidents and incidents involving youth on mental health living units unless staff or youth are in imminent danger (serious bodily harm to youth or staff) or with a security supervisor's approval. • See Training Recommendations for Controlled Use of Force • Policy Changes recommended
2. Within 30 days, identify accommodations for every Youth with a *Mental Health Designation* or an identified disability in each *Crisis Prevention Support Plan*. If not specified, require that a Mental Health Clinician identify appropriate accommodations.		• See recommendations for Crisis Prevention Support form change
3. Within 30 days, for a Youth with an identified disability, include the *Youth with Disabilities Coordinator* on the *Treatment Team*.		• Disagree. The Wards with Disability Coordinator can be available for consultation if needed workload issue
4. When intervening with a Youth with a *Mental Health Designation* or an identified disability, amend the *Crisis Prevention and Management Policy* to emphasize safe passage of time and patient interaction rather than reliance on force.	2. UOF policies must dictate the use of the less restrictive restraint options and staff must justify escalation of force. UOF policies should specifically review the circumstances in which more patience with mentally ill youth or not responding to less serious misconduct is the preferred staff response.	• Currently in Use of Force policy • See Training Recommendations
5. Train and coach staff members on meeting the special needs of a Youth with a *Mental Health Designation* or an identified disability in the following areas: • *Basic Behavioral Principles* • *Communication Techniques* • *Crisis Intervention* • *Conflict Resolution*		• See Training Recommendations

• *Factors to Consider in Assessing Imminent Threat* • *Alternative Interventions* • *Warning Signs and Events that Precipitate Force* • *Preventing, Identifying and Working Through Power Struggles* • *Affects of Psychotropic Medications on Youth Behavior*; emphasize the potential impact during stressful events like force incidents.		
3.5 Transitional events, transfers and movements were vulnerable times for Youth that triggered behaviors which led to non-compliance and conflict.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 6 months, implement an evidence-based policy on management of transitions, transfers and movements, including special provisions for a Youth with a *Mental Health Designation* or an identified disability; deliver training and provide coaching as necessary. *[Look to the literature and research on anxiety management.]*		•Conduct training to all direct care staff on assisting youth with transitions, transfers and movements. We will continue to utilize case staffing and large group structure to assist youth during these times. •Current recommended training plan addresses areas of effective youth management
3.6 Youth were not reintegrated constructively into the correctional community after conflicts occurred.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, implement a standardized *Youth Integration Process* based upon relevant research and literature; provide training and coaching as necessary.		•See recommendation on Progressive Crisis Intervention
2. Maintain positive programming throughout the correctional community. • Structure activities throughout the day. • Follow a consistent schedule. • Utilize common rehabilitative language. • Develop an effective token economy. • Enforce communal rules and expectations.		•See Youth Incentive Recommendations •See Training Recommendations
3. Educate Youth on the legal ramifications of hurting others in the correctional community, including other Youth, staff members and citizen volunteers.		•Already do this during orientation of all youth

IV. USE OF FORCE		
4.1 When Youth covered room windows, inconsistent procedures were used to intervene.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, amend the Crisis Prevention and Management Policy to include a standardized protocol for intervening with Youth who cover room windows; deliver training as necessary. • Develop the policy using an Interdisciplinary Team that includes representatives from Mental Health, Medical and Juvenile Facilities. • Emphasize avoidance of force; when force is used, the policy should stress using the least amount necessary. • Clearly define the rules that govern the removal of Youth clothing. • Include special provisions for a Youth with a Mental Health Designation or an identified disability.		• Addressed in revised Safety and Security Standards I & C 1800 section • Already supported in Use of Force policy • Already supported in Use of Force policy • Recommended Use of Force policy change to define provisions for removal of clothing • Already supported in Use of Force policy
4.2 Force was used to effect custody or gain compliance with a lawful order when a single Youth was not an immediate danger to others.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, issue an official statement that chemical agents shall not be utilized in situations involving a single non-compliant Youth.	9. Chemical restraints should not be used on youth with mental health disabilities in MH units unless the staff or other youth are in imminent danger of serious physical injury. "Imminent danger of serious physical injury" should be properly defined to include only those rare occasions where it truly applies. Chemical restraints should not be used on youth mental health disabilities in MH units who are involved in "single-youth incidents" (i.e., incidents that do not directly involve another youth) under any circumstances.	• Not a safe practice to eliminate chemical agents • Chemical Agents will not be used for single youth incidents, female youth incidents and incidents involving youth on mental health living units unless staff or youth are in imminent danger (serious bodily harm to youth or staff) or with a security supervisor's approval. • See Training Recommendations for Controlled Use of Force • Policy Changes recommended
2. Within 30 days, require that the Director of Juvenile Facilities conduct a special review and		• See above recommendation on chemical agents

report to the Chief Deputy Secretary any deviation from policy regarding a single non-compliant Youth, with consideration given to those rare incidents involving serious assault on a staff member, use of a deadly weapon and escape.		
3. Within 90 days, amend the *Crisis Prevention and Management Policy* to provide that chemical agents shall not be utilized in situations involving a single non-compliant Youth; provide training as necessary.		• Not a safe practice to eliminate chemical agents • Chemical Agents will not be used for single youth incidents, female youth incidents and incidents involving youth on mental health living units unless staff or youth are in imminent danger (serious bodily harm to youth or staff) or with a security supervisor's approval. • See Training Recommendations for Controlled Use of Force • Policy Changes recommended
4. Require that the *Inter-disciplinary Treatment Team* review and adjust the *Individual Treatment Plan* for every Youth involved in multiple force incidents.		• Agree- this will be added to recommendations for interdisciplinary treatment team meetings
5. Train and coach staff members on preventing, identifying and working through power struggles.		• See Training Recommendations
6. Train and coach staff members on communication techniques to employ throughout the continuum of force options.		• See Training Recommendations
7. Train and coach staff members on when and how to ask a co-worker for assistance in preventing further escalation of a Youth in crisis.		• See Training Recommendations
4.3 Chemical agents were applied to Youth repeatedly when not effective.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, require that the Superintendent and Senior Psychologist conduct a special review of any incident involving three or more applications of chemical agents to the same Youth and when necessary, take appropriate corrective		• See recommendations in Force Review Committee

action.		
2. Educate staff members on transference and counter-transference.		• See Training Recommendations
3. Encourage the use of the "*Tap-out Strategy*" in which colleagues assist co-workers in exiting interactions where they are contributing to the escalation of a Youth in crisis.		• See Training Recommendations • Already in current Use of Force policy
4. Train and coach staff members on using the least restrictive force option necessary to affect custody.		• See Training Recommendations • Already in current Use of Force policy
4.4 Controlled Force procedures were implemented rarely; instead staff members relied upon Immediate Force.		

UOF Report Policy, Practice and Training Recommendation	Expert Recommendations	UOF Implementation Team Recommendation
1. Within 30 days, enforce the *Crisis Prevention and Management Policy* regarding authorization for *Immediate Force*; provide training as necessary.		• See Training Recommendations • See Use of Force policy revisions recommendations
2. Within 30 days, enforce the *Crisis Prevention and Management Policy* regarding authorization for *Controlled Force*; provide training as necessary.		• See Training Recommendations • See Use of Force policy revision recommendations
3. Within 6 months, amend *Crisis Prevention and Management Policy* to reflect a continuum of interventions. Ensure the amended policy contains an array of interventions; include *Immediate Force* as the most restrictive intervention and other methods, such as time out, loss of privileges, time in safety area or zone as well as *Controlled Force*, as other viable options.	11. More staff training on the use of alternative dispute resolution with mentally disabled youths, and staff must be required to document their use of these alternative methods in UOF situations. DJJ should enhance staff training on behavior analysis and youth skills training, with an emphasis on how to de-escalate conflict situations. This training should be part of the IBTM approach but must be adapted to the special needs of mentally disabled youth. The reviews must address potential behavioral interventions that might have obviated the UOF. The UOF incident and review needs to be incorporated into the youth's treatment plan.	• Policy does not need changes, this is already in place • See Training Recommendations • Use of Force policy revision recommendations
4. Within 6 months, amend the *Crisis Prevention and Management Policy* to address barriers to implementing *Controlled Force*; survey staff members to identify ways to improve the current protocol.		• Don't feel survey would give you the information needed- refer to Violence Reduction Committee for input ideas
5. Train and coach staff members on factors to consider in assessing imminent threat, including intent, means, opportunity and ability to cause great bodily injury or death.		• See Training Recommendations
4.5 Chemical agents were used when physical strengths and holds may have been a viable alternative force option.		
UOF Report Policy, Practice and Training Recommendation	Expert Recommendations	UOF Implementation Team Recommendation
1. Within 30 days, in an effort to reduce the use of chemical agents, when physical force is a viable force option, encourage the use of physical strengths and holds.		• Focus will be on prevention force areas in training in efforts to reduce chemical agents

2. Within 6 months, conduct a pilot project that removes the use of chemical agents on a *Mental Health Unit*.		• See recommendations for Program Recommendations

V. HEALTH CARE SERVICES		
5.1 Medical care and reporting of Youth injury were inconsistent.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, enforce the *Access to Care Policy*, especially timeliness of services.		• Policies already in place to support this
2. Standardize *Section Five* of the *Use of Force* form (YA 8.412) completed by *Health Care Services* after each force incident. At a minimum, *Section Five* should include: • Youth name, identification number, sex and age. • The date and time of the incident, evaluation and treatment. • The location where medical treatment was provided. • Whether the Youth has a *Mental Health Designation* or an identified disability. • Any accommodations provided, including a *Staff Assistant*. • Medications prescribed. • A *Youth Statement* describing the incident and how any injuries occurred. • A *Body Profile*, front and back, which charts each injury. • Description and extent of any injuries sustained. • Medical treatment rendered and disposition. • Any refusal for medical examination and/or treatment. • Names of every: o Officer who escorted the Youth to the *Outpatient Housing Unit*. o Health Care Professional who conducted the evaluation. o Health Care Professional who completed the form.	6. Supplemental UOF reports should be developed that report on mental health or medical interventions that occur immediately after the incident.	• Modify section 5 of the Use of Force report

3. Enforce documentation requirements governing Health Care Professionals contained in the *Immediate and Controlled Use of Force Written Report Requirement* section of the *Crisis Prevention and Management Policy.*		• Supported in Use of Force policy- we have current expectations for supervisors
4. Enforce requirements in the *Crisis Prevention and Management Policy* for documentation of any Youth injury observed and the cause of said injury, if known, on a *Behavior Report* [*Serious Misconduct* (DJJ 8.403A) or *Supplemental* (YA 8.402)] and *Use of Force* form (YA 8.412).		• Already a process in policy to review reason for injury
5. As misdiagnosing might impede access to care, ensure that documentation of any Youth injury by an employee other than a licensed *Health Care Professional* is limited to observations.		• Supported in Use of Force policy
6. In the *Watch Commander Review*; Section 1 and the Superintendent / Assistant Superintendent / Designee Review; Section 3, of the *Use of Force Incident Review* form (DJJ 8.440), without an eyewitness account of a specific injury or concurrence from a physician, limit documentation of Youth injuries to observations; in the interest of decreasing inconsistencies in documentation, refrain from making judgments about whether injuries observed were due or not due to force.		• Agree- It is not within the scope of Health Care Services to investigate whether an injury was a result of force
7. Ensure that relevant *Youth Statements* given to Health Care Professionals post incident are communicated appropriately to living unit staff members.		• Disagree- could lead to investigation in staff misconduct
8. Hold staff members accountable for responding to Youth injuries, in accordance with their duties, roles and qualifications; deliver training as necessary.		• Policy already supports response to the youth
5.2 Force was used on Youth who had engaged in self-injurious behavior with no immediate intervention by a Mental Health Clinician.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, issue an official statement requiring immediate intervention by a Mental Health Clinician when force is being considered with a Youth who has engaged in suicidal or self-injurious behavior.	4. All incidents of youth engaging in self-injurious behavior should be immediately referred to a psychological counselor for intervention.	• Already in Use of Force policy • For Controlled Use of Force a clinician is to be contacted prior to the authorization of force (see Use of Force Policy changes)

2. Within 6 months, amend *Crisis Prevention and Management Policy* to include immediate intervention by a Mental Health Clinician when force is being considered with a Youth who has engaged in suicidal or self-injurious behavior.		• Already in Use of Force policy • For Controlled Use of Force, a clinician is to be contacted prior to the authorization of force (see Use of Force policy changes)
3. Train and coach Mental Health Clinicians and Correctional Peace Officers on effective interventions with self-injurious Youth that include the following modes of treatment: • Individual therapy. • Skills training. • Living unit support. • Staff member conferencing.		• Included in Training Recommendations • These areas of training are covered in the training on intervention strategies

VI. DOCUMENTATION		
6.1 Use of Force Reports did not sufficiently describe force incidents, contained conflicting information, omitted details and were redundant.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, ensure that every staff member, including Mental Health Clinicians, who observes, intervene, or is involved in a force incident, completes the appropriate reports; provide training as necessary.		• Already in Use of Force policy for all involved to complete Behavior Report • See Training Recommendations
2. Within 30 days, amend the *Crisis Prevention and Management Policy* to include a standard definition of force that excludes the application of authorized restraint equipment to a compliant Youth.		• Already have standard definitions in Use of Force policy
3. Within 9 months, revise the standards for *Use of Force* and *Behavior Reports*; provide training as necessary to any staff member who has interactions with Youth. At a minimum, ensure that each *Use of Force* or *Behavior Report*: • Date, time, location • Reviewed the *Crisis Prevention Support Plan* for a Youth for controlled UOF • Describes the behavior of the Youth and the circumstances that necessitated using force. • What strategies used to de-escalate and manage the behaviors of a Youth prior to, during and after a force incident if time permits • Cites the location and number of staff members and other Youth in the area at the time of the incident. • Indicates whether the living unit was on modified program and why. • Indicates whether a personal alarm was activated. • Cites the number and type of verbal instructions given prior to force. • Identifies the force used or observed, including the type, number of applications and duration of	8. UOF reviews need to be enhanced to include more information of the proximate events that led to the incident, what preventive steps were taken, and which staff were consulted to resolve the issue.	• Modify Use of Restraint Form to include additional items • See Use of Force policy recommendations

chemical agents. • Indicates whether a Youth was seen by a Registered Nurse, or designated medical personnel, for assessment after the incident. • Identifies the length of decontamination shower, whether clean clothes were provided and by whom. • Indicates whether a *Suicide Risk Screening Questionnaire* was conducted if place on tip (?) • Indicates the reasons for clothes removal from a Youth, if applicable. • Indicates whether a Youth was placed in the *Temporary Intervention Program.* • Describes involvement of any Mental Health, LPT,CWS Clinicians prior to, during and after the force incident. • Indicates whether the incident was gang related. • Indicates whether the Youth has a *Mental Health Designation* or an identified disability. • Indicates whether reasonable accommodations, including a *Staff Assistant* were provided. (if time permits) • Report is signed and dated correctly • Describe type of force used, amount used and distance deployed		
4. Implement a standardized *Use of Force Report* protocol system-wide; provide training as necessary. Noted elements missing from the current protocol include: • Separate *Medical* and *Mental Health* sections. • An *Incident Summary* prepared by the Watch Commander. • Identification of salient factors that preceded and followed a force incident. • Identification of each *Basis for Application of Force* that applies. • Designation of any section deemed inapplicable as such.		• Recommendation to modify the Use of Force Report

VII. DEBRIEFING		
7.1 After using force, incidents were not debriefed consistently.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. *Within 6 months, require that force incidents are debriefed according to standardized policy and procedures; deliver training as necessary. Ensure the policy and procedures require: • A representative sample of force incidents, including those stemming from one-on-one fights, assaults, noncompliance, self injuries, group disturbances and property destruction are debriefed at each facility annually. • Staff members attend the debriefings from every discipline whose work directly or indirectly affects the Youth involved in the force incidents being discussed. • The experience from the perspective of the Youth is represented; prior to selected debriefings, interviews are conducted with each Youth involved in the force incidents being discussed. • Both positive and negative aspects of the force incidents are analyzed. • Development of *Corrective Action Plans*, including accountability measures, to address the negative aspects of the force incidents is discussed. **Ensure that policy and procedures are developed based upon relevant research, literature review and recognized Best Practices.*		• Proposed Force Review Committee recommendations will enhance support and management's ability to review Use of Force incidents and provide timely and effective feedback to staff participants/witnesses in a Use of Force incidents • See above • Disagree- don't feel necessary for process policy in place for staff misconduct • Agree- see above recommendation for Force Review Committee changes • Disagree- Superintendent will review to deal with accountability measure

VIII. TRACKING SYSTEM		
8.1 The Use of Force Tracking System could not accurately account for the incidents of force that occurred during the sample period.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. During development of the standardized *Use of Force Tracking System*, implement an interim monitoring process for ensuring the *Southern Reception Center and Clinic* adequately tracks force incidents.		• As of October 2010 reconciliation occurs monthly for all Division of Juvenile Justice facilities Use of Force incidents
2. Within 6 months, implement a standardized *Use of Force Tracking System* with controlled numbering to ensure every *Behavior Report* is reviewed and matched with a *Use of Force Report* when force is used; amend the *Crisis Prevention and Management Policy* accordingly and deliver training as necessary.		• The current Ward Information Network generates a Disciplinary Decision Making System case number that also identifies Use of Force report number
3. Adopt a *Use of Force Database* similar to the one operating at *O.H. Close* for all facilities statewide.		• See Use of Force Data Base recommendations

IX. QUALITY ASSURANCE		
9.1 The Force Review Process was ineffective, redundant and produced inconsistent outcomes.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 90 days, review force incidents with every Youth at each *Case Conference*; update the *Crisis Prevention Support Plan* accordingly.		• Already addressed earlier in Crisis Prevention Support recommendations
2. Expand the scope of *Use of Force Reviews* beyond policy compliance to include identifying *Best Practices*.		• Already addressed in Force Review Committee recommendations
3. Require the inclusion of *Serious Incident Reports* in *Use of Force* packets.		• Agree- but only if Serious Incident Report was generated
4. Revise *Force Review Process* to increase efficiency and effectiveness; include flowchart. *[Please refer to the "Report of Site Visits to the California Department of Juvenile Justice Force Review Committees: Observations and Recommendations," submitted March 4, 2011, by Michael Gennaco, Expert to the Special Master.]*		• Agree- see Force Review Committee recommendation
9.2 Force reviews were not reflective of an inter-disciplinary process for decision-making, relied upon incomplete documentation to make decisions, did not address potential behavioral interventions that might have obviated the need to use force and were not based upon established standards and criteria as to what necessitates Immediate versus Controlled force.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Within 30 days, require that Health Care Professionals participate fully in *Institution Force Review Committee* meetings and document insights on the *Force Committee Review and Analysis Form* (DJJ 8.443).		• Agree- any cases discussed that involve staff discipline, non-supervisory staff are to be excused • See Force Review Committee recommendations for Health Care participation
2. Within 30 days, require that Mental Health Clinicians participate fully in *Institution Force Review Committee* meetings and document insights on the *Force Committee Review and Analysis Form* (DJJ 8.443).		• Agree- see above
3. If documentation is missing or an incident warrants investigation, require that *Force Review Committees* at the facilities suspend the process until all of the information is obtained or the investigation is completed.		• Agree- revision to Use of Force policy to add "if documentation is missing" (pg. 10 Use of Force policy)

4. Amend *Crisis Prevention and Management Policy* to include a requirement that the *Force Review Committees* at the facilities discuss potential behavioral interventions that might have obviated the need to use force.		• Addressed in Force Review Committee recommendations
5. Require that *Force Reviews* be based upon established standards and criteria as to what necessitates *Immediate* versus *Controlled* use of force.		• See Use of Force policy changes • Refer to Training Recommendations
6. Require that every attendee at a *Force Review Committee* meeting is documented on the *Force Review* form.		• Agree- see Force Review Committee/Division Force Review Committee recommendations • Use of Force policy change and standardize form
7. Request that the *Office of the Inspector General* re-examine its protocol, procedures and resources to ensure effective oversight of force, including overall reduction in incidents and focused attention upon Youth with a *Mental Health Designation* or an identified disability.		• Evaluate Office of Inspector General protocols to determine if appropriate
9.3 Force reviews did not focus upon how to prevent future incidents or ways to improve.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Require Facility and Division-level *Quarterly Qualitative Force Reviews* be conducted using a inter-disciplinary team approach where trends, patterns, and best practices are identified; as necessary provide training, request *Corrective Action Plans* and make systems changes. At a minimum, ensure the following occurs: • Forums for including the perspectives of Youth, families, and the community into the Quarterly Qualitative Review process are identified. • Ways to reduce the amount of force used with Youth who have a *Mental Health Designation* or an identified disability are examined. • Preventive steps and antecedent events, including staff members consulted, are included in discussions when reviewing specific force incidents. • Participants in *Quarterly Qualitative Force Reviews* and those who serve on *Violence Reduction Committees* share outcomes with each other.	7. The UOF review process needs to be revised to assist DJJ in reducing the amount of force used in mental health units. Multiple perspectives including those on non-security staff and youth should be incorporated in these reviews.	• Use of Force policy change for Departmental Force Review Committee to address best practices, trends and patterns • Disagree-current practice for quarterly family counsel provides opportunity for input • See Training Recommendations • See recommendations for Force Review Committee/Departmental Force Review Committee Recommendations

X. ACCOUNTABILITY		
10.1 Recommendations from the Department Force Review Committee were sometimes disregarded.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Ensure that Executive-level management actively monitors facility responses to recommendations issued by the *Department Force Review Committee* and when necessary; oversees the development of *Corrective Action Plans*.		• Already in current practice with Departmental Force Review Committee
2. Ensure that ten percent of incidents reviewed by the *Department Force Review Committee* are selected based upon established criteria. At a minimum the criteria should include: • Self-injurious behaviors and suicide attempts. • Serious injuries sustained by a Youth or a Staff Member. • Allegations of excessive or unnecessary force. • Single Youth Incidents. • Multiple applications of chemical agents. • Use of chemical agents on a Youth with a *Mental Health Designation* or an identified disability.		• Agree • Departmental Force Review Committee will adopt the 6 types of incidents identified for review-See Force Review Committee/Departmental Force Review Committee recommendations
10.2 Training, Corrective Action and Discipline related to force incidents was administered inconsistently.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Amend the *Crisis Prevention and Management Policy* to include a standardized process for implementing employee training, corrective action and discipline related to force incidents that is in line with the *Department Operations Manual*; as necessary, deliver refresher training to managers and supervisors on the *Progressive Discipline Policy* and the revised *Crisis Prevention and Management Policy*.		• Agree- we recommend that Division of Juvenile Justice follow established employee discipline in the Departmental Operations Manual chapter 3 article 22 • See training recommendations for Employee Progressive Discipline and Use of Force policy changes

XI. STAFFING		
11.1 Shifting staff members on living units interferes with the delivery of intervention strategies and treatment approaches; the practice hinders trust being established among colleagues which is foundational to forming strong collaborations and partnerships.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Eliminate the shift and bid process at each facility.		• Agree- but not likely due to recent Bargaining Unit contract
2. Maintain stable and consistent staffing on every living unit at each facility.		• Managers meet monthly with scheduler to maintain unit staffing consistencies
11.2 Mental Health Clinicians were not available to act as equal partners with custody staff when intervening in conflicts or force incidents during all shifts, including weekends and holidays.		
UOF Report Policy, Practice and Training Recommendation	**Expert Recommendations**	**UOF Implementation Team Recommendation**
1. Require that the primary work location for a Mental Health Clinician be on a living unit at a facility.		• Agree when possible, but due to office shortages not always possible
2. Require that at least one Mental Health Clinician be at the facility during the hours of 0600 through 2200 on weekdays, weekends and holidays.		• Rotational shifts to accommodate 8am-9pm Monday-Friday. Holiday and weekend coverage for clinicians will be on call coverage as noted and can be called to the facility for Suicide Prevention Assessment and Response, Use of Force or any Mental Health Crisis
3. Require that any Mental Health Clinician involved with an incident that commences but does not end prior to 2200 hours, sees the intervention through completion via working late and/or transitioning care to another Mental Health Clinician.		• Agree- Rotational shifts to accommodate 8am-9pm Monday-Friday. Holiday and weekend coverage for clinicians will be on call coverage as noted and can be called to the facility for Suicide Prevention Assessment and Response, Use of Force or any Mental Health Crisis
4. Require that a Mental Health Clinician be on-call and available over the telephone and in person during the hours of 2200 through 0600 on weekdays, weekends and holidays.		• Currently Psychiatrists are on call 1700-0800 7 days a week • Currently Psychologists are on call Friday 1700-Monday 0800 and holidays

31% Youth Involved in Multiple Incidents

Count of Youth	*Total Incidents*
1	9
1	7
1	6
9	5
21	4
44	3
96	2

There were 561 youth involved in 245 incidents. Of those, 388 were involved in just one incident and 173 were involved in multiple incidents.

Incidents Involving Force

Facility	*Total Incidents*	*Percent Incidents*	*Total Youths*	*Average# of Youths*	*Average Age of Youth*	*Total Staff*	*Average# of Staff*	*Out of Policy Before UOF*	*Out of Policy During UOF*	*Out of Policy After UOF*
CHAD	61	24.9%	126	2.1	18.4	230	3.8	8%	7%	80%
OHC	38	15.5%	170	4.5	16.2	247	6.5	0%	0%	11%
PYCF	57	23.3%	332	5.8	17.7	465	8.2	4%	2%	11%
SR	18	7.3%	54	3.0	16.4	56	3.1	6%	0%	22%
VYCF	71	29.0%	181	2.5	17.9	318	4.5	4%	0%	25%
Totals:	**245**	**100%**	**863**			**1316**				

Incidents involving chemical agents and youth with mental health designation: 121 *49%*
Total Incidents: 245

Living Unit Summary

	Total	*Pecent*
Different Living Unit	167	68%
Same Living Unit	78	32%
Total Incidents	245	100%

Most incidents requiring force involved youths from different living units.

CHAD

Living Unit	*Total*
Sacramento	41
American	31
Kern	19
McCloud	10
Feather	9
Mojave	5
Smith	3
San Joaquin	2
Pajaro	2
Unknown	1
Tuolumne	1
Merced	1
Archive	1
Youths Involved:	126

OHC

Living Unit	*Total*
Del Norte	65
Calaveras	23
Eldorado	22
Glenn	20
Fresno	19
El Dorado	6
Butte	5
Humboldt	5
Unknown	3
Inyo	2
Youths Involved:	170

PYCF

Living Unit	*Total*
Ironwood	73
Sequoia	61
Buckeye	45
Oak	37
Manzanita	30
Redwood	28
Mazanaita	20
Hawthorne	13
Ponderosa	11
Fir	5
Arbor	5
Evergreen	4
Youths Involved:	332

SR

Living Unit	*Total*
Pico	24
Sutter	7
Cabrillo	6
Marshall	6
Gibbs	5
Drake	4
Marshal	2
Youths Involved:	54

VYCF

Living Unit	*Total*
CLC	52
Montecito	21
Alborado	17
CDC	17
BV	12
MV	11
MC	10
AV	7
MM	6
Mira Mar	6
Monte Mira	4
Monte Vista	4
Alta Vista	4
ML	4
El Mirasol	2
El Toyon	1
CDA	1
Mira Monte	1
OHU	1
Youths Involved:	181

Summary of Youths Involved in Force

Facilities	Incident Type	Incidents	Youths Involved	FORCE USED Chemical	Physical	Mechanical	Youth Injury	CP Plan	MENTAL HEALTH SERVICES Out Pt.	Meds	MHU	SSR	YWD List	YWD or MH Total	%	Average Age
ALL	(No Data)	1	1	0	0	0	0	1	1	1	0	0	0	1	100%	
	1 on 1 Fight	110	213	193	31	8	0	77	35	55	59	18	53	122	57%	17.4
	2 on 2 Fight	5	16	15	1	0	0	4	6	1	0	0	1	7	44%	19.4
	Destructive Behavior	2	2	1	2	0	1	0	0	0	1	0	0	1	50%	18.0
	Escape Attempt	1	1	0	1	0	0	1	1	1	0	0	1	1	100%	16.0
	Group Disturbance	49	514	495	7	4	0	102	103	75	35	15	87	206	40%	17.3
	Non-Compliance	32	32	7	24	9	3	23	6	6	20	9	17	28	88%	16.9
	Other	3	3	0	0	0	0	1	0	2	3	2	0	3	100%	19.0
	Self Injury	9	9	0	9	2	0	8	0	7	9	6	4	9	100%	16.3
	Staff Assault	6	7	1	6	0	1	5	1	4	6	2	5	7	100%	18.1
	Staff Assault, Attempted	1	2	2	1	0	0	1	0	2	2	0	2	2	100%	17.0
	Suicide Gesture	2	2	0	2	1	0	2	0	1	2	1	1	2	100%	17.0
	Youth Assault	22	58	40	18	6	0	12	2	15	24	2	13	29	50%	17.5
	Youth Assault, Attempted	2	3	3	0	0	0	2	2	0	0	1	0	2	67%	19.3
	Totals:	**245**	**863**	**757**	**102**	**30**	**5**	**239**	**157**	**170**	**161**	**56**	**184**	**420**	*48.7%*	
CHAD	1 on 1 Fight	26	49	47	3	0	0	36	2	24	29	7	14	36	73%	18.2
	2 on 2 Fight	2	5	5	0	0	0	3	0	0	0	0	1	1	20%	23.6
	Destructive Behavior	1	1	0	1	0	0	0	0	0	1	0	0	1	100%	18.0
	Group Disturbance	6	41	27	0	1	0	24	6	12	14	7	13	28	68%	18.5
	Non-Compliance	16	16	3	12	2	2	14	2	2	11	5	9	14	88%	17.4
	Other	3	3	0	0	0	0	1	0	2	3	2	0	3	100%	19.0
	Self Injury	1	1	0	1	0	0	1	0	1	1	1	1	1	100%	17.0
	Staff assault	4	5	0	5	0	1	4	0	3	5	1	4	5	100%	17.2
	Youth Assault	2	5	2	1	0	0	3	0	0	3	0	2	4	80%	19.0
	Totals:	**61**	**126**	**84**	**23**	**3**	**3**	**86**	**10**	**44**	**67**	**23**	**44**	**93**	*73.8%*	
SR	1 on 1 Fight	13	26	21	5	4	0	0	4	4	4	0	4	9	35%	16.5
	Group Disturbance	1	18	18	0	0	0	1	6	6	0	1	3	9	50%	16.1
	Non-Compliance	2	2	1	2	1	0	0	0	0	2	0	1	2	100%	18.0
	Youth Assault	2	8	2	4	2	0	0	0	5	7	2	4	7	88%	16.6
	Totals:	**18**	**54**	**42**	**11**	**7**	**0**	**1**	**10**	**15**	**13**	**3**	**12**	**27**	*50.0%*	

Use of Force Review

Summary of Data Used in the Quantitative Analysis

Facilities	Incident Type	Incidents	Youths Involved	FORCE USED Chemical	Physical	Mechanical	Youth Injury	CP Plan	MENTAL HEALTH SERVICES Out Pt.	Meds	MHU	SSR	YWD List	YWD or MH Total	%	Average Age
OHC	(No Data)	1	1	0	0	0	0	1	1	1	0	0	0	1	100%	
	1 on 1 Fight	19	35	35	2	0	0	24	6	13	11	0	10	26	74%	15.9
	2 on 2 Fight	1	3	3	0	0	0	1	2	1	0	0	0	2	67%	16.0
	Escape Attempt	1	1	0	1	0	0	1	1	1	0	0	1	1	100%	16.0
	Group Disturbance	11	122	120	3	1	0	56	20	31	16	0	14	50	41%	16.3
	Non-Compliance	2	2	0	1	1	0	2	1	1	0	0	0	1	50%	14.5
	Youth Assault	3	6	6	0	0	0	4	1	4	3	0	2	5	83%	16.2
	Totals:	**38**	**170**	**164**	**7**	**2**	**0**	**89**	**32**	**52**	**30**	**0**	**27**	**86**	*50.6%*	
PYCF	1 on 1 Fight	27	52	52	3	0	0	9	16	6	0	5	7	21	40%	18.0
	2 on 2 Fight	1	4	4	0	0	0	0	0	0	0	0	0	0	0%	18.3
	Group Disturbance	22	263	263	1	0	0	19	65	20	1	5	42	95	36%	17.6
	Staff assault	1	1	1	0	0	0	0	1	0	0	0	0	1	100%	22.0
	Youth Assault	4	9	9	3	0	0	3	1	1	0	0	0	1	11%	18.1
	Youth Assault, Attempted	2	3	3	0	0	0	2	2	0	0	1	0	2	67%	19.3
	Totals:	**57**	**332**	**332**	**7**	**0**	**0**	**33**	**85**	**27**	**1**	**11**	**49**	**120**	*36.1%*	
VYCF	1 on 1 Fight	25	51	38	18	4	0	8	7	8	15	6	18	30	59%	18.3
	2 on 2 Fight	1	4	3	1	0	0	0	4	0	0	0	0	4	100%	19.8
	Destructive Behavior	1	1	1	1	0	1	0	0	0	0	0	0	0	0%	18.0
	Group Disturbance	9	70	67	3	2	0	2	6	6	4	2	15	24	34%	18.0
	Non-Compliance	12	12	3	9	5	1	7	3	3	7	4	7	11	92%	17.8
	Self Injury	8	8	0	8	2	0	7	0	6	8	5	3	8	100%	15.5
	Staff Assault	1	1	0	1	0	0	1	0	1	1	1	1	1	100%	15.0
	Staff Assault, Attempted	1	2	2	1	0	0	1	0	2	2	0	2	2	100%	17.0
	Suicide Gesture	2	2	0	2	1	0	2	0	1	2	1	1	2	100%	17.0
	Youth Assault	11	30	21	10	4	0	2	0	5	11	0	5	12	40%	17.6
	Totals:	**71**	**181**	**135**	**54**	**18**	**2**	**30**	**20**	**32**	**50**	**19**	**52**	**94**	*51.9%*	