SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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

TWENTY-SECOND REPORT OF SPECIAL MASTER

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APPENDICES

I. INTRODUCTION

The Special Master submits for filing the Twenty-Second Report of the Special Master. This report reviews the *Farrell* Education Experts' and the Disabilities Expertôs Comprehensive Reports of their seventh rounds of audits as well as 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 seventh comprehensive report of the Education Experts (site visits, February 2012 to March 2012) and the seventh comprehensive report of the Disabilities Expert (site visits, December 2011 to April 2012) are attached to this report as Appendix A and Appendix B respectively. In addition, the Office of Audit and Court Compliance also conducted a full round of audits and issued an annual report for the Education Services Remedial Plan and for the Ward with Disabilities Remedial Plan, which are attached to this report as Appendix C and Appendix D respectively. Consistent with an agreement by the parties, the Special Masterôs report limits the summarization of the experts' reports and instead identifies the major areas of improvement as well as areas of concern.

The report begins with an update on the implementation of the Integrated Behavioral Treatment Model (IBTM) followed by the analysis of progress in the education and disabilities areas. Issues relating to developments at the Ventura Youth Correctional Facility (VYCF), as well as when and how force is used are discussed next. The report concludes with recommendations regarding full transfer of monitoring of the education and disability remedial plans to Defendant.

II. INTEGRATED BEHAVIORAL TREATMENT MODEL

A. Current Progress

There continues to be good progress on meeting the projected deliverables in the IBTM project plan and there are many examples of Defendant responding to feedback from the *Farrell* Experts, Plaintiff and the Special Master regarding aligning current policy and processes with the IBTM. The IBTM Project Consultants from the University of Cincinnati Corrections Institute (UCCI) submitted a quarterly report that represents a summary of services rendered from February 1, 2012 through April 30, 2012. That report is attached to this report as Appendix E. The UCCI consultantôs review of all nine implementation areas indicates that all plan deliverables (work for the period October 1, 2011 through March 31, 2012 -- months 13 through 18 of the IBTM plan) have been completed. Another indicator of progress is that many of the topics of this report such as work at the VYCF and use of force are now showing signs of greater alignment with the principles of the IBTM.

A notable positive change is the clear awareness and understanding by the Director (A), Michael Minor, that the IBTM should be the framework for all program decision making. The Director understands how difficult it is for staff to grasp why the IBTM is important.[1] Director Minor has appointed a task force to help define the mission and to create a conceptual framework for the IBTM. He has regularly sought input from DJJ staff and the experts in this undertaking. He is also ensuring that senior staff understands the role and function of the IBTM. For example, he is directing all senior leaders in headquarters to attend the entire Crisis Prevention and Management Training

[1] As the former Superintendent of N.A. Chaderjian Youth Correctional Facility, Director Minor fully understands the tumultuous environment that staff has worked in and how difficult this has made it to create and support a unified vision of the future.

that includes elements such as Core Correctional Practices and the Reinforcement System (RS) that are foundational concepts of the IBTM.[2] The Director is demonstrating his support of the IBTM with staff throughout the organizational hierarchy by where he is focusing his attention and his expectation that the staff will learn about the IBTM and begin to align their respective areas of authority and responsibility to it.[3]

IBTM implementation team leadership continues to ensure that time frames for current deliverables are met and is planning for next steps. With just five months left on the current project plan, Defendant is reaching decisions and creating the project plan for expansion of the IBTM beyond the pilot project. Recognition that a robust IBTM includes behavior management and milieu management strategies that support the lessons of the cognitive-behavioral treatment (CBT) components is growing.[4]

Several milestones of the current implementation plan have been met this quarter. The overview provided in this report is not intended to discuss all of the accomplishments in this area. The lack of detail and specificity sometimes fails to create an accurate sense of the complexity and amount of work entailed in several of the areas discussed in this section of the report. The Special Master is well aware of and acknowledges the continued focus, commitment and level of effort Defendant has continued to demonstrate in the implementation of the IBTM.

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[2] *See* e-mail from Tammy McGuire regarding Executive Staff Block Training.

[3] The Special Master again asks that the Director and, at a minimum, Facility Superintendents be approved to visit other state juvenile corrections systems to experience functioning IBTM models. *See* Twenty-First Report of the Special Master, footnote 12.

[4] Current CBT programs include Counter Point and Aggression Interruption Training that are the foundation programs planned for all units. The Sex Behavior Treatment Program also has an excellent evidenced-based cognitive behavioral curriculum for sex offenders. There is also a Healthy Living Curriculum now used only in the Sex Behavior Treatment Program that could be adapted to all units. Finally, a substance abuse curriculum is in the adoption process.

The California Youth Assessment Screening Instrument (CA-YASI) has been integrated in the Ward Information Network (WIN) system. The unified case management system was implemented May 1, 2012 for the entire O.H. Close Youth Correctional Facility (OHCYCF).[5] This is an important step as it allows all the living unit staff and especially the youth correctional counselors to access both assessment and case plan information electronically. It also allows the youth counselors to enter progress notes directly into the case plan. Having a unified case plan that is based on valid risk and need factors allows the relevant staff engaged with youth to better define and develop behavior targets for youth and allows for many disciplines to understand defined behavior targets so they can actively work on reinforcing desired behaviors. Training of staff on the case plan started in April 2012 and will continue through June 2012.

It should be noted that it will take time for staff to learn how to translate the higher level assessment information into meaningful and concrete action steps jointly developed with a youth. Defendant will need to continue to focus on supporting staff to understand the assessment information and how to develop concrete behavior change that youth can understand and engage in. This will require both auditing by Defendant to understand whether staff is able to develop meaningful behavior targets and a support strategy to assist staff in their learning.

The implementation of evidence-based curricula and support components at OHCYCF in all high and low core units are nearly complete. Focus for these units is appropriately on quality assurance activities and milieu management that reinforces

[5] Information regarding the implementation process can be found in CC Protocol 4-11-12.final. Steve Lesch, IBTM Program Coordinator, and Teresa Perez, Program Administrator, developed the information in this document in response to issues raised in the Twenty-First Report of the Special Master.

learning from groups in all unit activities and interactions. As noted by the UCCI consultants, despite the effort to begin to implement elements of the IBTM at other facilities, there must remain coaching, support and quality assurance mechanisms at OHCYCF to ensure continued progress. Unit supervisors and treatment team supervisors must begin to take on more of the quality assurance functions. This will require training and support from the IBTM implementation team. Limited staffing of this unit may be problematic in providing these services.[6]

Work is underway to ensure alignment of IBTM components with the Sex Behavior Treatment Program (SBTP) and implementation of the components into the Behavior Treatment Program (BTP). The implementation team is creating a program for the BTP unit that addresses the problem of the short length of stay interfering with the youthôs ability to complete a lengthy program such as Anger Interruption Treatment (AIT). The team is modifying the pre-treatment sessions combined with additional social skills chosen to address pertinent issues such as aggression and poor decision making to be stand-alone sessions. This much needed program can be used at BTPôs in all institutions. [7] Finally, a significant remaining task is finalizing the OHCYCF Implementation Guide. This guide will be helpful in implementing the evidence-based curricula and support components at other facilities.

Staffing for the IBTM implementation team has improved. Two support staff members have been added to the team and hiring is underway for a Program Specialist (Trainer/Coach). While these are welcome additions to the IBTM implementation team,

[6] Appendix E, UCCI Consultant/DJJ Quarterly Report 4-30-12, pp. 3-4.
[7] *Id*, p. 2. The Special Master has reviewed the draft curricula for the first two units of the new BTP modules. The modules are high quality and focus on the issues related to aggressive behavior that are the reason youth are placed in a BTP.

by no means is the current staffing adequate to ensure true understanding and full implementation of the IBTM in OHCYCF, let alone provide acceptable support for the other two facilities. It is unclear if the team can meet its obligations with the past elimination of 10 positions and the remaining three vacancies.[8]

It is not realistic to expect team members who have other full-time jobs to provide sufficient coaching for staff. At least for a period of two to three years, there is a need for staff who are assigned to do nothing but coach living unit staff how to do things like write a meaningful case plan and/or how to use ñreinforcersò to gain behavior change rather than to rely on just a lack of negative consequences.[9]

Decisions have been made regarding the next implementation sites for this aspect of the IBTM. N.A. Chaderjian Youth Correctional Facility (NACYCF) has been chosen as the next site for implementation.[10] Many of the staff at this complex has already been engaged in various aspects of the IBTM training. The recently appointed Assistant Superintendent of the facility has been an active member of the IBTM implementation team. These factors and proximity to the IBTM implementation team should make the implementation move quickly at this facility. Implementation will begin with the intake unit and one low core unit, which will also handle intake overflow when necessary, followed by high core units, behavior treatment programs, the remaining low core units,

[8] At the April Case Management Conference, a DJJ representative asserted that the staffing decreases reported in the Twenty-First Report of the Special Master are a result of facility closures. It should be noted that three positions assigned to closed facilities were not included in the Special Masterôs calculations.
[9] The true culture change comes only when staff feels secure in their skills and abilities. All staff members are being asked to change how they motivate youth to learn and to change. This type of behavior change on the part of staff requires a significant level of support that is ñextraordinary.ò That is to say support beyond the normal organizational tools of policy, procedure and normal interaction with supervisory staff.
[10] Memo, Projected IBTM Timelines 5 3 12 for Mar 12-Dec 13(1).doc.

and finally the mental health units. Implementation will begin August 1, 2012 with an expected completion date of October 2013.

In December of 2012, implementation will begin at VYCF with a completion date of March 2014. Some IBTM components are projected to begin at VYCF intake and BTP units as early as August 2012. In the VYCF section of this report, work being done in the BTP units will demonstrate some alignment with the IBTM.

B. Issues to be Addressed

In her Twenty-First Report, the Special Master discussed several issues that need to be addressed to ensure effective implementation of the IBTM. Defendant has taken active steps to begin to address *all* of these issues since the last round. As discussed above, the Director's task force on the IBTM mission and vision is addressing the need for clearly defined principles and mission, and the addition of three staff to the IBTM implementation team has begun to address some of the team vacancies.

The Mental Health Expert and DJJ mental health senior leaders are discussing the issue of clarifying the roles and responsibilities of staff to ensure that all staff understands how to reinforce behavior targets for youth. The recently completed DJJ Youth Inventory provides a snapshot of DJJ youth and has served as a platform for discussions regarding the role of mental health staff in core units as well as the beginning work on defining a service delivery model for mental health units.[11] The same group is experimenting with a different staffing model for the VYCF's BTP. All of these efforts should aid in the

[11] *See* PoP 881, Youth Inventory. The Mental Health Experts suggested that an inventory of all DJJ youth be undertaken. The inventory was designed to assist Defendant to decide what mental health services should be provided based on the inventory findings, determine how best to deliver the services and to define the role of the mental health clinician when treating the population identified by the inventory. To define the role of the mental health staff requires a clear role definition of the other living unit staff. Progress on role definition will be discussed in greater detail in future reports of the Special Master.

development of clear roles for mental health, living unit, and management staff with regard to the day-to-day service delivery of an integrated behavioral model.

Defendant has agreed upon an evidence-based substance abuse program and is in the process of contracting with the UCCI to provide support for the implementation process. [12] Mental health senior leaders are actively engaged with the IBTM implementation team in the development of this training.[13]

The Reinforcement System is being piloted in the two IBTM implementation sites, Amador and Butte living units. As with any significant change, staff and youth are struggling to learn how to match positive reinforcement with an identified behavior that is specific to a youthôs desired behavior change. Living unit staff has historically tried to motivate youth through the absence of negative consequences. In other words, if you behave and do not do something to violate a rule, you are rewarded by not receiving a negative consequence. The concept of reinforcing intermediate behaviors that approximate a desired behavior is not yet well understood. That said, it appears youth are beginning to strive to be acknowledged for some positive behavior so they can receive a positive check that can lead to rewards. [14] Equally important, staff are expressing confusion and requesting help. This is a normal and healthy stage of the change process.[15]

[12] The current UCCI contract will be modified to implement the substance abuse curriculum.
[13] Dr. Juan Carlos Arguello has been the lead for the mental health staff on this project. He has kept the Mental Health Expert and the Special Master apprised of progress in this area.
[14] The Special Masterôs understanding of how the introduction of the Reinforcement System in the living units is proceeding is based on a phone conversation with Steve Lesch, Program Administrator, who shared responses from a query to IBTM implementation team staff members and treatment team staff in the living units.
[15] Helping staff to understand how to use a Reinforcement System is a task well suited to psychologists who have training in cognitive behavioral change strategies. Ideally, psychologists could be coaches for staff on units and help staff develop the skills and knowledge to use positive reinforcement strategies. This may also be a way to bolster the diminished resources of the IBTM implementation team.

Training on the Reinforcement System is part of the block training both custody and non-custody staff is currently undergoing. The Core Correctional Practices training that is also part of the block training also supports behavioral management concepts that rely on positive reinforcement strategies as well as use of negative reinforcement and consequences. Both trainings were created or modified by the IBTM implementation team and, as such, build on the principles of the IBTM.

Defendant has also taken steps to begin to address the unacceptable level of time that youth spend in unstructured activities like watching television. As of April 15, 2012, Defendant ensured that all youth who are high school graduates and/or who have a General Educational Development Certificate (GED) have either an educational, vocational or a work assignment. Each facility created a committee that both identified youth in need of an assignment and ways to create more viable placement options.[16] Headquarters staff have now visited each facility and interviewed a sample of youth[17] to determine if they are engaged in their assignments. Headquarters staff has been assigned to continue assessing both the availability of options for high school graduates/GED holders, the support for placement and the quality of the placements. Changes are planned for the WIN system to make documentation of such placements easier for living unit line staff.

Longer-term options to reduce the idleness of youth include the development of free venture programs at more facilities. Two programs are being explored for VYCF.

[16] *See* GED-Grad report final 5-15-12(2).doc. The number of youth who have met the criteria of being a graduate or GED holder is not insubstantial. DJJ assessment indicates that the percent of youth in these categories is: 49% at NACYCF, 16% at OHCYCF and 25% at VYCF.

[17] The staff wisely chose to find youth who were not actively engaged in some activity and interviewed them. Conversation between Mark Blaser, Program Specialist, and Special Master, Campbell, May 21, 2012

The Superintendent and the Director are actively engaged in securing these programs. The Director is also working with a youth advocate to develop more college programs for youth at VYCF.[18]

C. Next Steps

In addition to the continued implementation of pre-treatment, CBT and advance practice groups and quality assurance efforts in OHCYCF, Defendant is working on several of the critical next steps in the full development and implementation of the IBTM. These steps include:

- Development of a clearly articulated mission and principles for the IBTM.
- Clarifying the roles of living unit staff as well as psychologists and educators.
- Structuring youth time to reinforce behavior targets.
- Implementing the approved substance abuse curriculum.
- Defining the population to be served in mental health units as well as the service delivery model.
- Implementing the Reinforcement System.

Next on the agenda will be developing a comprehensive and robust behavior management system and skills training in milieu management. Defendant is to be congratulated for consistent forward movement this round in developing the IBTM.

III. EDUCATION

The *Farrell* Education Experts, Dr. Tom Oôrourke, Dr. Robert Gordon and Dr. Jack Catrett conducted their seventh round of monitoring compliance with the Education Services Remedial Plan (Education Plan) from February 2012 through March 2012. Appendix A provides the Education Expertsô Comprehensive Report which includes, (1) a summary report, California Division of Juvenile Justice Summary Education Report for School Year 2010-2011; (2) Remedial Plan Site Compliance Reports for each facility

[18] *See* Free Venture E-mail. Director Minor has continued to keep the Special Master apprised of progress in these areas.

(Attachment 1); and (3) a comparison of the Office of Audits and Court Compliance (OACC) findings with the Education Expertsô findings (Attachment 2). In December 2010, OACC started to conduct audits of all Education Plan audit items and assigned a rating for each item prior to the Education Expertsô visits. As a part of their audits, the Education Experts reviewed OACCôs ratings and, if deemed necessary, modified the ratings assigned by OACC. OACC has completed two rounds of audits under this protocol.

A. Continuous Improvement

The Education Expertsô Comprehensive Report (Appendix A) suggests that the Defendant is continuing to improve and is close to attaining full compliance with the Consent Decree requirements identified in the *Education Services Remedial Plan*.[19] With the exception of Johanna Boss High School (JBHS) at the sixth audit round, all three DJJ schools met or exceeded the threshold of an 85% overall rate of substantial compliance during the last two rounds of audits by the Education Experts as indicated in the following table:

Percentage of Items in Substantial Compliance

	Round 5[20]	Round 6[21]	Round 7[22]
N.A. Chaderjian High School	84%	86%	92%
Johanna Boss High School	91%	77%	92%
Mary B. Perry High School	84%	85%	88%

[19] Appendix A, Education Services Remedial Plan, Sections I, II, III, IV, V and VI, pp 1-45.
[20] DJJ Quarterly Compliance Report as of May 1, 2012.
[21] *Ibid.*
[22] *Ibid.*

The significant decline in JBHSôs overall rate of substantial compliance between the fifth and sixth round of audits was caused by a vacancy in a Language Speech and Hearing Specialist position, which had a domino effect on several audit items in the remedial plan.[23] Once this position was filled, it corrected several items to substantial compliance as indicated by the results of the most recent round of audits.

B. Key Outstanding Issues

In analyzing the Education Expertsô Comprehensive Report, the Special Master identified the following key issues that require resolution in order for Defendant to attain full compliance with the *Education Services Remedial Plan*. The issues are not identified in any order of significance.

1. The Education Experts and the OACC auditors found there continues to be high rates of absence among students at all three schools. During six sample months (two months for each facility) selected by the Education Experts and the OACC auditors, the absence rate ranged from 16.3% to 34%. The *Education Services Remedial Plan* notes that students are expected to attend schools except for verified medical conditions or when the student is an immediate threat to the safety of him/herself or others. The plan notes that schools with an absentee rate of 7% and higher will take corrective actions to reduce the rate to below the 7% threshold. Thus, all three schools were found to be non-compliant for the current round of audits as well as during previous rounds of audits.

It has been suggested by the Education Experts that the 7% threshold may be unrealistic and perhaps should be modified to reflect the nature of DJJôs

[23] *See* email of May 21, 2012 from Dr. Tom O'Rourke to Deputy Special Master John Chen.

student population.[24] Recent attendance data from one school, JBHS, show that the absentee rate can be reduced considerably. According to a document[25] produced by DJJ staff at the request of the Office of Special Master (OSM), the overall rate of absence for all students at JBHS for March and April 2012 were 8.4% and 5.8% respectively, which clearly show that there is a considerable margin for improvement at the other schools.

Defendantôs April 2012 attendance data show that an overwhelming portion of the absences was not attributable to education-related matters (i.e. no substitute teachers, etc.). For example, while the overall absence rate at N.A. Chaderjian High School (NACHS) was 24.4% for April 2012, the education-related absence rate was only .9% in comparison to non-education related rate of 23.5% for the month. Examples of factors included in non-education related rates are lockdowns, program change protocol and youth refusal to attend classes. While it is understood that a certain level of security-related disruptions are unavoidable in a correctional setting, the frequency of the occurrences at NACHS and Mary B. Perry High School (MBPHS) remain a cause of concern. As indicated in the following table,[26] a majority of youth absences during April 2012 at NACHS was attributed to safety and security-related issues and at MBPHS, it was caused by youth refusal and youth placement on Treatment Intervention Program:

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[24] The Education Experts have suggested that this rate may be too low. While it may seem that having a ñcaptiveò student population should make it easier for youth to attend school, the nature of the behavior problems of the incarcerated youth population may actually make it more difficult to achieve a lower absentee rate than a typical public school.

[25] *See* Attendance Rates: Comparisons: All Students; NO GRAD; >19 Years Old in DJJ PoP 887.

[26] Compiled from documents in PoP 887 titled "School Absence Audit Report, JBHS Period Covering: April 1-30, 2012," "School Absence Audit Report, MBPHS Period Covering: April 1-30. 2012,"and "School Absence Audit Report, NACHS Period Covering April 1-30, 2012."

Reasons for Absentee Rates in DJJ Schools

	NACHS	JBHS	MBPHS
Instruction Hours	14,461	14,366	18,093
Education-Related Absence	123 (.9%)	325 (2.3%)	685 (3.8%)
Non-Education-Related Absence (Rate)	3,411 (23.5)	504 (3.5%)	3,718 (20.5%)
Total Absence (Rate)	3,534 (24.4%)	829 (5.8%)	4,403 (24.3%)
Key Categories			
No Substitute	116	325	667
Youth Refusal	254	15	1,477
Treatment Intervention Program (1st 72 Hours)	324	206	925
Safety and Security-Related Issues [27]	2,550	178	684

What constitutes a reasonable absence rate must consider the nature of the student population and their unique challenges. Clearly, a challenge with incarcerated youth is a lack of a positive association with school. Until youth have a positive experience with school, refusals will be common. Similarly, there will be times that safety and security issues will result in school absences. As the data

[27] Includes various absentee codes such as Whole School Closed ï Safety and Security, Safety and Security Issues ï TTS Decision, and Program Change Protocol.

appear to indicate, the level of absence is still unreasonably high, even if it is increased to reflect a more realistic rate.[28] The above analysis suggests that while the threshold may be too low, more could be done to significantly reduce the high absence rates at the schools. For example, the disparity in youth refusal between OHCYCF and VYCF provides significant opportunity for improvement at VYCF in this regard.

The Special Master encourages the Education Experts and Defendant to identify a realistic absence rate and strategies to maintain the absence rate at JBHS and reduce the absence rate at NACHS and at MBPHS. As a vast majority of the absences are not directly related to provision of education programs, participation by the Safety and Welfare Expert in this task may be beneficial. This issue needs to be resolved before Defendant can assume full monitoring for the *Education Services Remedial Plan.*

2. Delivery of education services (regular and special education) to youth in VYCF's BTP units continues to be an issue. The Special Master has written about issues relating to adequacy of services provided to youth in VYCFôs BTP units in every quarterly report since the Eighteenth Report of the Special Master, which was released on July 1, 2011. While Defendant has been making a concerted effort that resulted in some needed improvements, VYCF continues to fail to deliver 240 minutes of mandated education services to youth in the BTP

[28] Education Expert, Dr. OôRourke has opined that one reason for the difference between JBHS and the other schools is the age of the students. JBHS has a young population that is more accustomed to going to school and finds themselves in an environment with peers. NACHS and MBPHS have much older youth populations. Young men in their twenties with histories of negative associations with school and little social support for attending school resist attending high school. Both education experts have indicated that assisting older students to get a GED and vocational skills is a more realistic option. The education experts have shared these perceptions at recent audit exit interviews and with conversations with the Special Master.

units. For the 13 audit items where the Education Experts found MBPHS to be in partial compliance or non-compliant, six items were directly related to the issues identified at the two BTP units. This issue needs to be resolved before Defendant could assume full monitoring responsibility for the *Education Services Remedial Plan*.

3. Full implementation of the ñProgram Service Dayò (PSD) continues to be an issue at each school site. PSD was developed to ensure that the mandatory 240 minutes of the school day is not infringed upon by other programs. The Education Experts found students continue to be pulled out for non-emergency medical, mental health and/or safety and security reasons. The Special Master will continue to work with the *Farrell* Experts to better coordinate scheduling issues that negatively impact delivery of education services to youth in DJJ system.

C. Quality Assurance System

Defendant must demonstrate that it has an adequate quality assurance system in order to assume full monitoring responsibility of the remedial plan. In December 2010, OACC started to conduct audits of all *Education Services Remedial Plan* items prior to the Education Expertsô site visits. OACC completed two rounds of audits under this protocol and released an Education Annual Report in May 2012 summarizing the results of its audits. OACCôs findings in general are similar to the Education Expertsô findings. OACCôs annual report is presented in this report as Appendix C.

A comparison disclosed that the overall rating variances between the Education Experts and OACCôs auditors have not been significant in both audit rounds. For

example, during their seventh round of audits, the Education Experts and OACC auditors reviewed 116 audit items in each of the three facilities. Of the total of 348 items rated (116 audit items multiplied by three facilities), the Education Experts raised OACCôs ratings for 11 of the audit items and lowered OACCôs ratings for 13 of the audit items. The Education Experts have discussed the rating discrepancies with the OACC auditors and Defendantôs Superintendant of Education to minimize future discrepancies.[29]

Comparison of OACC and Education Experts' Audit Ratings

Round 7

	NACHS	JBHS	MBPHS	Total
Experts Raised OACCôs Rating	6	4	1	11
Experts Lowered OACCôs Rating	2	3	8	13

Round 6

	NACHS	JBHS	MBPHS	Total
Experts Raised OACCôs Rating	2	8	8	18
Experts Lowered OACCôs Rating	5	6	4	15

Most of the rating increases stemmed from the corrective action taken by the facilities to address the issues identified during OACCôs 45-day review. Most of the rating declines were caused by the circumstances that occurred subsequent to the OACC audit or differences in sample selections. This suggests that OACCôs 45-day reviews were conducted thoroughly, objectively and added value to the process. As noted by the Education Experts in their Comprehensive Report for their sixth round of audits:

[29] *See* email of May 21, 2012 from Education Expert Tom OôRourke to Sara Norman of PLO.

ñThe high degree of rater agreement between the OACC and the education experts as documented in Attachment 2 of Appendix A (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.ò

In the comprehensive report for their seventh round of audits, the Education Experts noted:

ñDuring the two previous audits, school staff have been able to address items identified by the OACC audit team. The experts commend the DJJ education staff and the OACC audit team for their collaborative efforts to establish internal monitoring procedures to address Education Remedial Plan requirements. In many cases school staff were able to address deficiencies with corrective actions.ò

D. Outcome Measures

In addition to the compliance ratings issued by the Education Experts and OACC, the Special Master believes that there are certain outcome measures that demonstrate Defendant is achieving the purpose and intent of the *Education Services Remedial Plan.* While it is difficult to make meaningful comparisons of student achievement between DJJ schools and California public schools, given the decline in DJJ population and the extremely challenging nature of the DJJ youth population, a close examination of some outcome data found that DJJ schools in fact are making significant improvements in providing education services to youth. The major achievements that were identified in the Education Experts Comprehensive Report include:

- All three schools continue to meet the accreditation standards of the Western Association of Colleges and Schools.

- Each school provides a core curriculum that meets the Content Standards for the California Public Schools.

- Each school was able to document the presence of High School graduation plans for all students enrolled in the school program.

- Each school has developed a system to identify students not making progress toward their high school graduation plans. This system provides documentation of School Consultation Team and special education referrals.

- Each school was able to document that all teaching staff held valid California Department of Education credentials and that all teachers were teaching in the field.

- Defendant has a recruitment plan and recruiters to meet the need for future staff placement.

- Special education assessments currently meet the California Department of Education and Individual with Disabilities Education Act (IDEA) standards.

- Defendant is continuing to increase the enrollment in the vocational classes at each site.

- Defendant is implementing a Standardized School Calendar that meets the California Department of Education and remedial plan requirements.

- Defendant is providing a curriculum, instructional services, education supplies and materials that meet state and federal standards.

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

- Defendant continues to provide extensive training to special education and regular education staff on topics including student limitation, less modifications, adaptation of instruction, Individual Education Program (IEP) development and IEP referral requirements and procedures.

Moreover, despite the fact that the total youth population has declined significantly over the years, which in turn resulted in a much more challenging youth population, the proportion of youth who received high school diploma, GED certificate, or enrolled in college courses drastically increased. For example, after the *Education Services Remedial Plan* became effective, DJJ's youth population was approximately 3,133 as of December 31, 2005. DJJ's youth population was approximately 1,042 as of

December 31, 2011. The following chart identifies positive growth over a seven-year period (Source: June Principalsô Monthly Reports and dialogue with each school to confirm data):

Growth in Diploma, GED and College Enrollment

YEAR	DIPLOMA ISSUED[30]	GED ISSUED[31]	COLLEGE ENROLLMENT[32]	YOUTH POPULATION[33]	Ratio of Diploma & GED to Population
2004-2005	163	87	363	3,133	12.5/1
2005-2006	161	118	160	2,719	9.7/1
2006-2007	172	170	313	2,287	6.7/1
2007-2008	205	182	478	1,704	4.4/1
2008-2009	193	90	283	1,602	5.7/1
2009-2010	266	81	130	1,332	3.8/1
2010-2011	270	105	205	1,042	2.8/1

[30] From Education Service Annual Progress Report 2004-2011ò included in PoP 887.
[31] *Ibid.*
[32] *Ibid.*
[33]Compiled from data in DJJ website under ñResearch and Statistics.ò

The passing rate for the California High School Exit Examination (CAHSEE) provides another quantitative measure of Defendantôs performance under the *Education Services Remedial Plan*. Over the past three years, the passing rate of youth in DJJ schools compare favorably with two school districts (Fresno High School District and Grant Union High School District) identified by Defendant staff as having similar socio-economic population; high poverty, high crime and gangs. The following table provides a comparison of CAHSEE passing rate for math and English Language Arts (ELA) among the school districts and against statewide average during the past three years (Source: California Department of Education website):

Comparison of CAHSEE Passage Rates -- DJJ and School Districts

YEAR	DJJ High Schools		Fresno High School		Grant Union High School		Statewide Average	
	Math	ELA	Math	ELA	Math	ELA	Math	ELA
2009	22	27	20	26	11	25	34	34
2010	32	35	16	32	18	34	31	37
2011	32	24	19	19	30	33	38	38

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E. Next Steps

The Special Master believes Defendant is ready to assume full monitoring of the *Education Service Remedial Plan* subject to successful resolution of the key outstanding issues identified above. Based on their high degree of confidence with the quality of OACC audits, the Education Experts have recommended the following course of action for the remainder of 2012 and the beginning of 2013:

Johanna Boss High School and N.A. Chaderjian High School

- OACC will conduct a complete education audit of both high schools and provide findings, recommendations and corrective action responses to the Education Experts by December 15, 2012.

- Education Experts will prepare a summary report for both high schools based on OACC findings and address needed changes to site corrective action plans if deemed necessary.

- OACC will conduct a follow-up audit at both high schools during the first quarter of 2013 to verify that corrective actions have been fully implemented of issues identified in the previous audit reports and submit a summary report to the Education Experts.

Mary B. Perry High School

- Education Experts will conduct a follow-up audit at the high school by October 31, 2012 to review all audit items found to be partially compliant or non-compliant in the earlier audit.

- Education Experts will prepare a summary report of the follow-up audit to the Special Master within 30 calendar days of the completion of the audit.

- OACC will conduct a follow-up audit of the issues identified by the Education Experts by March 1, 2013 and submit a report to the Education Experts within 30 calendar days.

The Special Master finds the action proposed by the Education Experts to be prudent and reasonable. The plaintiff is also in agreement with the approach outlined by the Education Experts.[34] The Special Master commends the Education Experts and Defendant in their tireless efforts to work cooperatively to bring the *Education Services Remedial Plan* to closure.

IV. DISABILITIES

From December 2011 to April 2012, Logan Hopper, the *Farrell* Expert for youth with disabilities (Disability Expert), conducted his seventh round of audits for compliance with *the Wards with Disabilities Program Remedial Plan* (WDP or WDP

[34] *See* email of May 18, 2012 from Sara Norman of the Prison Law Office to the Education Experts.

Plan) and submitted a Comprehensive Report of those audits. As with the Disability Expertôs previous reports, this report contains a description of his auditing and reporting methodology, a summation of his key findings as well as a grid that identifies and explains facility-by-facility compliance ratings for each WDP Plan item audited. For items rated ñless than substantial compliance,ò as well as some items rated in substantial compliance, the Disability Expert makes specific recommendations for DJJ to meet WDP Plan compliance goals or to improve upon current conditions. The Disability Expertôs Comprehensive Report and the compliance grid are presented in the report as Appendix B and Attachment 1, respectively.

In December 2010, the OACC started to conduct audits of all WDP Plan audit items prior to the Disability Expertôs visits. As a part of his audits, the Disability Expert selectively reviewed audit items assigned to OACC and, if deemed necessary, modified OACCôs ratings. OACC completed two rounds of audits under this protocol and issued its first annual report in May 2012. OACCôs annual report is included in the report as Appendix D.

A. Compliance Results

With the advice and assistance of the Disability Expert, the Special Master finds Defendant has made great strides in achieving substantial compliance with the WDP Plan. According to Defendantôs Quarterly Compliance Report as of May 1, 2012, the overall percentage of WDP audit item rated ñin substantial complianceò steadily increased with each round of audits -- from 41% in the first round to 86% in the fifth round. The compliance percentage declined slightly to 83% in the sixth round. As noted in the Nineteenth Report of the Special Master, the rating decline was not considered

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 Disability 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 consistent between the fifth round and the sixth round. In the seventh round of audits, the overall percentage increased slightly to 85%. The following table presents the percentage of items in substantial compliance at each of the facilities and at the Central Office:

Percentage of Items in Substantial Compliance

	Round 5[35]	Round 6[36]	Round 7[37]
N.A. Chaderjian Correctional Facility	87%	86%	86%
O.H. Close Correctional Facility	88%	82%	89%
Ventura Youth Correctional Facility	83%	80%	85%
Central Office	74%	84%	84%

The Special Master has reviewed the Disability Expertôs Comprehensive Report and Defendantôs response to the issues identified in the report. The Special Master also requested additional information and documentation from Defendant staff, consulted with other *Farrell* Experts, and solicited input from Plaintiff on specific issues within the Disability Expertôs report. Based on the information and data analyzed, the Special Master believes Defendant is near overall substantial compliance with the WDP Plan. The remaining issues that are not in substantial compliance overlap with other remedial

[35] DJJ Quarterly Compliance Report as of May 1, 2012.
[36] *Ibid.*
[37] Compiled by OSM using data in the Disability Expertôs Comprehensive Report (seventh round).

plans and can be monitored by the *Farrell* Experts responsible for those plans. The basis for the Special Masterôs conclusion is discussed in the following sections of the report.

B. Issues Identified in the Disability Expert Comprehensive Report

In his Comprehensive Report, the Disability Expert identified nine issues that need to be resolved for Defendant to achieve substantial compliance. Each of the issues is discussed below:

1. Consistency of Facility WDP Coordinators (Audit Items 5, 36, 38 & 39). The Disability Expert identified several issues related to the facilitiesô inability to maintain stability in the WDP Coordinator position. The issues include high turnovers and delays in filling the position as one position was left vacant for about eleven months. In addition, the Disability Expert expressed concerns about the lack of a full-time WDP Coordinator at each of the three remaining facilities. Defendant has allocated a full-time WDP Coordinator position at VYCF and one position for the Stockton Complex, which includes NACYCF and OHCYCF.

The Special Master shares the Disability Expertôs concerns regarding high turnover in the WDP Coordinator position and believes Defendant has demonstrated the capacity to effectively address the problem when needed. It is true that the facilities have experienced high turnover in the WDP Coordinator position, and this condition may continue as a result of the State of Californiaôs fiscal dilemma that, in turn, continues to cause severe downsizing of the California Department of Corrections and Rehabilitation and staff changes. While high turnover certainly is undesirable as it could lead to errors and disruption of

services to youth, it is sometimes unavoidable especially in the current economic climate. When staff turnover occurs, it is incumbent on management to fill the position as rapidly as possible and immediately provide the necessary training and supervision to minimize disruption of services.

Except for one case cited by the Disability Expert when VYCF was unable to fill the position for about 11 months because of a hiring freeze imposed by the Department of Personnel Administration, evidence suggests Defendant filled the position rapidly when it was possible to do so. For example, when the WDP Coordinator position became vacant twice during the first four months of 2012, VYCF filled the position within 30 calendar days in both instances,[38] which is very prompt in any organization and especially in state government.

In the one case at VYCF where the Facility WDP Coordinator position was vacant for 11 months, the facility assigned two analysts, each of whom devoted approximately 50% of his or her time, to perform WDP-related activities. According to the Departmental WDP Coordinator who supervises the Facility WDP Coordinators, she was highly satisfied with the quality work of the two analysts in carrying out their WDP-related duties. Moreover, there is little evidence to suggest that the WDP-related activities had been compromised or that the two analysts covering the position have detrimentally impacted youth. Nevertheless, leaving a court-ordered position vacant for 11 months was in violation of WDP Remedial Plan and Defendant needs to re-examine its personnel

[38] *See* email of May 29, 2012 from Department WDP Coordinator Sandi Becker to Deputy Special Master John Chen.

practices and enact measures to avoid reoccurrence of similar unacceptable situations.

The key to staff performance is proper training, supervision and monitoring of work performed. Although there has been a high turnover at the facilities, there is stability in the Departmental WDP Coordinator position. The Coordinator has been in this position since March 2008. According to the Disability Expert, the Departmental WDP Coordinator ñhas gained an understanding of the programôs requirements as well as disability policy in general, and she has proven to be capable and dedicated to the task.ò The Departmental WDP Coordinator provides hand-on training to the Facility WDP Coordinator who, in accordance with the WDP Plan requirement, also receives a higher level WDP training through an online course recommended by the Disability Expert. In addition, the Department WDP Coordinator developed a series of checklists, which serve as a desk manual for the Facility WDP Coordinators. The checklists require a quarterly update of the program proof-of-practice binder for each audit item in the WDP Plan. The Departmental WDP Coordinator also reviews monthly and quarterly reports of the Facility WDP Coordinators and provides guidance and training as deemed necessary. When the Departmental WDP Coordinator was appointed to her current position in March 2008, she had oversight responsibility over the activities of nine WDP Coordinators. She now oversees the work of three WDP Coordinators,[39] which

[39] One at VYCF, one at the Stockton Complex, and a part-time (approximate ¼) position at Pine Grove Camp.

allows her to be much more proactive in ensuring that the WDP-related activities at the facilities are being properly carried out.

It should be noted that the Departmental WDP Coordinator, whom the Disability Expert found to be highly knowledgeable and proficient with WDP matters, is now housed in the Stockton Youth Complex and is available to provide additional support and assistance when necessary. The parties have thoroughly discussed this arrangement and concluded that in the absence of any evidence to suggest systemic failure in identifying and providing reasonable accommodations[40], a full-time Facility WDP Coordinator with the assistance of the Departmental WDP Coordinator is sufficient to address the needs of youth in the Stockton Complex. VYCF, which has a higher youth population, continues to have a full-time Facility WDP Coordinator.

In reviewing the Disability Expertôs Comprehensive Report and site visit reports, the Special Master found no clear case where a youth did not receive needed services or accommodations or work that has not been adequately completed because of insufficient effort by the Facility WDP Coordinator. This is an important testimony to the great strides made by Defendant under the direction of the Disability Expert. In his response to the partiesô comments about his draft

[40] Subsequent to the release of the Special Masterôs draft report on May 29, 2012, the Disability Expert on June 15, 2012 produced a ñconfidentialò report asserting Defendant may have failed to properly identify youth with disabilities or provided reasonable accommodations in numerous instances. The Disability Expertôs report also states ñIn most cases, the audit schedule did not allow for a full investigation of all circumstances related to the specific situation, nor provide for more detailed investigations of whether other youth not interviewed or for whom there were no records experienced similar incidents.ò To the Special Masterôs knowledge and based on a review of the Disability Expertôs reports over seven audit rounds and inquiry with Defendantôs staff, this is the first time the Disability Expert has produced data, which has yet to be validated by the Expert or Defendant, to suggest a possible systemic failure. The Special Master is investigating the Disability Expertôs allegations and this issue will be addressed separately with appropriate notification to the Court.

report for the OHCYCF audit, the Disability Expert alluded to two instances where he opined that inadequate time committed to the Facility WDP Coordinator position may have led to the problems. The first example given was problems with certification of interpreter for the two deaf youth at NACYCF, and the second example was a youth not provided with a text telephone (TTY) within the living unit and was unaware that one was available. Further examination of the issues disclosed that Departmental WDP Coordinator who is responsible for executing and monitoring the interpreter contract has addressed the issue of the interpreter's certification. The Departmental WDP Coordinator also said she personally was involved in the case about the deaf youth who either lost his TTY or neglected to bring it with him when he was transferred to another living unit. The Departmental WDP Coordinator provided the youth with a TTY once the issue was brought to her attention. Neither situation was caused by inadequate time committed by the Facility WDP Coordinator position.

2. Identification of Disability and Provision of Accommodation (Audit Items 41, 46, 86-95). The Special Master does not agree with the assertion by the Disability Expert that ñthe fact is that DJJ has not effectively provided consistent determinations of which youth should be included in the Wards with Disabilities Program, and which should not.ò The Special Master opines that this statement is one of professional opinion that differs from that of other highly qualified professionals and is not a ñfact.ò It is fair to say that a ñfactò that is agreed upon by the many professionals that have worked on this issue in the Wards With Disabilities Remedial Plan is that identifying an individual to be ña qualified

individual with a disabilityò requires a multi-step process that builds on the knowledge and expertise of several disciplines. Defendant has created just such an identification process. Upon intake, a youth undergoes assessments by a variety of practitioners including those in medical, mental health and education. If a disability is identified or suspected, this information is entered into the record. The WDP Coordinator reviews all cases that potentially are identified as having a disability. There is yet another level of review at the initial case review (ICR) where a group of practitioners, including the WDP Coordinator, conducts a review.[41] If by some chance a youth is not properly identified after this process, there are yet two other options for identification -- staff referral and youth self-referral. As the Disability Expert aptly notes, medical, mental health and/or education professionals provide a description of a condition based upon their knowledge, training and expertise.[42]

> ñIn normal practice, within the institutional context, medical professionals would provide a description of a specific medical condition and any impairment and its usual effect on the individual, but final determinations of disability would be made by those with the legal and practical application of the ADA and State regulations.ò

While there is documentation that the medical director has provided information and training regarding the Americans with Disabilities Act (ADA) to practitioners, they are not the sole decision-makers regarding identification of a

[41] The attendance of the WDP Coordinator at the ICR was a change made after discussions with the Disability Expert and Plaintiff. The original plan developed when there was a significantly greater population did not have the WDP Coordinator always attend the ICR. With a smaller population this is now possible and ensures that in addition to the expertise of the medical, mental health and education practitioners, the WDP Coordinatorôs specialized knowledge of disability issues is considered in the identification process.

[42] Appendix B, Disability Expertôs Comprehensive Report for 2011-12, dated May 21, 2012, p7.

disability.[43] The medical, mental health and education providers, like other staff in the institutional system, provide their assessment regarding a possible disability that is reviewed by the WDP Coordinator, and a multi-disciplinary group (ICR) has an opportunity to raise concerns or make a referral if it appears a disability is present. Concerns about possible failure to identify a youth by the Disability Expert led Defendant to enhance this process by having the WDP Coordinator attend any ICR when there is the possibility of a disability, and in *all* initial case reviews, the committee now asks a series of questions to the youth designed to affirm for the committee that the youth has no disabilities.[44]

The Disability Expert asserts that DJJ medical and mental health practitioners, as well as Plaintiff and other experts do not understand the criticality of understanding state and federal law in the identification process and further, limit identification to those cases where only accommodation is required. The Special Master finds that the parties do understand the importance of both issues in the identification process. The medical, mental health and education practitioners all have assessment processes specific to their discipline that are used to recommend the designation of a disability and/or accommodation of that disability.

The Special Master and the Medical and Mental Health Experts do not support the Disability Expertôs recommendation that additional guidelines for

[43] *See* E-mail re ADA info shared with practitioners for examples of information shared through conference calls, e-mails and meetings.

[44] This process is designed to ensure the needs of disabled youth or adults are met in the juvenile (*LH v. Brown*) and adult (*Valdivia v. Brown*) federal lawsuits regarding due process for youth and adults in parole revocation hearings. The Disability Expert was in the meeting with the parties when these additional steps in the identification processes were agreed upon and was asked to review the questions and to provide feedback. *See* E-mail re: ICR Guidelines and Initial Case Review Guidelines WDP Perspective 042312.pdf

medical and mental health practitioners are needed.[45] Defendantôs medical and mental health providers use professionally acceptable assessments to assist them in the identification of disabilities.[46] That said, there is always professional judgment and discretion in any assessment process. It is not uncommon for two psychologists to offer different mental health diagnoses on the same individual. Differences in clinical judgment are not uncommon and do not inherently discredit the assessment process. This is why there are several review options that ensure that the initial assessment is not the only basis for determining if a youth qualifies as WDP. Additional guidelines to medical and mental health clinicians will not, and should not, remove the necessary professional judgment that the highly qualified and credentialed professionals at DJJ so well employ.[47]

Confusion regarding this situation in the medical discipline may stem from the process used by the DJJ medical providers when working with youth with chronic conditions. The medical providers keep a list of youth who have a chronic disease. In the case of asthma, the chronic disease that represents the vast majority of chronic illnesses in this population,[48] the providers keep all youth who have asthma on a chronic disease list and see the youth on a set schedule to ensure the illness has not changed. These youth were not labeled as disabled because their

[45] The Special Master is not discussing the identification process with the educational practitioners because the Disability Expert does not suggest additional guidelines for this group.

[46] The Disability Expert has played an important role in helping to determine what type of assessments mental health practitioners should use. At the Disability Expertôs direction, Defendant uses the Test of Non-verbal Intelligence (TONI) and the Kaufman Brief Intelligence Test (K-BIT 2) as well as interviews and other assessments to identify other possible types of disabilities beyond cognitive functioning. At the Disability Expertôs suggestion, Defendant assessed all youth who they had not been assessed with the K-BIT 2 instrument to ensure all youth were properly assessed on this dimension. The assessment is now used at intake.

[47] The credentials and experience of most of the medical doctors and psychologists at DJJ are impressive. They are highly skilled and trained professionals.

[48] Medical Expert Joe Goldenson, M.D., indicated that the vast majority of chronic illness in the DJJ youth population is asthma in two conference calls in January and May 2012.

illness sometimes does not limit ña major life activity.ò[49] Because major life functioning may not be impaired, the youth may not need accommodations. Physicians have historically still monitored them through the chronic disease check process. While this appears to be an approach that is consistent with the ADA, Defendant has agreed to label all youth on the chronic disease list as disabled. In practice, nothing changes for the youth.

The Disability Expert has worked with Defendant in the area of mental health to create a robust and expansive identification process. For example, the Disability Expert was instrumental in ensuring that Defendant screens all youth for potential disabilities, has a protocol for screening and testing and further, he encouraged Defendant to expand the classification of borderline intelligence to ensure that more youth receive accommodations.[50]

That said, the area of mental health presents a different challenge from the medical area for identifying youth with disabilities. The Mental Health Expert notes:

> The problem for DJJ is that 86% of the youth have an Axis I diagnosis (excluding substance abuse); 45% have conduct disorder. Additionally, 18% of young adult youth have a personality disorder. While the data available at this time does not indicate how many youth have neither a personality disorder nor an Axis I diagnosis, the percentage is likely 5% or below (and many of them are likely to have disabilities other than mental health). In short, virtually all youth could be looked at as having a qualifying mental health diagnosis.[51]

As noted by the Mental Health Expert, Dr. Bruce Gage, a challenge for a corrections agency like DJJ is that a significant percentage of youth have some

[49] Appendix B, 2012 DJJ WDP LHopper Final Comprehensive Report 5_21_2(2), pp. 7-8.
[50] *See* E-mail Psych Testing.
[51] Mental Health Disability Definitions in DJJ Youth (3). This information is based on the inventory referenced on p.7 above.

type of conduct or personality disorder that could qualify them as having a mental health diagnosis. Most youth have some functional impairment as a result of this disorder. For example, the youth may be aggressive with authority figures. The significant variation in the identification of disabilities in the area of mental health between correctional agencies often reflects different perspectives regarding whether conduct disorders are considered a disability for purposes of adhering to the requirements of the ADA.

The Special Master asked Defendant and Dr. Gage to research how DJJ compares to other similar systems with regard to the percentages of youth who are identified as disabled. Given that systems differ significantly in the nature and type of populations they serve, as well as the fact that there is discretion in the identification of issues such as mental health diagnoses, such comparisons can only serve as a gross measure of accuracy of identification efforts. Recognizing these caveats, the comparison appears to affirm that the identification process at DJJ does not produce significantly different outcomes from other systems.[52]

Through the implementation of the IBTM, Defendant is attempting to develop an effective intervention for typical conduct and personality disorders. Defendant is taking the approach that barring some other functional impairment most youth at DJJ will be best served through the IBTM intervention. Dr. Gage is working with the parties to develop a definition of mental health that will help to guide mental health practitioners to ensure that those youth who have an

[52] A brief synopsis of a phone conference between the Special Master, Medical and Mental Health Experts about the review that was undertaken can be found in the minutes of the phone conference. By no means was a comprehensive review undertaken. The effort was undertaken by the Special Master as a way to confirm what appears to be an effective identification process. *See* WDP Call 5-13-12.

additional disability beyond those typically identified with conduct and personality disorders and that are addressed through the IBTM will automatically be identified as disabled and considered for additional accommodations.

The Disability Expert has not presented evidence of a systemic failure of the current process to properly identify youth who are entitled under law to services rendered by the ADA.[53] Despite this, the parties are responding to his concerns and modifying current practices to attempt to create an even better identification process.

The question before the Court is what is a reasonable measure of substantial compliance in this area. The Special Master believes a reasonable measure is that the existing process is clear, thorough and comprehensive, understood by staff, and is consistent with state and federal law. The Special Master finds the process of identification for disabilities to adhere to these measures. The review process ensures that there is not just reliance on the medical, mental health or educational assessments but includes a review by other practitioners like the WDP Coordinator who are well versed in the ADA and state law.[54] In addition, there are self-referral processes for youth and a referral process for staff should there be any reason to believe a disability assessment or accommodation is required. Given that no data has been presented that shows a

[53] One of the challenges of any Consent Decree is to determine when substantial compliance in any area has been achieved. One measure of whether a proposed system, in this case to identify disabilities, is working is if there is a significant enough number of instances where the system has failed. There will always be some amount of human or mechanical errors in any system. No system achieves perfect results. The challenge before the Court is to determine if the level of error is significant enough to constitute a systemic failure or if it is the rare exception. The former clearly indicates substantial compliance has not been achieved. The latter could indicate it has. Hence the term ñsubstantialò and not ñperfectò compliance.

[54] WDP Coordinator, Sandi Becker, has worked in her position for four and a half years and has been well trained by the Disability Expert. She also serves as a system monitor and trainer. She has been extremely proactive in resolving both individual and system problems.

clear or consistent pattern of failure to identify youth with disabilities and the identification process is sound, the Special Master believes the identification process is in substantial compliance.

3. Use of Force (Crisis Prevention and Management) for Youth with Disabilities (Audit Item 53). This audit item specifies Defendant shall ensure staff awareness of accommodations afforded to youth with disabilities when developing and implementing security procedures including use of force, count, searches, transportation, visiting and property. The Disability Expertôs concern with this audit item primarily focuses on use of force against a single non-compliant youth or similar incidents where it is possible to isolate youth with disabilities.

The Disability Expert noted that the WDP Plan specifies that security staff must be aware of the accommodations to be provided to youth with disabilities prior to use of force. However, there is virtually no indication or acknowledgment in the current use-of-force reports or in the review process that this requirement has been met.

The Special Master shares the Disability Expertôs concern and agrees that this issue has not been resolved in a timely manner. As noted in the Disability Expertôs report, the problems with Defendantôs use-of-force process have been repeatedly identified in previous *Farrell* Expertsô reports and Defendantôs internal studies. Under Defendantôs former use-of-force policy, security staff was required to take into consideration factors such as accommodations for youth with disabilities only in incidents that involved ñcontrolledò use of force. In actual

practice, controlled use-of-force incidents rarely occur at DJJ as staff routinely considers all force incidents to be ñimmediateò use of force. Thus, there is very little, if any, evidence in place to suggest staff were aware of and addressed the accommodation needs of disabled youth in use-of-force incidents.

The recently revised Crisis Prevention and Management Policy, approved by the parties, if properly implemented, would address the Disability Expertôs concern in this regard. The policy is consistent with the principles of the IBTM and was adopted after extensive discussions between the parties. Prior to release, the policy was circulated for review and comment by the OSM and the *Farrell* Experts. With respect to the Disability Expertôs concern about incidents involving a non-compliant youth, the new policy specifically states:

> ñForce shall not be used against youth for refusing to follow staff instruction except in the following situations:
>
> - Youth repeatedly and intentionally ignored staff instructions over a significant period of time; and
> - Staffôs efforts of intervention and de-escalation to include consulting with the youthôs Crisis Intervention Plan and utilizing the principles of Core Correctional Practices have proven unsuccessful and ineffective, and
> - Further continuance of the situation would immediately and directly preclude other youth from receiving their mandated programs and/or services.
>
> When all above conditions are met, staff may use force after obtaining approval by the Superintendent or designee and on weekends and/or after hours by the Watch Commander.ò

Thus, for every force incident that involves a non-compliant youth, staff under the new policy is required to review the youthôs crisis intervention plan and seek approval before force is applied. The accommodation needs of disabled youth are supposed to be identified in the crisis intervention plan. As staff

members are compelled to review the crisis intervention plan prior to any application of force against a non-compliant youth, they should be cognizant of the disabled youthôs accommodation needs and act appropriately. The newly designed force review process, which is being disseminated to the *Farrell* Experts for review and comment, contains specific procedures to review compliance with this requirement.

While the new policy is sound, there is a need for continuous monitoring to ensure proper implementation. The Special Master has discussed use of force in every report since the Seventeenth Report of the Special Master and will continue to do so until this matter is sufficiently addressed. As evidenced in the use-of-force sections of this report, Defendant has assigned this issue a high priority and is devoting significant resources to it. The entire block training for this year is devoted to use of force. In addition, Law Enforcement Training and Research Associate (LETRA) training, a 32-hour training course, is currently being provided to all custody staff and is scheduled to be completed in August 2012, which further underscores Defendantôs commitment to this important issue.

To avoid duplication of effort, continuing monitoring responsibility for compliance with the Crisis Prevention and Management Policy rightfully should be assigned to the Safety and Welfare Expert.

4. Disability Training for Staff (Audit Items 23 & 25). The WDP Plan specifically requires Defendant to provide annual training to all staff on sensitivity, awareness and harassment. Defendant was to deliver the training through annual block training in 2012. However, because of budget constraints

and scheduling problems, a significant portion of staff did not receive the required block training. In at least two of the most recent audit rounds, the Disability Expert found this audit item to be in partial compliance.

Defendant acknowledges that this is an outstanding issue that needs to be addressed. Defendant also pointed out that most staff members have previously received the same disability awareness training as many as three times and suggest that it may be more efficient and effective to provide future training through on-the-job training. The Special Master agrees that this is a sound approach, and Defendant has agreed to develop a proposal for consideration. New employees will continue to receive the current curriculum that was approved by the Disability Expert at the academy for new employees.

5. Disability-related Grievances and Due Process for Youth with Disabilities (Audit Items 72-85). The Disability Expert noted a failure of Defendant to provide staff assistance and reasonable accommodation to youth in the informal phase of the grievance process. For grievances not involving allegation of staff misconduct, Defendantôs current policy requires youth to try to resolve the issue with involved staff informally before filing a formal grievance. If a youth files a grievance without going through the informal process, the grievance form is returned to the youth with instruction to address the issue informally within five days.

Defendant believed staff assistance was to be provided once a grievance was filed. A grievance is considered filed when placed in the grievance lock box. Thus, if a grievance is rejected because the youth did not go through the informal

process, staff assistance is supposed to be provided at the time the grievance is returned to the youth.

If a youth follows the current policy and attempts to resolve the issue informally before filing a grievance, no staff assistance or accommodation is provided during the informal process unless the youth specifically requests such services. The Disability Expert believes Defendant staff must be more proactive in providing staff assistance, accommodation, and representation throughout the grievance process, including the informal phase of the process.

The Special Master shares the Disability Expertôs concern in this regard. The Special Master obtained and reviewed documents related to a case cited by the Disability Expert where a disabled youth filed a grievance over his property.

The grievance was returned because the youth did not attempt to resolve his issue at the informal level. In the form that returned the grievance, the Facility Grievance Coordinatorôs instruction to the youth, which apparently is standard language for all returned grievances, is as follow:

> ñPlease make the necessary corrections and resubmit your grievance by placing it in the grievance lock box within five days of receiving this letter. If completing a new grievance form, please record the original grievance number on the new form. If you do not resubmit your grievance within five days, your grievance will be closed.ò

According to the Departmental Disability Coordinator, the youth in this particular case was able to successfully resolve his concern at the informal level and thus did not resubmit his grievance. The Departmental Disability Coordinator also stated that the department typically does not reject youth grievances for failure to meet the prescribed timeframe. Nevertheless, the Special Master can

certainly envision some youth accepting this restrictive language literally and cease to follow-up or be discouraged to resubmit the grievance. This concern applies to all youth in the DJJ population, not just to youth with disabilities.

Defendant indicated that it is updating the grievance policy and process and will consider the Disability Expertôs recommendations. The revised grievance policy and process must include procedures to provide disabled youth with appropriate staff assistance, accommodation and representation throughout the grievance process, including the initial point of filing an informal grievance as noted by the Disability Expert.

6. Education for Youth with Disabilities (Audit Items 48, 49, 51, 55, & 56). Although the Disability Expert identified several audit items under this topic, a closer examination disclosed that one audit item (Item 51) is the core concern. The Disability Expert rated this item partial compliance for NACYCF and VYCF because of Defendantôs inability to deliver mandated education services to youth in restricted programs at the two facilities. This issue is also monitored by the Education Experts who found the facilities to be non-compliant. Since her Eighteenth Report, the Special Master has been identifying and monitoring the issues relating to treatments and services to youth in restricted programs, including provision of education services. The Special Master has identified a myriad of issues and problems. However, she has not found any evidence in any of the reports or in her observations to suggest that youth in restricted programs were denied education services because of a disability. There appears to be little added value in having two sets of experts reviewing the same issue and the

Special Master believes monitoring responsibility should rest with the Education Experts.

7. Youth Orientation on Disability Programs (Audit Item 96). The Disability Expert questions the effectiveness of youth orientation on disability programs. The Special Master agrees with the Disability Expertôs assessment but found the matter of lack of effectiveness in youth orientation is not isolated to the disability programs. On March 23, 2012, the Deputy Special Master accompanied the Disability Expert and the Departmental WDP Coordinator to observe the youth orientation process at NACYCF. The focus was on the WDP presentation, but the group attended the entire orientation session. According to the presenter, three youth originally were scheduled to attend the orientation. However, two youth had scheduling issues and thus only one youth attended the session.

The Deputy Special Master observed that the orientation session almost exclusively consisted of the presenter reading the verbiage in the PowerPoint presentation. Topics covered a broad range of issues presumably in line with the youth handbook. The presenter used quite a few acronyms (i.e., SPAR, CRT, YASI), which must have been confusing and difficult to comprehend for a youth newly assigned to DJJ. Throughout the session, which lasted about one hour, the presenter made little attempt to engage the youth in a conversation or encourage him to ask questions. The presenterôs desk phone rang several times during the orientation session and she had to answer it twice.

The Deputy Special Master believes the current approach of relying exclusively on a PowerPoint presentation is not an effective way to acquaint

youth in the new environment and shared his concerns with Defendant staff.[55] Defendant staff indicated that they have similar reservations about the current orientation process and agreed to revamp the process to make it more interactive and more conducive to learning. As the orientation process covers all topics concerning youthôs stay at DJJ, not just disability programs, the Safety and Welfare Expert should monitor this matter.

8. Monitoring of Psychotropic Medications (Audit Item 9). Both the Disability Expert and OACC auditors found that monitoring timelines for youth prescribed with certain psychotropic medications were routinely missed and that counseling was sporadic. The Disability Expert also indicated that some youth interviewed were confused about the reason and nature of their prescriptions.

The Disability Expert noted that Mental Health Experts are working with Defendant staff to revise the psychopharmacological policy that will address this issue. Defendant will circulate the policy to the Disability Expert for review and comment. When the policy is adopted, monitoring responsibility should rest with the Mental Health Experts.

9. Self-Monitoring (Audit Item 10). Contrary to the experiences of other *Farrell* Experts, the Disability Expert found the self-monitoring effort by OACC auditors to be ñless than satisfactory.ò The Disability Expertôs assessment is based on the large number of items where he lowered OACCôs ratings, especially those more complex items that were not turned over to OACC to monitor.

The Special Master does not agree with the Disability Expertôs assessment regarding the quality of work by OACC auditors. Since Defendant instituted the

[55] *See* email of April 3, 2012 from Deputy Special Master John Chen to Tammy McGuire.

self-monitoring process, every *Farrell* Expert who interfaced with OACC found the work to be exemplary in terms of thoroughness and objectivity. The testimonies of the Education Experts of OACC audits are included in the education section of this report. In his last Comprehensive Report, the Safety and Welfare Expert found the work of OACC auditors to be ñhighly professional, thorough, and objective.ò

The Disability Expert alluded to the OACC audit at VYCF where he lowered OACC ratings on 13 audit items. Upon closer examination, the Special Master believes most of the discrepancies were opinion-based rather than evidence-based. Some examples include:

- Audit Item 36: Maintain WDP Coordinator at each facility.
- Audit Item 38: The facility WDP Coordinator shall perform the oversight function as set forth in the WDP remedial plan.
- Audit Item 39: Within six months of the court approval and adoption of this plan, the facility WDP Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department.

The OACC rated all three items in substantial compliance because the facility had a full-time WDP Coordinator at the time of its audit. Since the WDP Coordinator was newly appointed, there was insufficient time for her to attend the higher level of training at the time of OACC audit. The Disability Expert lowered OACCôs rating on all three items because of the high turnover in this position. However, there was no evidence suggesting that staff assigned to cover the duties during the vacancy period was not carrying out the duties of the WDP Coordinator.

- Audit Item 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 Department of Education.

OACC rated this item in substantial compliance because the facility produced a sign-in sheet showing training was provided and attended by a surrogate parent. The Disability Expert lowered OACCôs rating to partial compliance on the basis that ñit is not believed that this is a sufficient number to adequately serve the population.ò It should be noted that VYCFôs high school principal indicated that he could not recall any instance where an IEP meeting had to be cancelled because of an issue with a surrogate parent. Since the Disability Expertôs visit, VYCF has added another surrogate parent who has attended the required training.

- Audit Item 94: Credentialed education staff shall complete education assessment within 50 calendar days.

OACC rated this item in substantial compliance because assessments were completed within the specified time frame. The Disability Expert lowered the rating to partial compliance because ñthere were several records found where youth were not **fully** assessed and placed **appropriately** within the 50-day time periodò (emphasis added). The bolded and underlined terms are highly subjective.

In his Comprehensive Report, the Disability Expert highlighted Audit Item 72 where he reduced OACCôs rating for this particular item. Monitoring responsibility for this audit item rests with the Disability Expert, not OACC. This audit item specifies staff assistance ñshall be assigned to each grievance (from filing to resolution) involving a ward with a mental or physical disability who currently requires an accommodation.ò OACC assigned a rating of substantial

compliance on the basis that youth have been provided accommodation upon formal filing of a grievance by placing it in the grievance lock box. The Disability Expert lowered OACCôs rating because he believes youth are entitled to accommodation upon initial filing of an informal grievance. As previously indicated in her comments regarding the Disability Expertôs concerns about the grievance process, the Special Master agrees with the Disability Expert that staff assistance should be provided at the initial point of filing an informal grievance.

In cases or issues involving professional judgment, it is not unusual that differences of opinion sometimes occur because of difference in interpretation or in data analysis. In this section of the report, the Special Master agrees with the Disability Expertôs opinion on the grievance process while differing with him on the issues regarding the WDP Coordinator and the youth identification system and process. She does not suggest or imply in any way that the quality of work of OACC or the Disability Expert is less than thoughtful, thorough or objective as a result of the opinion differences.

C. Next Steps

Under the guidance of the Disability Expert, Defendant has made significant progress toward achieving compliance with the WDP Plan. While differences in opinion still exist as to what more needs to be done under the remedial plan, it is clear that there is not a systemic pattern of failing to identify youth with disabilities, denying reasonable accommodation or staff assistance, nor have any significant problems been identified with individual WDP youth. There are systemic issues in a few of the areas that cross over remedial plans such as use of force or providing appropriate education for youth in

restricted programs that can be monitored by other *Farrell* Experts. Thus, in the absence of major systemic issues that are WDP-specific, and where Defendant performs thorough and credible auditing, it is the opinion of the Special Master that Defendant should assume full monitoring of WDP Plan starting with the next round of audits subject to the following action:

- Defendant is to consult with the Mental Health and Disability Experts to develop a definition of mental health and/or additional processes that provide sufficient guidance to mental health practitioners to accurately identify youth with disabilities.

- Defendant is to develop a proposal for on-the-job training on WDP awareness, including measures to track the training, for review and comment by the Disability Expert by August 1, 2012. On June 13, 2012, Defendant submitted a proposal to the Disability Expert, Plaintiff, and the Special Master for comment. Comments have been received and the proposal is being revised with assistance from Defendantôs education department staff. The revised proposal will be resubmitted for further review by the stakeholders. When the proposal is finalized, Defendant should invite the Plaintiff, Disability Expert and the Special Master to attend a training session.

- Defendant is to develop procedures to provide accommodation and staff assistance to youth throughout the grievance process, including the initial point of filing an informal grievance, for review and comment by the Disability Expert by August 1, 2012.

- Defendant is to revise its youth orientation process and provide the proposed module to all *Farrell* Experts for review and comment by August 1, 2012.

- Defendant is to coordinate with the Safety and Welfare Expert, the Education Experts and Mental Health Expert for assumption of monitoring responsibility of concerns identified by the Disability Expert on cross-over issues (use of force, grievance, education in restricted programs, psychotropic medication).

The Special Master acknowledges and commends the efforts of the Disability Expert whose experience and knowledge has been instrumental in the significant progress and improvement made under the WDP Plan during his tenure.

V. VENTURA YOUTH CORRECTIONAL FACILITY

A. Current Progress

The conditions at VYCF's BTP units continue to improve. In January 2012, the tension between youth and staff was exceedingly high as youth were highly agitated and critical of staff for placing them on lockdowns and program change protocol status for prolonged periods.[56] During their site visit on April 18, 2012, the *Farrell* Safety and Welfare Expert and the Deputy Special Master observed the conditions to be much calmer. This observation is shared by the California Department of Corrections and Rehabilitationõs (CDCR) ombudsman who reported to the Undersecretary of CDCR that, based on confidential interviews during her April 2012 visit, ñThe positive, relaxed atmosphere in the BTP was a marked improvement from previous visits. The mood and morale among both staff and youth have improved exponentially.ò[57] Further, there has been a reduction in physical violence and staff and/or youth assaults as the number of code alarms declined significantly, from 55 in January 2012 to 16 in April 2012.[58]

The BTP units no longer place every youth in restraints during youth movements. Instead, use of restraints is based on individualized behavior of youth with frequent re-evaluation to assess whether restraints could be removed. Since the implementation of the new protocol, VYCF reported that youth continue to program safely with a few incidents where youth scaled the fence of the recreation yard.[59] Consequently, there have been few occasions where youth had to be restrained in short durations during

[56] *See* Twenty-First Report of the Special Master, p. 28.
[57] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.
[58] *Ibid.*
[59] *Ibid.*

movements.[60] Three BTP youth recently achieved formal certification with ñServSafe,ò a National Restaurant Association/Education foundation.

VYCFôs BTP youth population also declined significantly. Since January 2012, VYCF transitioned 16 BTP youth into core units.[61] In general, most youth have successfully integrated into the core units and, to date, only three[62] have been returned to the BTPs. The decline in the BTP youth population makes the units more manageable. In January 2012, the total BTP youth population was 39, with 19 youth housed in Monte Vista and 20 in El Mirasol.[63] As of May 23, 2012, the total BTP population was 26 youth with 11 in Monte Vista and 15 in El Mirasol.[64] More importantly, it appears that youth integration is starting to take place as the number of program groups has declined. In January 2012, the Deputy Special Master observed that the 19 youth in Monte Vista were segregated into nine program groups including three youth on ñprogram soloò status and the 20 youth in El Mirasol were divided into seven program groups including two youth on ñprogram soloò status. By May 24, 2012, the number of program groups at Monte Vista and El Mirasol declined to five (including two youth on program solo) and three (including youth on program solo), respectively.[65] Less program groups allow staff to provide more treatment and services to youth. The Special Master cautions that, based on past history, the number of program groups tends to fluctuate fairly significantly in the BTP units.

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[60] Based on phone conversation between Superintendent Victor Almager and Deputy Special Master John Chen on May 29, 2012.
[61] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.
[62] Based on comparison of VYCFôs listing of youth transferred out of BTP and listing of youth assigned to BTP units on May 24, 2012.
[63] *See* Twenty-First Report of the Special Master, p. 29 and p. 34.
[64] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.
[65] *See* email of May 24, 2012 from Treatment Team Supervisor Jeff Bryant to Deputy Special Master John Chen.

VYCF has developed a renovation plan to make improvement and repairs at all livings units. The estimated cost for the two BPTs is approximately $1.3 million for each unit. Defendant allocated $1.8 million to begin construction activities at El Mirasol starting July 2012 and at Monte Vista starting October 2012.[66] In the meantime, efforts are being made to improve the appearance and functionality of the living units such as painting, planting flowers and adding ping pong tables in dayrooms.

B. Continuing Challenges

While evidence suggests that VYCF clearly is moving in a direction that has resulted in a more stable BTP environment, challenges remain in providing meaningful services and treatment to youth in the living units. Challenges include:

- Delivery of adequate education services (regular and special education) to youth. The Special Master has written about issues relating to adequacy of services provided to youth in VYCFôs BTP units in every quarterly report since the Eighteenth Report of the Special Master, which was released on July 1, 2011. As found by the *Farrell* Education Experts, VYCF continues to fail to deliver 240 minutes of mandated education services to youth in the BTP units. This matter is also hampering Defendantôs effort to assuming full monitoring responsibility for the Education Services Remedial Plan.

- There continue to be little meaningful and structured activities for youth. During their site visit on April 18, 2012, the *Farrell* Safety and Welfare Expert and the Deputy Special Master observed the youth ñprogramò activities still mainly consisted of watching television while the staff congregated in the YCC station with virtually no interaction with youth. There appears to be a lack of clarity of the roles and responsibilities of various staff members in the BTP units.

- There is little positive reinforcement of youth in the BTP units. The *Farrell* Mental Health Expert repeatedly advised that the need for a level and incentive system that reinforces desired behavior and not rely exclusively on the absence of negative behavior is even more acute at the BTPs than the core units. There is an urgent need for revisions to the level and incentive systems in the BTPs. Current systems are inadequate and not designed to achieve the objective of reduction in violent behavior. Defendant needs to develop a level system and an incentive

[66] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.

system to provide both immediate ñreinforcersò as well as long-term incentives and privileges.

C. Multi-Disciplinary BTP Task Force at VYCF

At the initiative of Director Mike Minor, VYCF had a meeting on May 2, 2012 to develop a strategy to address issues confronting BTP on a comprehensive basis. Attendees of the meeting included Director Minor, Superintendant Victor Almager, key program administrators and managers, and mental health clinician involved with the BTP programs. At the invitation of Director Minor, the *Farrell* Mental Health Expert and the Special Master team also participated in the strategic planning meeting. As a result of the meeting, VYCF has formed a multi-disciplinary group tasked to:

- Define the BTP Unit Purpose
  Parameters include:
  - Reduce violent behavior in the milieu.
  - Begin integration process into core population.

- Create a Formal Program (Operations Plan that is consistent with the RS, defines level system, describes the method of communication, case management, and documentation.)
  Elements include:
  - Reinforcement System ï immediate ñreinforcersò as well as longer-term incentives/privileges.
  - Level System and Incentives: Incentives and privileges/levels driven by behavior.
  - Documentation and case planning: Progression in program is documented.
  - Program services built on premise of ñimmediacy.ò Little lag time between behavior and reinforce or consequence.

- Provide input regarding the role of the Treatment Team Supervisor (TTS), Senior Youth Correctional Counselor (SYCC), Youth Correctional Counselor (YCC), Case Manager and Psychologist, what is their decision authority and how do they function. Decision authority for this remains with Superintendent and Director.
  - Staff Roles and Responsibilities will be clear and designed to support the program goals.
  - Provide SYCC coverage of living units first and second seven days a week.

The VYCF task force has been meeting on a weekly basis and progress is being made. The BTP Treatment Team has conducted weekly planning meetings and has developed the following Mission & Vision Statement[67]:

> **Mission:** To decrease violence and disruptive behavior in the youth by creating a strongly contingent, rapidly responsive environment that maximizes the reinforcement of other, more acceptable behaviors, and minimizes the reinforcement of aggressive behavior.
>
> **Vision:** Our vision is to create a positive, humane, and highly structured environment that will quickly motivate youth to decrease aggressive behavior to the point that they can successfully reintegrate into their sending unit.

The BTP Treatment Team is working to develop the behavioral requirements for assignment to an Incentive/Privilege Level System. The *Farrell* Mental Health Expert is scheduled to be onsite at VYCF in early June 2012 to provide training, advice and consultation.

D. Twenty-First Report of the Special Master Follow-up

In her Twenty-First Report, the Special Master identified a number of areas where she believes VYCF could benefit from support from Defendantôs Central Office. The following provides a status of each of the identified areas:

- Provide stability in staff assignments, particularly those in the BTP and high core units. DJJ is currently undergoing the post and bid process for its living units. VYCF expects to complete the facilityôs process by the end of February 2012. In light of the progress being made at the BTP and the high core units, it would be beneficial to maintain continuity in staffing, particularly in TTS, SYCC and YCC positions.

  Status: The rebid process has been completed. The TTS, one of the two SYCCs, and approximately 50% of the YCCs remained in the BTP units. A new psychologist has been assigned to each BTP unit.

[67] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.

- Provide BTP training to the treatment team members. Since the Central Office staff provided the BTP training in June 2011, VYCFôs BTP units have a new TTS and two new SYCCs. In addition, a review of training records disclosed that approximately 50% of staff at the El Mirasol unit who attended the BPT training are no longer working in the unit. More staff turnover is expected as the facility is undergoing the post and bid process. It is important for the Central Office to provide the training again as soon as the post and bid process is completed and staff assigned to their units.

  Status: BTP training has been provided to treatment team members in April 2012, shortly after the completion of the rebid process.

- Prioritize the upcoming Core Correctional Practice, use-of-force and Reinforcement System training for BTP and high core units at VYCF.

  Status: Of the 17 staff members in the high core units, eight has received use-of-force training and nine are scheduled to complete training by July 2012. For the 26 staff members in the BTP units, 17 have been trained and 10 are scheduled to complete training by July 2012.[68]

- Invest financial resources to continue to upgrade the look and feel of the facility to a more treatment-oriented setting.

  Status: As previously noted, major construction activities for improvements and repairs are to begin at El Mirasol starting July 2012 and at Monte Vista starting October 2012.[69] In the meantime, efforts are being made to improve the appearance and functionality of the living units such as painting, planting flowers, and adding ping pong tables in dayrooms. However, there appears to be a more urgent repair need at the high core units. According to the TTS of the high core units: ñRoom conditions - most of the high core rooms are damaged or in poor condition. Work orders have been completed, but the response to fixing the rooms is extremely slow. We are working on some rooms that have been damaged (holes in the wall, the metal plate pulled off of the wall, etc.) for approximately four months."[70]

- Build on the current success at the high core units through implementation of the IBTM at the Casa Los Caballeros living unit. Defendant has already begun taking action on this matter but, given the location of VYCF in proximity to the Central Office and the IBTM staff, the Central Office needs to devote adequate resources to provide guidance, support and assistance to ensure the success of the project.

[68] *See* email of May 25, 2012 from Superintendent Victor Almager to Deputy Special Master John Chen.
[69] *See* memorandum of May 23, 2012 from Superintendent Victor Almager to Director Mike Minor.
[70] *Ibid.*

Status: The TTS of the Casa Los Caballeros has engaged with monthly conference calls with other TTS, Program Administrators and managers to discuss problems and solutions to challenges in the BTPs throughout all facilities.

- Work with the Mental Health Expert to develop a system or a process to promptly transition youth out of BTP based on youth readiness rather than artificial barriers such as the timing of Juvenile Justice Administrative Committee (JJAC) meetings or availability of bed spaces in high core units. If necessary, Defendant should contact the Plaintiff for exception on the number of beds in high core units on a temporary basis to accommodate the placement of BTP youth.

  Status: The availability of beds at the high core units apparently has not been an issue as 22 youth have been successfully transitioned from the high core units to the lower core units since January 1, 2012.[71] Subject to advice and consultation with the Mental Health Expert, VYCFôs multi-disciplinary task force has addressed the system for youth transition.

- Ensure the accuracy and reliability of the WIN data by reviewing and resolving the issue identified by the OACC auditors regarding the apparent discrepancy between the WIN and unit logs on out-of-room time.

  Status: On April 6, 2012, VYCF completed a random review of youth out-of-room time entries in the log book against documentation in the WIN for March 5th and 6th 2012. Of the 43 records reviewed, the facility found four discrepancies between the log and the WIN. However, as opposed to the OACC finding of the WIN data not supported by unit logs, the results of the latest random review found the unit log showed more youth out-of-room time than the WIN.[72] While the sample size is too limited to draw any conclusions, it continues to raise questions on the accuracy and reliability of the WIN data that merit review and resolution by Defendantôs Central Office on system-wide basis.

VI. USE OF FORCE

Defendant continues to make steady progress toward implementation of an effective use-of-force model. Defendantôs efforts are guided by a Force Prevention Plan, agreed to by the parties, that delineates the vision, goals, tasks to be performed, deliverables and performance indicators for effective management of use of force in DJJ. Staff in the DJJ Policy Unit tracks the tasks, timeline and deliverables of the Force

[71] *Ibid.*
[72] *Ibid.*

Prevention Plan. A schedule of the progress for each task under the plan as of May 9, 2012 is attached as Appendix E.

The Force Prevention Plan anticipated completion of all identified tasks by the end of fiscal year 2011-12 except for LETRA training, which is a 32-hour training course that is to be fully completed by July 6, 2013. A review of the status of the various tasks in the plan indicates that Defendant is slightly behind schedule (by approximately one month). This was primarily caused by a delay in finalization of the Crisis Prevention and Management Policy, which was negotiated by the parties and released in March 2012 after having been circulated to the *Farrell* Experts for review and comment. The Special Master believes the revised policy, which incorporates the principles of the IBTM, encourages prevention and promotes increased application of positive incentives throughout the DJJ system, representing a vast improvement over the former policy.

Defendant also made progress toward revising the force review process. In her Twenty-First Report, the Special Master noted Defendantôs inability to develop a multi-disciplinary force review model that places primary emphasis on prevention and de-escalation after having contracted with an outside force expert for advice and assistance on this matter. In May 2012, Defendant staff developed such a model and an outline of training to be provided in the new model. The documents are in the process of being circulated to the *Farrell* Experts for review and comment.[73] The Special Master has reviewed a preliminary version of this model and found it to be consistent with the new Crisis Prevention and Management Policy and the intention of helping to train staff about how to prevent use of force. Defendant intends to finalize the force review model and

[73] *See* Pop 893, "Force Review Process Overview" per email of May 24, 2012 from Doug Ugarkovich to *Farrell* Experts.

deliver training to all staff potentially involved in the force review process by the end of June 2012.

Block training is underway for staff throughout DJJ with custody staff receiving 24 hours of training and non-custody staff receiving 16 hours of training. The entire block training for this year is devoted to use of force, which encompasses Crisis Prevention and Management Policy, Core Correctional Practice training, and reinforcement strategies and sanctions. The block training is scheduled to be completed by the end of July 2012. The first phase of LETRA training, originally scheduled for completion by early July 2012, will be completed in August 2012. While policy on psychotropic medication is still under development, on-the-job training has been provided to all staff to help staff understand the possible behavior of psychotropic medication and the best ways to assist the youth to deal with such medication.

While Defendant is moving in a positive direction, the Special Master cautions that meaningful reform will not take place without full commitment from senior management at the headquarters office and at the facilities. Senior managers need to demonstrate, by words and by actions, they clearly understand and fully embrace the purpose and intent of the Crisis Intervention and Management Policy and actively engage in the force review process. Senior managers also need to review and monitor process and outcome data and take proactive actions to reduce use of force throughout the system. In addition, there remains a need for a quality assurance system to ascertain if management policies and directives are being followed and to ensure meaningful and productive outcomes. For example, as reported in the Twenty-First Report of the Special Master, the Deputy Special Master, during one of his site visits to VYCF, found the

individualized Crisis Intervention Plans were not being updated and some youth had no plan. The matter was conveyed to the Superintendant who in turn issued a memorandum directing staff to update the plan after each case conference. During his visit with the Safety and Welfare Expert to observe VYCFôs BTP units on April 18, 2012, the Deputy Special Master again reviewed the two BTP unitsô Crisis Intervention Plan binders and found no evidence of any of the plans in the binder being updated since his last visit in February 2012. The Team Treatment Supervisor acknowledged that the plans were not updated as there were other more urgent matters confronting the BTP units. This is but one example of the need for a quality assurance system.

VII. CONCLUSION

Defendant has made progress in all areas discussed in this report. This is the first time in her tenure that the Special Master has been able to make such a statement.[74] Defendant has clearly paid close attention and invested time and energy to the issues and concerns discussed in the Special Masterôs last report about the IBTM as well as use of force and challenges with the BTP at VYCF. Progress in so many areas is commendable.

Until this point in the case, for the most part, the various *Farrell* Experts have been able to work independently from one and other. Now with the development of a true IBTM, the overlap that has been identified in the various remedial plans is creating new and healthy challenges for the parties and the Special Master. Just as the transfer of monitoring has been handled differently in each plan, so may the full transfer of monitoring and the removal of plans from the case.

[74] The Special Master was appointed in February 2010.

Given the very different nature of the subjects of the six remedial plans, the approach to transfer of monitoring and removal from the case will likely differ. The parties have worked well together to craft plans that reduce the time and attention of external monitors while ensuring that any outstanding issues continue to be monitored and just as importantly, allow for a shift in focus toward critical remaining issues such as the IBTM driving a new culture that relies more on evidence-based behavioral strategies than moral platitudes and use of force. As Defendant moves toward full monitoring of some plans, it is also important to ensure that the remedial plans are well integrated.

Integration will require in some instances that an expert now assume responsibility for some areas once addressed by a different expert. There is no one path or simple solution regarding how to do this. For example, responsibility for the IBTM resides in many plans. It appears that the Safety and Welfare Expert is ultimately responsible for the IBTM and yet the Mental Health Experts are doing most of the developmental work in the IBTM. Similarly, the Disability Expert has had responsibility for areas such as grievances and ensuring delivery of educational services that are also the responsibility of other experts.

The Special Master concludes if the outstanding issues that are identified below are addressed satisfactorily that it is time to transfer monitoring in full to Defendant in both the education and disability areas. Outstanding issues include:

Education:

- Education Experts and Defendant identify a realistic absence rate and strategies to maintain the absence rate at JBHS and reduce the absence rate at NACHS and at MBPHS.

- Adequate delivery of education services (regular and special education) to youth in VYCF's BTP units.

- Ensure that other programs do not infringe upon the mandatory 240 minutes of the school day.

Disabilities:

- Defendant is to consult with the Mental Health and Disability Experts to develop a definition of mental health and/or additional processes that provide sufficient guidance to mental health practitioners to accurately identify youth with disabilities.

- Defendant is to develop a proposal for on-the-job training on WDP awareness, including measures to track the training, for review and comment by the Disability Expert by August 1, 2012. On June 13, 2012, Defendant submitted a proposal to the Disability Expert, Plaintiff, and the Special Master for comment. Comments have been received and the proposal is being revised with assistance from Defendantôs education department staff. The revised proposal will be resubmitted for further review by the stakeholders. When the proposal is finalized, Defendant should invite the Plaintiff, Disability Expert and the Special Master to attend a training session.

- Defendant is to develop procedures to provide accommodation and staff assistance to youth throughout the grievance process, including the initial point of filing an informal grievance, for review and comment by the Disability Expert by August 1, 2012.

- Defendant is to revise its youth orientation process and provide the proposed module to all *Farrell* Experts for review and comment by August 1, 2012.

- The Parties in conjunction with the Special Master are to coordinate with the Safety and Welfare Expert, the Education Expert and Mental Health Expert for assumption of monitoring responsibility of concerns identified by the Disability Expert on crossover issues (use of force, grievance, education in restricted programs, psychotropic medication).

The Education and Disability Experts are to be commended for the dedication that they have demonstrated that has resulted in such significant progress. Both education and disability are complex areas and the reform that the experts have led at DJJ is indeed commendable. Today youth at DJJ receive quality educational services that rival and in many cases exceed the public school system. Similarly, the rights of youth with disabilities are protected and addressed, as they were not in the past. In neither area are

the systems perfect but in both areas, if the remaining issues identified in this report are satisfactorily addressed and compliance levels in other areas are maintained, they will have achieved a level of substantial compliance that may support removal from the Consent Decree.

The Parties are to be congratulated for creating what appear to be reasoned and thoughtful strategies to accomplish the transfer of monitoring in both the education and disability remedial plans.

The Special Master respectfully submits this report.

Dated: July 5, 2012

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Nancy M. Campbell
Special Master

California Remedial Plan Site Compliance Report

Area : EDUCATION **Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon,Dr. Jack Catrett** **From Feb. 2012 through March 2012**

Ratings:	SC Substantial compliance	PC Partial Compliance		NC Non compliance	
	Site	**Chaderjian**	**Boss**	**MBPHS**	
	Date of Review	**2/7/2012**	**2/9/2012**	**3/5/2012**	
	Items Reviewed				
I. Overview					
1.1	Schools meet WASC accreditation standards	**SC**	**SC**	**SC**	
1.2	Curriculum meets CA state standards	**SC**	**SC**	**SC**	
1.3	High School Graduation Plans in records	**SC**	**SC**	**SC**	
1.4	Semi-annual reviews of High School Graduation Plans	**PC**	**SC**	**NC**	
1.6	Progress being made toward high school diplomas	**SC**	**SC**	**SC**	
1.7	English Language Learner screening & services	**SC**	**SC**	**PC**	
1.8	Transition planning (90 days prior to release)	**SC**	**SC**	**SC**	
II. Staffing					
2.1	Teachers hold valid CA credentials and teach in-field	**SC**	**SC**	**SC**	
2.2	Adequate credentialed staff in content areas for gradua	**SC**	**SC**	**SC**	
2.3	Recruitment plan for education staff and 2 recruiters	**SC**	**SC**	**SC**	
2.4	Time between education vacancy and hiring	**PC**	**PC**	**NC**	
2.5	Pool of substitute teachers = 15% of teaching staff	**SC**	**PC**	**SC**	
2.6	Class cancelled due to teacher absence/lack of subs	**SC**	**SC**	**SC**	
2.7	In-field teacher used for teacher vacancy of 45 days	**SC**	**SC**	**SC**	
2.8	Psychologist and related service providers available	**SC**	**SC**	**SC**	
2.9	Time from referral for testing and report completed	**SC**	**SC**	**SC**	
2.10	Time from referral for related services to service delive	**SC**	**SC**	**SC**	
2.11	2 school psychologists for each restricted program	**SC**	**NA**	**SC**	
III. Student Access & Attendance					

	Date of Review	2/7/2012	2/9/2012	3/5/2012	
3.1	Standardized Academic Calendar meets CA requireme	**SC**	**SC**	**SC**	
3.2	Standardized Academic Calendar-basis of student serv	**SC**	**SC**	**SC**	
3.3	Policy & practice-all students enrolled within 4 days	**SC**	**SC**	**SC**	
3.4	Registrars request records on new students within 4 da	**SC**	**PC**	**SC**	
3.5	Students meeting GED criteria have GED opportunity	**SC**	**SC**	**SC**	
3.6	SCT services for students with academic/ behavioral p	**SC**	**SC**	**SC**	
3.7	SCT records of interventions and referrals	**SC**	**SC**	**SC**	
3.8	Students not making academic progress referred to SC	**SC**	**SC**	**SC**	
3.9	Development of SCT tracking system	**SC**	**SC**	**SC**	
3.10	Documentation of progress reviews of SCT plans	**SC**	**SC**	**SC**	
3.11	SCT logs show follow-through on eligibility testing	**SC**	**SC**	**SC**	
3.12	Students referred from SCT receive special education	**SC**	**SC**	**SC**	
3.13	SCT training (procedures, roles & responsibilities, form	**SC**	**SC**	**SC**	
3.14	Teachers informed of missing student's whereabouts	**SC**	**SC**	**SC**	
3.15	Document school attendance for previous 30 days	**NC**	**NC**	**NC**	
3.16	Cooperative Agreements to ensure students' attendan	**SC**	**SC**	**SC**	
3.17	Quarterly reviews of school attendance by Exec.Team	**SC**	**SC**	**SC**	
3.18	Plans (due 4/05) to remediate deficient attendance	**SC**	**SC**	**SC**	
3.19	Quarterly corrective action plans for high absence rates	**SC**	**SC**	**SC**	
3.20	Policy & procedure to eliminate class cancellations	**SC**	**SC**	**NC**	
3.21	Teacher records indicate missing students	**SC**	**SC**	**SC**	
3.22	Exclusion from school forms have complete data	**SC**	**SC**	**SC**	
3.23	Observation of students not being sent to school	**NC**	**SC**	**NC**	
3.24	Accurate attendance data in WIN database	**SC**	**SC**	**SC**	
3.25	Mgmt team monthly review of attendance data	**SC**	**SC**	**SC**	
3.26	Performance expectations on attendance (due 7/05)	**SC**	**SC**	**SC**	
3.27	Training on attendance expectations	**SC**	**SC**	**SC**	
3.28	Implementation of attendance policy & procedures (due	**SC**	**SC**	**SC**	
3.29	Incentives developed for increased school attendance	**SC**	**SC**	**SC**	
3.30	Annual state school calendar implemented	**SC**	**SC**	**SC**	
3.31	Yearly calendar w/44 student advising/case conference	**SC**	**SC**	**SC**	
3.32	Adequate instructional space	**SC**	**SC**	**SC**	
3.33	Structured classroom behavior management system	**SC**	**SC**	**SC**	
3.34	Alternative behavior management classroom at each s	**SC**	**SC**	**SC**	
3.35	Staff training on behavior management system	**SC**	**SC**	**SC**	
3.36	Behavioral goals for spec. ed. students-restricted progr	**SC**	**SC**	**SC**	
3.37	Use of small classrooms (adequate size) in restricted s	**PC**	**SC**	**NC**	
3.38	Staff ratio & credentialed teachers in restricted settings	**SC**	**SC**	**SC**	
3.39	Instructional program in restricted placements	**SC**	**SC**	**NC**	
3.40	Training provided to staff in restricted settings	**SC**	**SC**	**SC**	

Date of Review		2/7/2012	2/9/2012	3/5/2012	
IV. Curriculum					
4.1	Curriculum Guides & policies aligned with CA Educatio	**SC**	**SC**	**SC**	
4.2	Process to develop and revise curriculum on cyclical ba	**SC**	**SC**	**SC**	
4.3	Curriculum guides for all core & vocational classes	**SC**	**SC**	**SC**	
4.4	Core Curriculum Guides available in electronic form (du	**SC**	**SC**	**SC**	
4.5	Schools meet CA & WASC standards for books & mate	**SC**	**SC**	**SC**	
4.6	Annual inventory & needs assessment of books & equi	**SC**	**SC**	**SC**	
4.7	Textbooks & library books available in classrooms	**SC**	**SC**	**SC**	
4.8	Books available in mini-libraries on living units	**SC**	**SC**	**SC**	
4.9	Professional development for school leadership persor	**SC**	**SC**	**SC**	
4.10	Training schedule on new procedures-educ & custody	**SC**	**SC**	**SC**	
4.11	Training attendance-new procedures-educ & custody s	**SC**	**SC**	**SC**	
4.12	Formation of Trade Advisory Committees & quarterly m	**SC**	**SC**	**SC**	
4.13	Annual surveys for vocational course planning (due 7/0	**SC**	**SC**	**SC**	
4.14	Annual Career Technical job studies to evaluate CTE p	**SC**	**SC**	**SC**	
4.15	Use of technology at each site (due 6/05)	**SC**	**SC**	**SC**	
4.16	Distance learning courses meet CA Content Standards	**SC**	**SC**	**SC**	
4.17	Use of Global Classrooms distance learning (due 6/06)	**SC**	**NC**	**SC**	
4.18	Distance learning provided in restricted units	**SC**	**NC**	**SC**	
4.19	Automated library system at each HS (due 6/06)	**SC**	**SC**	**SC**	
4.20	Teachers use course syllabi & lesson plans	**SC**	**SC**	**SC**	
4.21	Quarterly teacher observations using revised rubric	**NC**	**PC**	**SC**	
4.22	5 year strategic plan & reading initiative implemented	**SC**	**SC**	**SC**	
4.23	Policies revised to reflect operational changes	**SC**	**SC**	**SC**	
4.24	Education policies available electronically (due 6/06)	**SC**	**SC**	**SC**	
V. Special Education					

	Date of Review	2/7/2012	2/9/2012	3/5/2012	
5.1	Special Education Policy Manual revised & available (c	**SC**	**SC**	**SC**	
5.2	Files transferred & services implemented in 4 days	**SC**	**SC**	**SC**	
5.3	Screening provided and referrals for psychological test	**SC**	**SC**	**SC**	
5.4	Teachers identify special ed students in classrooms	**SC**	**SC**	**SC**	
5.5	Referral for testing-update eligibility; reports complete &	**SC**	**SC**	**SC**	
5.6	Site has full continuum of placement options	**SC**	**SC**	**NC**	
5.7	Continuum of services available in restricted settings	**SC**	**SC**	**NC**	
5.8	Segments & services listed in IEPs are provided	**SC**	**NC**	**NC**	
5.9	Accuracy & completeness of special education data sy	**SC**	**SC**	**SC**	
5.10	Assessment procedures updated & standardized	**SC**	**SC**	**SC**	
5.11	Training and reports of assessment completion rates	**SC**	**SC**	**SC**	
5.12	Procedures standardized, including county intake (due	**SC**	**SC**	**SC**	
5.13	Clinics-agreements with Intake & CS on providing IEPs	**SC**	**SC**	**SC**	
5.14	Procedures for Intake & CS on providing IEPs	**SC**	**SC**	**SC**	
5.15	Pre-existing valid IEPs implemented	**SC**	**SC**	**SC**	
5.16	Changes in IEPs documented w/rationale	**SC**	**SC**	**SC**	
5.17	Eligibility determined prior to IEP meeting	**SC**	**SC**	**SC**	
5.18	IEP eligibility meetings held timely & with notices, parti	**SC**	**SC**	**SC**	
5.19	IEPs include consideration of related svc/transition plar	**SC**	**SC**	**SC**	
5.20	Training on specific topics for special ed teachers	**SC**	**SC**	**SC**	
5.21	System of IEP progress reviews implemented	**SC**	**SC**	**SC**	
5.22	Compensatory special education svc provided when ne	**NC**	**SC**	**NC**	
5.23	Education Stakeholders' Committee w/quarterly meetin	**PC**	**PC**	**PC**	
5.24	Training to education and custody staff on Spec Educ	**SC**	**SC**	**SC**	
5.25	Regional Prog Specialist site reviews of spec ed compl	**SC**	**SC**	**SC**	
VI. California High School Exit Exam					
6.1	CA assessment program provided to eligible students	**SC**	**SC**	**SC**	
6.2	CYA curriculum in LA & math related to Graduation Tes	**SC**	**SC**	**SC**	
6.3	Students have multiple opportunities to pass state exar	**SC**	**SC**	**SC**	
6.4	Students have appropriate test accommodations /modi	**SC**	**SC**	**SC**	
6.5	Students with equivalent passing scores- waivers requ	**SC**	**SC**	**SC**	
6.6	Students failing test receive remediation	**SC**	**SC**	**SC**	
6.7	Test data is monitored & basis of school improvement	**SC**	**SC**	**SC**	
6.8	Students have range of alternatives to complete educa	**SC**	**SC**	**SC**	

Comparison of OACC and Education Experts Audit Ratings

Ratings:	No Change in Audit Rating	Ed. Experts raised OACC Rating		Ed. Experts lower / OACC Rating		NA No BTP
	Site	**Chaderjian**	**Boss**	**MBPHS**		**% audit agreement**
	Date of Review	**2/7/2012**	**2/10/2012**	**4/5/2012**		
	Items Reviewed					
I. Overview						
1.1	Schools meet WASC accreditation standards	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
1.2	Curriculum meets CA state standards	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
1.3	High School Graduation Plans in records	**PC TO SC**	**SC-SC**	**SC-SC**		**66%**
1.4	Semi-annual reviews of High School Graduation Plans	**PC-PC**	**PC TO SC**	**SC TO NC**		**33%**
1.6	Progress being made toward high school diplomas	**SC-SC**	**PC TO SC**	**SC - SC**		**66%**
1.7	English Language Learner screening & services	**SC-SC**	**SC-SC**	**SC TO PC**		**66%**
1.8	Transition planning (90 days prior to release)	**SC-SC**	**SC-SC**	**PC-PC**		**100%**
II. Staffing						
2.1	Teachers hold valid CA credentials and teach in-field	**PC TO SC**	**SC-SC**	**SC-SC**		**66%**
2.2	Adequate credentialed staff in content areas for gradua	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.3	Recruitment plan for education staff and 2 recruiters	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.4	Time between education vacancy and hiring	**SC TO PC**	**PC-PC**	**PC TO NC**		**33%**
2.5	Pool of substitute teachers = 15% of teaching staff	**PC TO SC**	**SC TO PC**	**SC-SC**		**33%**
2.6	Class cancelled due to teacher absence/lack of subs	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.7	In-field teacher used for teacher vacancy of 45 days	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.8	Psychologist and related service providers available	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.9	Time from referral for testing and report completed	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.10	Time from referral for related services to service delive	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
2.11	2 school psychologists for each restricted program	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
III. Student Access & Attendance						

	Date of Review	2/7/2012	2/10/2012	4/5/2012		
3.1	Standardized Academic Calendar meets CA requireme	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.2	Standardized Academic Calendar-basis of student serv	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.3	Policy & practice-all students enrolled within 4 days	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.4	Registrars request records on new students within 4 da	**SC-SC**	**PC-PC**	**SC-SC**		**100%**
3.5	Students meeting GED criteria have GED opportunity	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.6	SCT services for students with academic/ behavioral p	**NC TO SC**	**SC-SC**	**SC-SC**		**66%**
3.7	SCT records of interventions and referrals	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.8	Students not making academic progress referred to SC	**PC TO SC**	**SC-SC**	**SC-SC**		**66%**
3.9	Development of SCT tracking system	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.10	Documentation of progress reviews of SCT plans	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.11	SCT logs show follow-through on eligibility testing	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.12	Students referred from SCT receive special education	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.13	SCT training (procedures, roles & responsibilities, form	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.14	Teachers informed of missing student's whereabouts	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.15	Document school attendance for previous 30 days	**NC-NC**	**NC-NC**	**NC-NC**		**100%**
3.16	Cooperative Agreements to ensure students' attendan	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.17	Quarterly reviews of school attendance by Exec.Team	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.18	Plans (due 4/05) to remediate deficient attendance	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.19	Quarterly corrective action plans for high absence rate	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.20	Policy & procedure to eliminate class cancellations	**SC-SC**	**SC-SC**	**SC TO NC**		**66%**
3.21	Teacher records indicate missing students	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.22	Exclusion from school forms have complete data	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.23	Observation of students not being sent to school	**SC TO NC**	**SC-SC**	**NC-NC**		**66%**
3.24	Accurate attendance data in WIN database	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.25	Mgmt team monthly review of attendance data	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.26	Performance expectations on attendance (due 7/05)	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.27	Training on attendance expectations	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.28	Implementation of attendance policy & procedures (due	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.29	Incentives developed for increased school attendance	**SC-SC**	**PC TO SC**	**SC-SC**		**66%**
3.30	Annual state school calendar implemented	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.31	Yearly calendar w/44 student advising/case conference	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.32	Adequate instructional space	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.33	Structured classroom behavior management system	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.34	Alternative behavior management classroom at each s	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.35	Staff training on behavior management system	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.36	Behavioral goals for spec. ed. students-restricted progr	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
3.37	Use of small classrooms (adequate size) in restricted s	**PC-PC**	**SC-SC**	**NC-NC**		**100%**
3.38	Staff ratio & credentialed teachers in restricted settings	**PC TO SC**	**SC-SC**	**SC-SC**		**66%**
3.39	Instructional program in restricted placements	**SC-SC**	**SC-SC**	**SC TO NC**		**66%**
3.40	Training provided to staff in restricted settings	**SC-SC**	**SC-SC**	**SC-SC**		**100%**

Date of Review		2/7/2012	2/10/2012	4/5/2012		
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4.1	Curriculum Guides & policies aligned with CA Educatio	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.2	Process to develop and revise curriculum on cyclical ba	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.3	Curriculum guides for all core & vocational classes	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.4	Core Curriculum Guides available in electronic form (du	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.5	Schools meet CA & WASC standards for books & mate	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.6	Annual inventory & needs assessment of books & equi	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.7	Textbooks & library books available in classrooms	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.8	Books available in mini-libraries on living units	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.9	Professional development for school leadership persor	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.10	Training schedule on new procedures-educ & custody	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.11	Training attendance-new procedures-educ & custody s	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.12	Formation of Trade Advisory Committees & quarterly m	**PC TO SC**	**NC TO SC**	**SC-SC**		**33%**
4.13	Annual surveys for vocational course planning (due 7/0	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.14	Annual Career Technical job studies to evaluate CTE p	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.15	Use of technology at each site (due 6/05)	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.16	Distance learning courses meet CA Content Standards	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.17	Use of Global Classrooms distance learning (due 6/06)	**SC-SC**	**SC TO NC**	**SC-SC**		**66%**
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4.19	Automated library system at each HS (due 6/06)	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.20	Teachers use course syllabi & lesson plans	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.21	Quarterly teacher observations using revised rubric	**NC-NC**	**PC-PC**	**SC-SC**		**100%**
4.22	5 year strategic plan & reading initiative implemented	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.23	Policies revised to reflect operational changes	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
4.24	Education policies available electronically (due 6/06)	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
V. Special Education						

	Date of Review	2/7/2012	2/10/2012	4/5/2012		
5.1	Special Education Policy Manual revised & available (c	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.2	Files transferred & services implemented in 4 days	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.3	Screening provided and referrals for psychological test	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.4	Teachers identify special ed students in classrooms	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.5	Referral for testing-update eligibility; reports complete &	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.6	Site has full continuum of placement options	**SC-SC**	**SC-SC**	**SC- NC**		**66%**
5.7	Continuum of services available in restricted settings	**SC-SC**	**SC-SC**	**PC TO NC**		**66%**
5.8	Segments & services listed in IEPs are provided	**SC-SC**	**SC-SC**	**PC TO NC**		**66%**
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5.10	Assessment procedures updated & standardized	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
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5.12	Procedures standardized, including county intake (due.	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.13	Clinics-agreements with Intake & CS on providing IEPs	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.14	Procedures for Intake & CS on providing IEPs	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
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5.20	Training on specific topics for special ed teachers	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.21	System of IEP progress reviews implemented	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.22	Compensatory special education svc provided when ne	**NC-NC**	**SC-SC**	**NC-NC**		**100%**
5.23	Education Stakeholders' Committee w/quarterly meetin	**PC-PC**	**PC-PC**	**NC-PC**		**66%**
5.24	Training to education and custody staff on Spec Educ	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
5.25	Regional Prog Specialist site reviews of spec ed compl	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
VI. California High School Exit Exam						
6.1	CA assessment program provided to eligible students	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.2	CYA curriculum in LA & math related to Graduation Tes	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.3	Students have multiple opportunities to pass state exar	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.4	Students have appropriate test accommodations /modi	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.5	Students with equivalent passing scores- waivers requ	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.6	Students failing test receive remediation	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.7	Test data is monitored & basis of school improvement	**SC-SC**	**SC-SC**	**SC-SC**		**100%**
6.8	Students have range of alternatives to complete educa	**SC-SC**	**SC-SC**	**SC-SC**		**100%**

California Division of Juvenile Justice Summary Education Program Report
For School Year 2011-2012

Section I. Introduction

Background

During December 2002, Mr. Stephen Acquisto, Deputy Attorney General, California Department of Justice contacted Dr. Tom OÕRourke 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. OÕRourke 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 seven 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, from February 2011 through April 2011 and from February 2012 through March 2012 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.
***** This facility was closed before completion of the 2012 cycle

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

- Each of the three audited 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, 2010-2011 and 2011-2012 review cycles, all sites were required to send specific written reports and other relevant documentation to the education experts two weeks prior to their site visit.

- All sites were audited by the Office of Audits and Court Compliance (OACC) Juvenile Court Compliance Branch team 45 days prior to the Education Experts audit beginning with the 2010-2011 audit cycle and continuing during the 2011-2012 audit cycle. The DJJ Central Office and individual school administrators were provided with copies of the OACC audit finding 30 days prior to the Education Experts audit. Corrective action responses to the OACC audit and summaries of ratings were incorporated into the Education Experts final reports.

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

- A five-part approach was used to obtain information in order to monitor progress toward compliance with the Educational Remedial Plan:

  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.

  5) Comparison of OACC audit findings and a review of corrective actions taken by the individual sites and interviews with the OACC audit team were conducted by the Education Experts during their audit. A summary of findings by the OACC team have been incorporated into the Education Experts final summary report.

- 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.

- Beginning with the 2011 / 2012 monitoring cycle the Education Experts team was expanded to include Dr. James F. Catrett, who conducted on site visits at Johanna Boss High School, N. A. Chaderjian High School and Mary B. Perry High School.

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 Masterôs office within 30 calendar days of the site visit. After review, the Special Masterôs 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 ï item was not monitored at the site because the specific standard did not apply

Not Audited ï 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 ï report indicating the compliance ratings on specific items in the Remedial Plan for each school program reviewed

III. Major Commendations and Recommendations ï 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

Summaries of the experts' findings are found in Attachment A and Attachment B:

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 report, 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 Court Compliance Report and the Experts Audit Reports.

On this report, 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. Percentages of audit agreement are noted in this report.

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:

- Johanna Boss High School, N. A. Chaderjian High School and Mary B. Perry High School continue to meet the accreditation standards of the Western Association of Colleges and Schools.
- Each school provides a core curriculum that meets the Content Standards for the California Public Schools.
- Each school was able to document the presence of High School Graduation plans for all students enrolled in the school program.
- Each school has developed a system to identify students not making progress towards their high school graduation plan. This system provides documentation of School Consultation Team and special education referrals.

Recommendations:

- The reduction in the number of DJJ facilities has made it necessary to refine the Educational Central Office Organizational Chart. The DJJ Central Office and individual site administrators must continue to develop written job descriptions. DJJ administrative staff must provide oversight of all functions of the educational program to include major program changes, new courses, program deletions and staffing.
- All non-high school graduate students have a high school graduation plan that must be reviewed by education and treatment staff for progress towards completing the required courses. It's necessary that school staff at Mary B. Perry High School and N. A. Chaderjian High School take immediate steps to insure that this vital review is conducted and documented.

II. Staffing

Commendations:

- Each school was able to document that all teaching staff held valid California Department of Education credentials and that all teachers were teaching in field.
- The DJJ currently has in place a recruitment plan and recruiters to meet the need for future staff replacements.

- Special education assessments currently meet California Department of Education (CDOE) and Individual with Disabilities Education Act (IDEA) standards. School staff provided documentation that they are conducting all assessments including those required for related services such as speech, language, hearing, within the prescribed timelines established by DJJ policy and federal law.

Recommendations:

- Time delays between the occurrence of teaching vacancies and actual hiring and placement continues to be a problem at the Mary B. Perry High School. DJJ must balance staffing and teacher allocations at each location to insure the availability of certified staff.

- Each school was able to demonstrate the availability of an adequate pool of substitute teachers that met the 15% minimum remedial plan requirements. It is noted however, Mary B. Perry High School continues to use substitute teachers to fill long term teaching vacancies. This practice results in class closures.

- The DJJ must provide related service providers in the restricted programs at all sites. It is necessary to immediately address this problem.

III. Student Access and Attendance

Commendations:

- DJJ is commended for continuing to increase the enrollment in the vocational classes at each site.

- The DJJ is commended for their efforts to implement a Standardized School Calendar that meets California Department of Education and remedial plan requirements.

Recommendations:

- Full implementation of the "Program Service Day" continues to problematic at each site. 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 ñProgram Service Dayò is necessary at each site 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 implementation of the school program. The program service day must be implemented immediately.

- The full implementation of the SCT to include referral of studentôs not making progress in their academic efforts has not been documented at N. A. Chaderjian High School. It is recommended that the DJJ consider replication of programming by the other facilities as a means of correcting

this pressing issue.

- The remedial plan notes that students are expected to attend school except for verified medical conditions or when the student is an immediate threat to the safety of him/her self or others. The plan notes that schools with an absentee rate of 7% and higher will take corrective actions to reduce the rate to below the 7% threshold. Each site exceeds the 7% standard. It is noted however, that less than 6 % of the absences at each site are the result of education related matters (i.e. no subs etc.). Other absences are attributed to non education related matters (i.e. medical, treatment, mental health safety and security etc).It is recommended that the DJJ disaggregate attendance data (age, high school graduates vs. non high school graduates, access, other factors, etc.) to determine specific reasons for the high absentee rate. Focused corrective actions should be based on the results of this data. .

- Mary Perry High School staff were unable to implement policies and procedures specifically designed to eliminate class closures in the mainline and restricted programs. The school administration and DJJ Central Office staff must take immediate steps to implement existing policies and procedures.

- It is noted that school eligible students at Chad and Mary B. Perry were observed being held back from school for reasons other than safety and security or medical emergencies. This practice must be addressed immediately.

- Access to school programming for students placed on the restricted units continues to be a problem at the Mary B. Perry High School. This systemic practice must be corrected.

IV. Curriculum

Commendations:

- The DJJ is commended for providing a curriculum, instructional services, educational supplies and materials that meets state and federal standards.

Recommendations:

- Johanna Boss High School has not fully implemented distance learning on the restricted unit.
- School administrators at the Chaderjian High School and Johanna Boss High School must fully implement the practice of conducting quarterly teacher observations using the approved rubric before DJJ will be compliant in this area.

V. Special Education

Commendations:

- Chaderjian High School, Johanna Boss High School and Mary B Perry High School are commended for maintaining substantial compliance ratings on 20 of 25 special education audit areas measured by Section V. of the California Remedial Plan Site Compliance Report.
- Teachers at all facilities were well versed in the identification, eligibility and referral requirements for special education.
- The DJJ continues to provide 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

- Students at Mary B. Perry High School are not afforded the opportunity to access a full continuum of placement options. Eligible students do not have access to required services when placed in restricted programs.
- The DJJ has failed to provide compensatory services to all eligible students at Chaderjian High School and Mary B. Perry High School. Corrective actions must be provided to assure these services are provided.
- The DJJ has failed to insure that Education Stakeholderôs Committeeôs are meeting quarterly at each site. The Principal must take responsibility to assure that these meetings are being conducted.
- All segments and services listed in the IEP are not being provided at the Mary B. Perry High School and Johanna Boss High School.

VI. California High School Exit Exam

Commendations:

- Experts noted that all ratings in this area continue to be substantially compliant for this audit cycle. 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

Comments:

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.

During the 2010-2011 and 2011-2012 education monitoring cycles, the Office of Audits and Court 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.

During the two previous audits, school staff have been able to address items identified by the OACC audit team. The experts commend the DJJ education staff and the OACC audit team for their collaborative efforts to establish internal monitoring procedures to address Educational Remedial Plan requirements. In many cases school staff were able to address deficiencies with corrective actions.

The high degree of rater agreement between the OACC and the education experts audits, as documented in Appendix B (Comparison of OACC and the Experts Audit Ratings), strongly supports the continued validity of the OACC findings.

The continued improvements in the corrective actions taken at the Johanna Boss High School and N. A. Chaderjian High School document that staff at these two facilities are capable of monitoring and implementing the Educational Remedial Plan.

Recommendations:

The following recommendations by the Education Experts regarding the 2012-2013 monitoring cycle are offered:

1. The OACC will conduct a complete educational audit of Boss High School and Chaderijan High School by November 1, 2012.

2. The OACC findings, recommendations and corrective action responses will be provided to the Education Experts no later than December 15, 2012.

3. The Education Experts will review the OACC audit and request any additional audit information from the DJJ or the sites in order to verify compliance with the Education Remedial Plan.

4. Summary reports will be written for the Boss High School and Chaderijan High School sites by the Education Experts. The summary reports will verify OACC findings and address needed changes to site corrective action plans if deemed necessary.

5. The OACC team will conduct a follow up audit at the Boss High School and Chaderijan High School schools during the first quarter of 2013. The purpose of this audit is to verify that corrective actions have been fully implemented to address any audit items found partially or non compliant in the OACC first quarter 2012 audit.

6. The OACC audit team will provide a summary report of these corrections to the Education Experts verifying that all audit items comply with the Education Remedial Plan.

7. The Education Experts will conduct a follow up audit at the Mary B. Perry High School no later than October 31, 2012. This audit will review all audit items found to be partially or non compliant in the March 2012 audit.

8. Education Experts will provide a summary report of this follow up for Mary B. Perry High School to the Special Master within 30 calendar days of the completion of the audit.

9. The OACC team will audit Mary B. Perry High School by March 1, 2013.This audit will verify that corrective actions have taken place and that all audit items are in compliance with the Educational Remedial Plan.

10. OACC will provide the Education Experts with a copy of this audit within 30 calendar days. If the facility is found to be in satisfactory compliance in all audit areas the Education Experts will submit a formal request to the Special Master asking to be removed from the case.

Introduction

This report represents the results for the seventh annual round of auditing at DJJ facilities by the *Farrell* Disabilities Expert and Auditor, Logan Hopper, during the 2011-2012 fiscal year, and is termed as "Attachment 1" to the overall 2012 WDP Comprehensive Report. Audits were held at N.A. Chaderjian (Cha) on December 15 & 16, 2011, O.H. Close (Clo) on February 14 & 15, 2012, Ventura (Ven) on March 14 & 15, 2012, and DJJ Headquarters (HQ) on April 4, 2012.

The report describes the general level of compliance for all applicable items from the Wards with Disabilities Program (WDP) Remedial Plan and the Disabilities Audit Instrument, using the codes given below. Ratings of compliance and comments are based on the sources specified in the "Method" column, unless otherwise indicated.

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

During the previous audit cycle in 2010-11, a number of audit line items were transferred to be audited by CDCR's Office of Audits and Court Compliance, subject to sampling by the Disabilities Expert, in mutual agreement by the parties, the Office of the Special Master, and the Disabilities Expert. Since OACC has taken the responsibility for auditing these items, no ratings or information on these items are given in this report. Refer to the separate OACC"s "Report of Findings" for each facility, unless the item was randomly or specifically monitored by the Disabilities Expert during this audit.

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

Facility Compliance Chart

No	Item	Method	Cha	Ven	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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
	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	SC	Sandi Becker is entering her fourth year as the full-time Departmental WDP Coordinator.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
3	Ensure duty statement encompasses all Departmental WDP Coordinator duties defined in the WDP Remedial Plan.	Review duty statement.	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	SC	Sandi Becker is believed to be performing the required oversight functions in an effective and commendable manner.	
5	Establish and maintain full-time WDP Coordinators at each facility by Feb., 2006.	Verify positions are in place and filled.	NA	NA	NA	PC	It has been reported that each facility currently has an assigned facility WDP Coordinator in place, although this has not been verified, and reports are that one or more of the Coordinators are only temporary. Findings are that Coordinators have not been "maintained" (as required by the Item description in column 1) on a consistent basis throughout the year. See also items 36-38 and the detailed discussion within the 2012 Comprehensive Report.	Headquarters and State Personnel representatives should develop improved procedures for the interviewing and hiring process for new Coordinators, or for promoting existing staff, on a timely basis, and DJJ should evaluate why Coordinators have not been able to be kept in place for sufficient amounts of time to be effective, and make corrections as needed.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	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 is therefore still effective. In response to comments and recommendations by the disabilities expert in previous reports, the WDP Manager and previous 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 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.
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	SC	Monthly reports were typically provided by the facilities throughout the fiscal year. 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.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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 implement-tation and review document-tation to ensure compliance.	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". Medical directors of the two remaining OHU's submitted statements of knowledge and compliance with the "action plan", and lists of youth recently in OHU's did not indicate any long-term stays that might be problematic. 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	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	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. Reviews of mental health chronological records in WIN by the OACC Auditor indicated little if any documentation of effective monitoring of these prescriptions, and time limits for medication counseling reviews were often exceeded for all such youth. Interviews with youth taking psychotropic medications indicated a lack of consistent and comprehensive monitoring. Details of proposed revisions to the Psychopharmacological Policy draft were to be sent to the Disabilities Expert, and these are still expected, but not yet received.	Provide documentation of the implementation of the required monitoring activities, including the tiered administration system, and adherence to the timelines for reviewing and monitoring prescriptions with wards and parents. Consider revisions to the psychopharmacology guidelines to improve ward interaction, advocacy, and monitoring. Provide details of proposed revisions to the Psychopharmacological Policy draft to the Disabilities Expert.
10	The CYA shall conduct annual compliance reviews of the court-approved Disabil-ities 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.	Verify comple-tion of annual com-pliance reviews.	NA	NA	NA	SC	CDCR's Office of Audits and Court Compliance has been assigned the primary auditing responsibility of from 52-64 of the audit items contained in the WDP audit instrument and has prepared compliance reviews at all four facilities throughout the last fiscal year. In some cases, the Disabilities Expert has arrived at differing results and compliance ratings. The Departmental WDP Coordinator and facility Coordinators have also been involved in auditing sites prior to the audits, and "Quarterly Audit Checklists" have been prepared for use by facility WDP 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	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.	Review the outside consultants training material to determine compliance with the requirements contained in the WDP Plan. Review/confirm training schedule to ensure all individuals complete training.	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.	
12	Develop the Disability Health Services Referral Form.	Monitor for completion by December, 2005.	NA	NA	NA	SC	The "Disability Referral/ Evaluation Form" (DJJ 8.288) was completed and distributed on February 25, 2008, and the form is at facilities. 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).
	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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	Accessible vans have been purchased and are presumably in use.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	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.	
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	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	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	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	SC	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.	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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	PC	The Policy contained in PoP #867, previously reviewed and approved with qualifications by the Disabilities Expert, was released as CN456 "Youth with Intellectual Disabilities" and was signed by the DJJ Director on April 4, 2012 (the day of the HQ audit). Even though this policy represents an effective culmination of the meetings with the study team and the initial preparation of the written policy as described in the Item column, as of this date, it has not yet been through the overall approval process (such as union approval) nor yet distributed to the facilities for implementation. See also items 24, 86, & 115.	Complete the overall approval process, distribute to the facilities, and begin the implementation. See also item 115.

No	Item	Method	Cha	Ven	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 deter-mine comple-tion /level of operation	NA	NA	NA	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	SC	The needs assessment described in the Item column, while believed to be cursory and non-specific, was indeed completed in 2007. Its applicability to current DJJ (1,200 youth, 3 facilities) is probably very slight. A course curriculum for the sensitivity & awareness portions of the training was developed with 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 in its review of the original training document (prior to the ADAA of 2008) and as required due to later regulations.
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 assess-ment is completed within the given timeframe.	NA	NA	NA	SC	A screening tool for youth with developmental disabilities was prepared in May, 2010, and was reviewed and approved by the Disabilities Expert. It is in use by clinical psychologists at the facilities, although there are indications some still do not use the screening form consistently or correctly. See also item no. 86.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	PC	A course curriculum for the sensitivity, awareness, and harassment portion of the training has been developed, and training sessions for current staff were combined with block training covering numerous other topics, with some training being give at all facilities. Two years ago, the auditor's report gave the percentage of completion by all staff to be about 80%, based on the data presented. Last year, the auditor's report gave the percentage of completion by all staff to be about 60%, based on very definitive data (including the names of all staff completing the training and the range of total staff at each facility during the year). For this year, OACC audits showed a low percentage of training, and training rosters presented at the HQ audit showed a much lesser percentage, estimated to be below 50% (it was stated that block training was not able to be presented on a consistent basis during the year, so more detailed statistics were not obtained, but could be if requested). It is clear that a greater effort needs to be made to provide the required training to all staff within the next 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. See discussion within the 2012 Comprehensive Report.	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	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	PC	The Departmental WDP Coordinator has prepared an excellent form for use by work and camp supervisors to evaluate the essential functions and necessary accommodations for these youth, and the Director sent a memo to the facilities on implementing the form and the evaluation process on April 11, 2012 (a week after the HQ audit). Despite this progress, it cannot be verified if or how the form will actually be used by facility staff to assure equal access until supervisors begin to use the form. See also item 98.	Some additional guidance either from HQ or the facility WDP Coordinators is recommended to assist work supervisors in the proper application of the new form.
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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
	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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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	SC	The Intake and Court Services Unit staff still have to wade through the poor documentation 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.	
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	*	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	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 recommendations also apply here.

No	Item	Method	Cha	Ven	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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. See item 96.
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	NA	A system of reporting by e-mail is in place at each facility. It should be noted that this item has been monitored very literally - that is, only that reports of wards with a disability that requires accommodation is placed in a restrictive setting are transmitted are transmitted to the Deputy Director (actually Mark Glaser). The item's compliance rating does not include any monitoring of what happens past that point.	

No	Item	Method	Cha	Ven	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 accommodations during institutional Youth Authority Board (YAB) hearings.	Audit Case Report Transmittal Form.	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	NC	SC	NA	Each facility had a person present as a WDP coordinator at the time of the audit. However, since the audit, all of these Coordinators have left. The item states DJJ should ***maintain*** Coordinators, not change them every few months (if indeed even that has occurred). The Coordinator at Ventura had been in place two days prior to the audit, and reportedly left shortly thereafter. Despite the "SC" ratings given at two facilities due to a literal interpretation, the inability to keep the facility WDP Coordinator position filled for a reasonable period of time is a cause of major concern. See discussion in the 2012 Comprehensive Report, and items 5 & 38.	This item should be continued and closely monitored, due to the inability to keep Coordinators in place and maintain consistency.
37	Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	Review duty statement.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	Again, as described in Item 36 above, a literal interpretation of this requirement was met at the time of each audit.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	PC	PC	PC	NA	Even though Coordinators were available at times during the year, there were significant periods when Coordinators were not present. Second, it is impossible to perform all duties fully without adequate training (see item 39). Third, it was not possible to verify the exact percentage of time the Coordinators were specifically scheduled for WDP duties. Regarding the "compliance method" in column 2 to be used as a basis for review, no facility Coordinator provided any documentation of activities or functions necessary to oversee daily operation of the WDP program. See also items 5, 36, & 39, and the 2012 Comprehensive Report.	
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.	PC*	PC*	PC*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle. However, in our opinion, the "SC" ratings given by OACC were incorrect, as none of the Coordinators present during the OACC audit received any type of training required by columns 1 & 2. The six-month period was intended to allow for the preparation of training materials, which are supposed to be readily available for new Coordinators, and that period ended in December, 2005. It is true that very recently, due to the numerous changes in Coordinators, some current Coordinators undertook an alternative training, but all of those persons left shortly thereafter. But for the majority of the fiscal year, each facility did not have a Coordinator who had been adequately trained.	Provide the required training to any new Coordinators, and then keep current, trained Coordinators in the position for an extended period, so that youth with disabilities are afforded with resource providers who are trained to effectively assist them.
40	The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	Review monthly reports.	SC	SC	SC	NA	Basic, simplified monthly reports printed from WIN were submitted monthly to the departmental coordinator, either by the departmental coordinator herself, or by interim facility coordinators 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	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	NA	While the processes (initial review procedures, meetings, ICR's, etc.) involved in this item have indeed been recently strengthened and better defined, DJJ has misinterpreted this item to refer solely to the process and not the end result of properly indentifying youth, i.e., does the youth have a disability under the law or not? Headquarters has still not disseminated comprehensive guidelines appropriate for proper identifications, screenings, and assessments of medical and mental health disabilities, although recent discussions with Dr. Wisdom, the department's CMO were positive, and it has been reported that further discussions between these staff and the medical and mental health experts are planned. In general, the various disciplines are using their best efforts to identify affected wards, but overall departmental guidelines regarding the legal and practical definitions of disability are still needed. Assuming that an individual practitioner is fully knowledgeable on the intricacies of disability law is not enough. Of particular concern are asthma and other chronic and hidden medical disabilities, and mental health classifications. It should be noted that youth with similar DSM-IV mental health diagnoses and treatment plans housed in special mental health units (such as ITP) are sometimes listed as WDP, and sometimes not; greater consistency is needed. See discussion in the 2012 Comprehensive Report.	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 sent out 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 implement-tation (this has been recommended for the past three years, but the Disabilities Expert has received no significant information to review). The Disabilities Expert should be more involved in this issue and could assist staff or prepare a draft report on the subject, but this has not been desired by either OSM or DJJ in the past, and the Disabilities Expert would want agreement from DJJ that this is desired before beginning such a task.

No	Item	Method	Cha	Ven	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	While no specific instances of the removal of devices were encountered, audit time limits did not allow for full evaluation of this audit item.
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.	PC*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle. See "Method" column. As a follow-up, I undertook a review of this item to determine continuing compliance. Information received after the Chad audit indicated that the only deaf youth within DJJ was not provided with a TDD for much of the year. During the visit to his living unit, the TDD was not available. Living unit staff on duty at the time stated that they did not know of the presence of one at the unit at any recent time. DJJ has maintained that a sign language interpreter was available to assist in phone conversations, but other interpreter issues made this an unacceptable option. See discussion in 2012 Comprehensive Report.	This item requires that a TDD, or alternately, a videophone (which is provided by the State for free), must be readily available (i.e., at the living unit) to all deaf youth or hard-of-hearing youth at all times.
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*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle. The rating at Chad was improved by the Disabilities Auditor at the audit.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	NA	This item should most likely be given an "NA" rating, but DJJ has objected to this rating in the past when the item was not applicable, since it would be impossible to ever achieve compliance. The "Health Care Services Request Form" and the "Disability Referral/Evaluation Form" (DJJ 8.288) were both available to wards for self-referrals. It seems that a self-referral process is in effect and that wards are not precluded from self-referring. Nevertheless, there were few documented instances where a ward used the self-referral process, and such use is still uncommon. The only instances reported were initiated by the WDP Coordinator during initial interviews with youth. Interviews with "Education Advisors" (as listed in the Item column) did not indicate a common knowledge that they were to be involved in this WDP process.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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.)	SC	SC	SC	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	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 facilities.	It should be noted that the Education audits also assess a similar item, and either through a review of different files, or through a more rigid set of criteria than involved in the WDP Remedial Plan, those audits found some problems in this area. Therefore, audits through the WDP auditing process should continue.
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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.	PC	PC	SC	NA	O.H. Close showed steady improvements in providing educational services for youth with disabilities, and thus achieved its first "SC" rating for this item. At other facilities, based upon WIN data and student files reviewed, 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, and students with disabilities still do not have the full range of placement options available to other students. Students with disabilities were placed on T.I.P. less than in previous years, yet records showed that for those youth extended in T.I.P. for more than 72 hours, mandated educational services were not always provided. It should be noted that the Special Master has requested (in OSM 19 and through expert meetings) that these items be coordinated with the educational experts. I have reviewed the most recent Education Audit Reports for all facilities and found that the results of my audit are very similar to those education reports. I have also discussed these issues with Dr. O'Rourke.	(1) Continue to implement the Program Service Day and other policies designed to improve attendance at school. (2) Provide better compensatory services for special education students unable to attend classes. (3) Provide a broader range of placement and instructional options at restricted and special purpose / treatment units. (4) Provide mandated educational services for youth with disabilities placed on T.I.P. past the 72-hour limit.
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 procedure. Interview wards to determine effective non-emergency communications.	SC	SC	SC	NA	Standardized written operational procedures are reportedly available to staff, although time limitations did not allow these to be provided to the Auditor at all facilities. Since only two wards with hearing disabilities were present (at Chad), 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. Thought needs to be given by DJJ living unit staff about how other youth with low communication skills are affected by this item.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	NA	Reviews of use of force (UOF) logs, reports, and other documents still indicated continuing problems in this area. From a quantitative perspective, the data for the 3-month period prior to each audit was reviewed (although Close had insufficient data available), and it was evident that UOF incidents had not decreased significantly from the previous audit. From a qualitative perspective, reviewed UOF reports for WDP single-youth incidents did not indicate that the staff involved in the initial incident, or in the subsequent reviews by senior staff, were aware that the involved youth were WDP, or what their accommodations were. As found in the UOF study conducted by DJJ staff last fall and using the same criteria as they did, most of these single-youth incidents did not indicate immediate threats to life or safety, but were inappropriately treated as such. While a few reports stated that there was some degree of "dialogue", there was no documentation showing how alternative conflict and violence resolution techniques were actually utilized. The Special Master has indicated that the S&W Expert should take the overall lead on this topic, and these findings have been provided in separate reports and discussed with the S&W Expert. See also the 2012 WDP Comprehensive Report.	Recommendations for documenting the procedures contained in the WDP Remedial Plan (pages 40-44) have been made to the appropriate staff. Improved procedures incorporating the recommendations of the DJJ UOF Study Team are needed to comply with these requirements. See also the 2012 WDP Comprehensive Report.
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*	SC*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle. The rating at Chad and Ventura was improved by the Disabilities Auditor at the audit	See also item no. 34.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	PC	SC	SC	NA	This is a marginally compliant item at all facilities. Most of the audited files indicated that youth attended such meetings. This policy appears to be partially implemented, since teachers and some youth stated that the pre-meeting was occurring. Nevertheless, more objective written documentation (such as a student signature in the Special Education file) and details of the actual content of the pre-meetings are still lacking.	Standardize departmental-approved for consistently documenting the dates, times, and participants in IEP "pre-meetings". The WDP Coordinator should follow-up with the MST from time to time to verify that the approved procedures are being followed.
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	NA	SC	NA	Attendance rosters for trainings at all facilities during FY2011-12 were provided at the audits. At Ventura, a sign-in sheet showing attendance by only one surrogate parent was provided to the auditor. Even though this facility houses many adult students, it is not believed that this is a sufficient number to adequately serve the population. In reviewing the roster with the Principal, he confirmed that the surrogate program was not functioning as it should, so it is believed that an audit of a program that is insufficient in serving the needs of youth is not appropriate.	Provide the surrogate training annually, and assure that all surrogate parents to be used attend.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	PC*	*	*	NA	*Monitoring was transferred by agreement of the Expert and parties to DJJ for this audit cycle. However, this item was also audited by the Disabilities Expert, and we disagree with the "SC" rating given by the OACC auditor at Chad. In particular, we encountered a youth who was listed as requiring the accommodation of a hearing aid due to a hearing impairment (his hearing loss was later documented), and who was prominently listed on the WDP list. A detailed review of this situation showed several inadequate procedures both on the part of WDP and of medical staff (who according to the records subsequently provided, failed to provide the follow-up appointment required by the audiologist). The very fact that the WDP list had the accommodation of a hearing aid (if indeed that was not required, a medical decision that was never accurately documented) for over a year with no staff catching it, signals ineffective procedures. The "Method" column indicates my interview of such youth is required, and in doing so, I have no reason to question the veracity of a youth who states he needs a hearing aid, particularly when the WDP list concurs. In addition, informal complaints and formal grievances regarding the competency and effectiveness of several sign language interpreters raised, in our opinion, many valid points (see also item 59).	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.
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 Coordinator s to confirm accom-modations.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	PC	SC	NA	NA	The WDP Remedial Plan requires a current certification from the Registry of Interpreters (RID) for all interpreters. At Chad, for the vast majority of the year and during our audit, only four of the eight interpreters utilized for two deaf youth held this certification. This may be thought by some to be only a minor technical violation, but informal complaints and formal grievances regarding the competency and effectiveness of several sign language interpreters raised, in our opinion, many valid points. At Close, no deaf youth requiring an interpreter was present at the facility during the audit. While DJJ has objected in the past to a "NA" rating in lieu of an "SC" rating when items do not apply, I am not convinced, based upon the department-wide interpreter issues, that current conditions would provide the degree of interpreting necessary if a deaf youth were to arrive at the facility.	Continue to fine tune contracting procedures for providing interpreting services. Utilize only RID certified interpreters. If complaints arise, consult with interpreters on confidentiality and expectations for effective interpreting.
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 accom-modation to deter-mine if alternate method provided reason-able access.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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 com-pliance.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	While Casework Specialists appear to be 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.
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	NA	NA	NA	NA	DJJ no longer paroles youth. Youth are discharged to the county of commitment. Treatment recommendations are included in the Discharge Release Packet, and information regarding treatment youth received while committed to DJJ is usually included.	There has been confusion about this item since the beginning of auditing. Even though parole has been discontinued, it is unclear if this item should be continued or removed from the audit instrument. It is my understanding that in the future, youth would 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	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	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	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	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle. The rating given by OACC for OH Close was upgraded from “NC” to “SC” at the audit.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	NA	The facility WDP coordinator at Chad and Close (since departed) was aware of the requirement and stated she was beginning to generally review DDMS/grievance forms and dispositions - even though there was no evidence of such reviews, I trusted the understanding of the particular Coordinator interviewed and gave the SC rating at the time of the audit. Since the prospective Coordinator at these two facilities served in this position before, it is assumed that she will continue this practice. At Ventura, there was no evidence that the previous facility WDP coordinator was aware of the requirement or reviewed grievance forms and dispositions. The new Coordinator has been apprised of this requirement, but was not yet able to undertake such reviews. At all facilities, while mental health staff may have undertaken a general degree of review when this item has been called to their attention, there was no documentation that patterns of misbehavior were monitored to the extent necessary to determine if these played a role in the behavior.	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	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	PC	PC	NA	There were actually very few documented grievances filed by WDP youth, as reported by either the WDP or the Grievance Coordinator at each facility. Of these, a number of youth at each facility were not provided with a Staff Assistant at the point of filing or throughout the review process. 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 sometimes 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, a large number of the 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 intimidate youth from proceeding, due to fears of staff retribution or retaliation (whether or not such fears were justified). See also the discussion in the 2012 WDP Comprehensive Report.	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 for WDP youth, given the common accommodation of the need for assistance, additional time, and alternate resolution techniques. See also the discussion in the 2012 WDP Comprehensive Report.

No	Item	Method	Cha	Ven	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	Completed staff training at the departmental level would be needed to comply with this requirement. See item 25
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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	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 no 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. 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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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 Coordinator. 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 accommodations or allege discrimination to determine compliance of protocol within stated time constraints.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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 accommodations / allege discrimination.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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	PC	PC	NA	Documentation and interviews indicated that no complying procedure is in place. Reviewed grievances and interviews did not indicate any accommodation of additional time for a youth with a disability. (Chad audit actually allowed no time for this review.)	Further review and refinement of procedures is needed, and further documentation of this activity is appropriate.
	D. Programs							
	1. Reception Center & Clinic Function: ***Introduction:*** During the audits, it was reported the two new reception centers actually began accepting new male youth and functioning around October. The number of youth processed should usually serve as a large enough sample to audit its activities and compliance, but the fact is that there were few Disability Referral and Evaluation Forms, or DREF's (DJJ 8.288) completed or filed during this period, particularly for Education. While it was clear that the various disciplines provided screenings to a certain degree, for the WDP program, accurate record-keeping is an essential part of the disability identification process. In the past, DJJ has objected to the "NA" rating being used instead of an "SC" rating when data were not sufficient to provide adequate audit results, citing the fact that if there were no occurrences related to an item, DJJ could never reach substantial compliance. However, in this case, the situation is somewhat different, since it was impossible to determine if the lack of DREF forms were because (1) they were not needed (although we know in a few cases they were), or (2) if DREF form filings were incorrectly omitted. Therefore, some "NA" ratings are given in this section because of the general finding that the reception center was not far enough along in establishing its processes at the time of the WDP audit (and the OACC audit should have reported the same conditions).							

No	Item	Method	Cha	Ven	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.	SC	SC	NA	NA	Records and documentation provided to the Disabilities Auditor showed the KBIT testing of youth was proceeding, enough for the "SC" rating, but not fully complete. However, UHR's showed an unsatisfactory absence of the actual KBIT and DD evaluation forms used by psychologists; this aspect needs to be followed more closely. There are also indications that some still do not use the screening form consistently or correctly.	Continue to use the department-approved assessment process to evaluate youth, and provide the required follow-up evaluations to those youth who score below the prescribed limit or refuse KBIT testing. For those youth falling within the applicable KBIT criteria for possible inclusion into the program, provide a written evaluation by the clinical psychologist regarding the results of the KBIT score or other criteria to be used to make an appropriate assessment and placement. See also item 115.
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	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	NA	NA	Assigned Casework Specialists do not usually make these referrals themselves, but mental health professionals usually proceed with the referral and/or evaluation process.	Standardization of forms and procedures by all reception centers and guidance from Headquarters is needed to assure long-term compliance.

No	Item	Method	Cha	Ven	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	NA	NA	Assigned Casework Specialists do not usually make these referrals themselves, but medical professionals usually proceed with the referral and/or evaluation process.	Standardization of forms and procedures by all 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.	SC	NA	NA	NA	At Chad, even though there were no RSCT or DREF forms provided for review, the SEAT process seems to have been used during intake. An "SC" rating was given because the new WDP Coordinator had made great strides to understand and act on this requirement – but she has since left. At Ventura, no copies of the form "Disability Referral/ Evaluation Form", DJJ 8.288, or any other forms were related to new Educational referrals provided for audit. It was not clear to what extent Casework Specialists (or those who review files for Education) or Education file reviewers take on this task. Some DREF forms related to Education were improperly filled out or handled. See *Introduction* to this section and item 41.	The RSCT forms and DREF forms still need to be used by Education staff (see *Introduction* to this section). Standardization of forms and usage by all reception centers and guidance from Headquarters is needed to assure long-term compliance.
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	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	SC	NA	NA	NA	At Ventura, no copies of the form "Disability Referral/ Evaluation Form", DJJ 8.288, or any other information related to new Educational referrals or disability screenings were provided for audit. Some DREF forms related to Education were improperly filled out and handled. See *Introduction* to this section and item 41. At Chad, an "SC" rating was given because the new WDP Coordinator had made great strides to understand and act on this requirement – but she has since left.	
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 documentation for completeness and timeliness.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
94	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness.	PC	SC	NA	NA	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.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
95	If it is determined prior to or during the ICR that a ward is in need of an accom-modation 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	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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.
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.	PC	PC	NA	NA	At Chad, the OACC audit held in October gave a "PC" compliance rating, citing that there was no evidence that the approved WDP Power Point presentation had actually been presented to youth. My audit at both reception centers yielded similar findings. A sign-in sheet showed that 24 youth at Chad and 50 youth at Ventura attended some type of presentation at the orientation unit, but that was weeks prior to my audit, and did not account for at least that many youth who had entered either before or after that date, some of whom had moved on to their permanent living unit. Furthermore, while the descriptions of the format, content, and method of delivery presented during the audits by one Youth Counselor who provides some of the orientations was acceptable, it was not clear that the described procedures have been in effect long enough (or are guaranteed to proceed in the future) to achieve a substantial compliance rating. The Special Master has asked that the disabilities expert/auditor coordinate criteria and findings with the S & W expert, and I have done so. There has been some confusion over exactly what the WDP orientation is to entail, but the S&W Expert has agreed that the orientation should be an approved presentation that allows for interaction between youth and staff to fully understand the program. See discussion in the 2012 Comprehensive Report.	Efforts to provide a more formal, standardized orientation and better ways of providing and documenting WDP orientation are still needed. It is still recommended that the facility WDP coordinator assist in coordinating and supplementing these efforts and be included in these presentations to improve implementation of this provision (even though this was previously denied by DJJ senior management).

No	Item	Method	Cha	Ven	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.	SC	PC	NA	NA	A standard form for documenting accommodations was provided to the Auditor, but actual accommodations provided to youth during the orientation (as described above) were not specifically documented.	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	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 few if any 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	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	NA	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	SC	NA	PC	NA	At Close, even though the previous WDP and SCT Coordinators were beginning to solve any time-related and other procedural issues, records of educational referrals over the last several months showed significant time gaps from the initial referral to consideration by the SCT or other education staff. At Ventura, no copies of the form "Disability Referral/ Evaluation Form", DJJ 8.288, or any other information related to new Educational referrals or disability screenings were provided for audit. Some DREF forms related to Education were improperly filled out and handled.	See item 99 above.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	SC	NA	SC	NA	Documentation provided indicating that this time line (admittedly a difficult one, and one which would be given some leniency) was usually, but not always, 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	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
105	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	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.	SC	SC	SC	NA	This item should most likely be given an "NA" rating, but DJJ has objected to this rating in the past when the item was not applicable, since it would be impossible to ever achieve compliance. However, few records of WDP assessment reports were provided during the audit, so it was impossible to determine if special case conferences were actually held, or even required.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
109	The Department shall ensure that staff reviews the level of care placement and any reasonable accom-modations for wards with disabilities at regularly scheduled case conferences.	Audit ICP forms for wards with disabilities to determine level of review.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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 docu-men-tation for complet-eness of infor-mation.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	Continue to improve data entry and report techniques. Additional training on how to generate detailed reports is still needed.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
	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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	PC	NA	PC	NA	The identification process has generally proceeded well since the last audit. See item 86. Few youth were specifically identified by DJJ as being developmentally disabled, and it could not be fully verified that this list was complete, since some youth currently at DJJ had previously been identified as developmentally disabled at other facilities. At the final DD Study Team meeting with OSM, DJJ, and the Disabilities Expert, it was agreed that supportive services would be individually determined for youth within the existing classification framework, rather than implementing a department-wide DD residential unit. Detailed criteria for establishing individualized supportive services were agreed upon. These criteria were later included in the development of PoP #867 & CN #456, "Youth with Intellectual Disabilities" Policy, though not yet adopted or implemented at the facilities. While identified develop-mentally disabled youth have indeed been provided with some special support services, these youth were not evaluated for the degree of supportive services required by the new policy.	Provide better documentation to the Disabilities Auditor, including written evaluation by a clinical psychologist regarding the results of the KBIT score or other criteria used to make an appropriate placement and identification of individualized supportive services. Formally include all identified youth in WIN and include in the WDP program. Implement fully the criteria for providing supportive services for identified youth as described in the "Youth with Intellectual Disabilities" Policy, using the special case conference process (see item 106) to determine the supportive services necessary for these youth.

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
	4. Removal of Architectural Barriers							
116	The Dept. 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; visit each institution upon completion to ensure compliance with accessibility criteria.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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	Monitor the project timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

No	Item	Method	Cha	Ven	Clo	HQ	Comments	Recommendations
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	
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.	*	*	*	NA	*Monitoring transferred by agreement of the Expert and parties to DJJ/OACC for this audit cycle.	

California Department of Corrections and Rehabilitation - Division of Juvenile Justice
Wards with Disabilities Program (WDP) Comprehensive Report for 2011-12
by Logan Hopper, *Farrell* Disabilities Expert and Auditor
May 21, 2012

Introduction

This report represents the seventh 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.

For fiscal year 2011-12, one two-day site visit to each of the following correctional facilities and a day at Headquarters was scheduled for the Disabilities Auditor (listed in the order of the visits):

N. A. Chaderjian Youth Correctional Facility
O.H. Close Youth Correctional Facility
Ventura Youth Correctional Facility
Division of Juvenile Justice Headquarters

At the end of each facility visit, a summary report giving compliance ratings, findings, and recommendations was submitted to the Office of the Special Master and subsequently to the parties for review and comment. Upon a review of the parties' comments, a final report was then issued. The Court-approved Audit Instrument showing the combined results and compliance ratings for all facilities is included as Attachment 1 to this annual, comprehensive report.

Executive Summary

During the first six years of monitoring under Farrell, DJJ has made gains in compliance to such an extent that the majority of individual line items as contained in the WDP Audit Instrument have been in substantial compliance. However, despite some gains in some areas, during the past fiscal year, the majority of the major areas of compliance relating to services for youth with disabilities that have been discussed in previous reports and that were still needing resolution during this year (as listed in the paragraph below) have not shown significant improvement toward substantial compliance. In addition, several other items for which a substantial degree of compliance had been previously reached have regressed, and unless corrected, these will tend to cause new compliance issues.

In this annual, comprehensive report intended to be a summary document, I have not attempted to cover all of the items in the WDP Audit Instrument. Instead, I have focused on critical aspects of the WDP Remedial Plan that are particularly noteworthy or pose the greatest challenges for DJJ. Therefore, while this comprehensive report will attempt to acknowledge areas where improvements have been made, it will by necessity concentrate on those areas in need of positive actions, with the intent being to hasten the goal of everyone involved - to reach substantial compliance in all areas as soon as possible. As has been requested by all parties in the past, I will again (as I have in past facility reports) list specific recommendations within this comprehensive report that will lead to substantial compliance. These areas, as described in detail in the remainder of this report, are listed below (in order of importance / severity of the lack of

compliance). All of these topics are specifically included within the purview of the Disabilities Expert in the *Farrell* Consent Decree.

1. Consistency of Facility WDP Coordinators
2. Identification of Disability and Provision of Accommodations
3. Use of Force on Youth with Disabilities (in Single-Youth Incidents)
4. Disability Training for Staff
5. Disability-related Grievances and Due Process for Youth with Disabilities
6. Education for Youth with Disabilities
7. Youth Orientation on Disability and DJJ Programs
8. Monitoring of Psychotropic Medications
9. Self-monitoring

During the first five years of auditing, I tried to be positive in my reports and reflect upon successes rather than failures, feeling the need to inform and nurture those to whom a disability perspective was new. However, last year's report described a slow-down in compliance efforts in several critical areas that worsened throughout the past year that this year's report addresses. In last year's report, I stated emphatically that "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."

In considering the recommendations in OSM 19 regarding a multi-disciplined approach to resolving what were termed "cross-plan issues", I have always been open to the recommended approach, with others being actively involved in resolving remaining issues contained in the WDP Remedial Plan and Audit Instrument. After the last case conference related to WDP matters, I was asked to attend a meeting on September 29, 2011, with the Office of the Special Master (OSM) and DJJ representatives (no plaintiffs' representatives were present). The basic result of that meeting was that others - either DJJ staff, other *Farrell* experts, or the parties' attorneys - were to take on some of the major responsibilities for resolving some of the main remaining issues, and I agreed to provide assistance in any way that I could. However, for these topics, the most important of which are listed above, I did not receive any significant additional information past that date in resolving these issues, and few showed any progress toward substantial compliance. Substantial compliance on these issues still remains as the major impediment to an effective rehabilitative program for youth with disabilities.

It should be acknowledged at the outset that the Wards with Disabilities Program, as a Departmental entity, has made significant strides in compliance under the supervision of Sandi Becker. During the four years of her tenure, Ms. Becker has gained an understanding of the program's requirements as well as disability policy in general, and she has proven to be capable and dedicated to the task. She has proceeded to resolve a number of issues that are within that program's control (such as the Wards with Developmental Disabilities Program evaluation form, the overseeing of the preparation of compliance binders, and similar topics). However, the responsibility for the major issues listed above and described in detail in this report lies mainly within the purview of others at DJJ, and those persons and/or departments will have to take equal ownership of these issues to meet the recommendations contained in this report and effect substantial compliance in these areas.

Statistical Analysis of Compliance Ratings within the WDP Audit Instrument

Both DJJ and OSM have computed statistics as part of past reports, and I will again rely on these other parties to present the overall numbers, which I believe to be somewhere in the mid-80 percentile overall, and statistically for all items, likely to be somewhat improved from last year. However, it should be noted that these overall statistics contain many items that were resolved years ago, or are no longer applicable to DJJ. (For example, DJJ parole has been disbanded, and those items, some of which were not in substantial compliance, make statistics appear improved.) Therefore, it can be confusing and contradictory to rely too strongly on any set of statistics. Statistics that are the most important to my monitoring tasks are best shown by the chart below, which includes only those items that are remaining and subject to Expert auditing, since these represent the major issues still applicable and the focus of this report. There are a number of ways these statistics can be prepared, and one variable in any set of statistics in the presence of "NA" (Not Applicable or Not Available) ratings. While one could argue that these should be included (although I am not sure where), the statistics below do not include the "NA" ratings, because if the data was not available to rate the item, they could be any rating (although if data was not available, it is more likely that the item itself was not far enough along for an "SC" rating).

Statistics for the remaining Audit Items not removed from Expert auditing & transferred to OACC (35 at Reception Centers; 27 at Non-reception Center; 22 at HQ):

Facility	Current Year (2011-12) Substantial Compliance
N.A. Chaderjian	71%
O.H. Close	75%
Ventura	59%
Headquarters	77%
Overall	70%

However, a reliance on any such statistics, whether showing either a decrease or increase in compliance, was best described by Dr. Krisberg in his latest comprehensive report; "I urge caution in placing too much reliance on the compliance percentages to assess the success of DJJ's reform efforts. The original S&W audit items are not weighted relative to difficulty and complexity in implementation and criticality to the reform efforts. Moreover, as the primary focus of the S&W Standards and Criteria is to determine compliance, these ratings by themselves do not constitute adequate measurement of performance of the facility's reform efforts on the fundamental issues that were initially raised in the Farrell v Cate Consent Decree." I believe the same applies to the WDP Audit Instrument and statistics derived from it. Therefore, rather than relying on these statistics to tell the whole story, this report more appropriately deals with the major compliance items still needing resolution.

In the past, the Court focused on what was termed the "dashboard" to gauge progress, although I have not received information on that aspect of the case in a while and do not know the current status of this reporting method. I feel the dashboard is still valid and is at least equal in describing progress as are audit item percentages. Originally, the WDP Dashboard consisted of twelve items. The last version I have is dated March 22, 2010, and it contains 9 items, 6 of which are still not adequately resolved, and those are most of items primarily discussed in this report.

Major Compliance Issues Requiring Resolution

1. Consistency of Facility WDP Coordinators (Audit Items 5, 36, 38, & 39)

During the last audit period, tremendous volatility in the staffing of these vital positions has, in my opinion, been the root cause of setbacks in day-to-day compliance at the three remaining facilities. During this time, these three facilities had at least ten different persons reportedly serving in this capacity, with some being termed "interim" or "temporary". In addition, there was an aggregate of about eleven months where there was no facility WDP Coordinator present at a facility at all - sometimes due to a leave, and sometimes due to a vacancy. Furthermore, in my opinion, for most of the time that a Coordinator was present, the time commitment was for significantly less than that required for necessary involvement in WDP activities.

During the facility audits, senior facility management gave what they felt were valid justifications for these frequent turnovers and the extended vacancies. It is certainly understood that the State is near fiscal crisis on a daily basis. It is not within the purview of this report to evaluate all of the reasons why these deficiencies have occurred or who is responsible for them, but the fact is that the State has been unable to keep these positions filled and effectively active, in direct contradiction to the requirements of the WDP Remedial Plan, and this systemic failure has caused inconsistencies and failures in both procedural and attitudinal progress on compliance with the WDP Remedial Plan.

I feel that it is necessary to report on the recent circumstances as appropriate context for the current situation, since the overall ability to have an active, trained, and committed facility WDP Coordinator has repeatedly been out of compliance and is a major cause for concern. Even though current positions may be stabilizing, they are still somewhat in question due to conflicting information that has not been verified by audits. At O.H. Close, the Coordinator present during the audits was described as being permanent, and though new to the assignment, seemed capable with extensive ADA experience and very committed (calling it her "dream job"), and with the required training, could have been a valuable asset, but she was dismissed from the position soon after the audits (with some audit items being specifically rated based on her perspectives and actions). It has been reported to me that the Coordinator who served previously in that position at Close (for about 18 months, but for only 50% time delegated to WDP duties at Close only) will again be assuming the duties, again with a 50% time commitment. She should bring experience to the position, although the challenges of re-focusing efforts on the issues described in this report, as well as a re-emphasis on contact with youth with disabilities, need to be stressed. The situation at Chaderjian was the same, with the Coordinator being dismissed soon after the audit and the same new Coordinator assuming part-time duties. In addition, it is still unclear to me if the percentage of time commitment, less than that described by the WDP Remedial Plan and the approved Business Rules, will allow her to adequately perform all oversight functions.

At Ventura, the Coordinator present during the WDP audit had only been in the position for two days prior to the audit. She had served full-time as the Assistant Superintendent's administrative assistant, and while she stated during the audit that she was committed to full time duties as the WDP Coordinator, this was not verified by senior management, and there was no one who had been appointed to the secretarial duties. (It should be noted that a different person was present as the facility WDP Coordinator during the OACC audit, following three other temporary or part-

time Coordinators.) It has since been reported that a different person was actually being considered for the position and was going through the appointment process with State Personnel, with the exact time frame being unknown but possibly extending prior to the audit . All of this conflicting information, which is very different than what was portrayed at the facility's WDP audit, raises concerns about these four recent appointments over the last three months, and a more detailed assessment regarding the exact conditions regarding these temporary appointments may be in order. Whatever the result, recent history suggests caution in stating that this issue is fully resolved.

Each of my first six annual report summaries stated that a major strength of the program intended to provide equal access for youth with disabilities was the continuing efforts of the facility WDP Coordinators to bring about compliance on a daily basis. For example, my fourth annual report in May, 2009, stated: "The extent to which the program has progressed at each facility is almost directly proportional to the length of tenure of the WDP facility coordinator. Despite the varying degrees of experience with the details of the program, the actions of all of these WDP coordinators represent the strongest aspects of the Wards with Disabilities Program." In my opinion, this aspect of the overall WDP program is still the most crucial, and to get the program back on track, this aspect needs to strengthened, not lessened.

Many of the remaining problems experienced during the year (e.g., the issues related to sign language interpreters, provisions of reasonable accommodations and Staff Assistants, and similar items discussed in the Attachment No. 1 Audit Instrument) are directly attributable to the decrease in WDP Coordinator involvement in assuring these accommodations and services. While DJJ reports have described the ability of facility Coordinators, or others within DJJ in their absence, to prepare the monthly reports for Headquarters, certainly an important activity, these are computer mechanized and fairly easy to prepare. The critical aspect is following up on information contained in these reports. Numerous examples of the lack of follow-up were encountered during this year's audits, and expounding on all of them would be too time-consuming in this summary report (although, as requested, a more detailed list will be provided to the parties in separate correspondence). One typical example is described in Attachment 1 under audit item 57. In this instance, a youth was listed for about a year on the WDP Accommodations List as requiring a hearing aid, one he never received during the year. While it is still unclear the extent to which one should be provided (the records provided show that Medical failed to schedule a return visit required by an outside audiologist), the critical point here is the lack of follow-up and coordination on the part of either living unit staff or the WDP Coordinator. In my estimation, while it would ideal if living unit and treatment staff assumed total responsibility for seeing that required accommodations were provided, I appreciate the complexities of their activities and roles, and feel that ultimate responsibility for this task is best left to the facility WDP Coordinator, who should be specifically trained to understand the nature of accommodations and their importance to youth with disabilities. Another example, which might be termed "anecdotal" evidence by some, is based on observations that I believe to be valid, since the WDP Audit Instrument lists interviews / interactions with youth or staff to be the primary audit method in at least 19 instances. During visits to living units during the audits, it became increasingly commonplace, more so than in previous years, for (1) living unit staff not to know who the current WDP Coordinator was, that the previous Coordinator had left, or what the role of the Coordinator was, (2) living unit staff to be unable to retrieve documents and forms

required to be on the units (such as the WDP Accommodations List, the blank Disability Referral/Evaluation Forms to be used by youth, the Emergency Procedures Protocols) and sometimes to be unaware what these were, and (3) youth with identified disabilities to not know who the WDP Coordinator was, what their role was, how to contact them, or how they could be assisted with accommodations or other issues. This is why one of my recommendations included at the end of this section is that facility WDP Coordinators become more "hands-on" in daily activities, as they were during the first five years of WDP implementation.

During the September 29, 2011, meeting with DJJ and OSM, both indicated that they felt the duties for this position did not require anywhere near full-time activity. I disagreed at the meeting, and based on what I saw transpire over the subsequent seven months, with the three remaining facilities functioning with less than sufficient oversight of the WDP program, I still believe the position should be as close to full-time as possible. I fully understand the State's dire fiscal problems and the fact that DJJ is being asked to streamline positions, but it is my opinion that the savings of a few thousand dollars in salaries and benefits will not compare to the costs involved in delayed compliance in so many areas related to this item. It was represented to me at the September 29 meeting that the parties had agreed to the Business Rules by stipulation, and that those rules changed the percentage to 75%. Very recently, I received a communication that even that 75% percentage had been changed and that there was a tentative agreement that a facility Coordinator could split time between Chaderjian and Close (50% at each facility); however, this communication did not specify any changes for Ventura. That communication did not indicate that this decision was final, in that it requested that I give additional background information if I felt such information was appropriate. It should be noted that I was never consulted about the status of facility WDP Coordinator involvement for my input prior to now, but I have done so in this Comprehensive Report and will also do so as requested in separate communication (since such details are not common in this summary report), and I hope that it will be taken into consideration by all parties. Therefore, it is still unclear to me (and I assume to the OACC Auditor) exactly what the requirements are to be for auditing purposes, and further discussion and clarification is needed. I would like to reiterate that whatever the decision is when fully considered by all parties, I will certainly abide by that decision and audit accordingly.

Recommendations:

(1) After discussion and agreement by all parties, provide definitive information to both the Disability and OACC Auditors regarding the appropriate percentage of time the facility WDP Coordinator duties is to be at all of the three remaining facilities. Provide this percentage at each individual facility. (It should be noted that it is still my opinion that the Coordinator should be close to full-time at each of the three facilities. Some minor adjustment may be feasible at some future point for Chaderjian and Close, after stabilizing the overall WDP program.)

(2) Maintain one trained facility WDP Coordinators in place at each facility for the entire next fiscal year.

(3) Coordinate the position-maintenance issues with State personnel senior management to assure cooperation with the emergency-like nature of these positions.

(4) Reinforce to the facility WDP Coordinators the priorities of the assigned duties, with increased emphasis on personal contact with both staff and youth to resolve the issues described in this report.

2. Identification of Disability and Provision of Accommodations (Audit Items 41, 46, 86-95)

While this topic has been difficult for many who are unfamiliar with the ADA to grasp, the fact is that DJJ has not effectively provided consistent determinations of which youth should be included in the Wards with Disabilities Program, and which should not. Much time has been spent in recent months refining the process by which youth undergo initial screenings and case reviews, and this has indeed assisted in defining how these processes should proceed. But in some ways, these purely procedural discussions are a potential diversion to the real issue at hand. Procedures and practices for evaluating youth with potential disabilities need to be undertaken with the knowledge of what Federal and State law require in defining a ”qualified individual with a disability”. In this regard, both in the outside world and within DJJ, misconceptions and biases abound, and DJJ must share the responsibility for providing guidelines to its practitioners to remove any of these misconceptions and biases and provide an objective basis for responsible decision-making. This has yet to be accomplished.

Within the medical field, there are a number of diagnoses that describe impairments that could limit a major life activity (such as working, learning, walking, and breathing, to name just a few). The Americans with Disabilities Act Amendments of 2008 was specifically enacted to provide guidance in applying the original Americans with Disabilities Act of 1990 in these decisions, and it stresses a much broader application of disability than had been previously perceived by many. Conditions such as diabetes, asthma, occupational asthma, hypertension, latent-form epilepsy, and immune deficiency disorders, to name a few, are specifically listed in ADAA 2008 as the type of potentially limiting conditions that must be evaluated. Within the mental health field, the same types of determinations need to be made for conditions such as ADHD, anxiety disorders, panic disorder, post-traumatic stress disorder, and personality disorders, again, to name a few. Facility audits have encountered numerous situations where youth with similar conditions are evaluated differently, usually by different practitioners, with no indication that individual circumstances would indicate such differing evaluations. Some mental health practitioners have indicated to me that they need guidance form Headquarters on how to make these determinations more effectively.

Principles contained in the Americans with Disabilities Act Amendments of 2008 are important in understanding how this area should be evaluated. In addition to many other similar statements, this legislation states, “The comparison of an individual's performance of a major life activity to the performance of the same major life activity by most people in the general population usually will not require scientific, medical, or statistical analysis.” In normal practice within the institutional context, medical professionals would provide a description of a specific medical condition and any impairment and its usual effect on the individual, but final determinations of disability would be made by those with the legal and practical application of the ADA and State disability regulations.

Within this topic’s discussions in recent months, DJJ and the Prison Law Office have repeatedly referred to accommodations provided to youth as its primary source of interest related to the disability identification issue. While providing accommodations is certainly of major importance, it is not the sole criteria for making these difficult determinations. ADAA 2008 states that “the determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures” (i.e.,

accommodations). Several medical and mental health practitioners involved in this topic have suggested that once provided with an accommodation, a person would not need to be listed as having a disability. In addition, ADAA 2008 states that "the determination of whether or not an individual's impairment substantially limits a major life activity is unaffected by whether the individual chooses to forgo mitigating measures. For individuals who do not use a mitigating measure (including for example medication or reasonable accommodation that could alleviate the effects of an impairment), the availability of such measures has no bearing on whether the impairment substantially limits a major life activity." Within DJJ, some youth decline accommodations for various reasons or no accommodations have been determined to be available or effective, and I believe in some cases DJJ has not provided the appropriate accommodations (see paragraph below), but these situations do not negate the right of a youth to be classified as a "qualified person with a disability". Both the ADA itself and the WDP Remedial Plan afford many rights unrelated to individualized accommodations to these youth; they have the right to be so designated, and DJJ has the responsibility to perform appropriate identifications.

This broad area has been in the forefront of issues related to non-compliance for some time, and it has been specifically highlighted within the past three WDP annual reports. While the major Audit Instrument Item No. 41 has been primarily used to report compliance on this topic and recommend corrective actions, there are a total of approximately 20 separate auditing line items that relate to the overall topic, with several being rated "PC, and with many others being rated "SC" in a realistic intent to avoid duplicity of negative ratings (a complication of the Audit Instrument). While there were some discussions during the past year about methods and procedures to improve compliance in this area, I have received no additional information, either through informal submittals or formal audits, which addresses this major remaining task, and there has been no significant progress in this deficiency since my last comprehensive report.

In addition, during this audit cycle, the appropriate provision of accommodations was called into question by my findings in several instances. It should be noted that reasonable progress was made in this area from the beginning of auditing seven years ago, and "substantial compliance" ratings have been given in audit items relating to this topic in the last few years, as the progress was steady and it would have been difficult to apply accommodations perfectly in the wide variety required for such a diverse population. However, at this point in time, after the WIN system has only recently been far enough along to evaluate the area objectively, several "glitches" are still present that require refinement. The lack of stability and involvement of a consistent facility WDP Coordinator has exacerbated these problems, in that computerized systems, which are still sometimes unreliable, and data entry by many who do not possess a comprehensive knowledge of WDP processes, have caused problems that should have been caught if someone was watching closely enough. For example, it has become clear that the provision of a Staff Assistant, if indeed an appropriate accommodation, is not necessarily entered in WIN after a youth is identified by a staff referral (i.e., the youth did not enter DJJ with an IEP). I attended one case conference at Ventura for a youth with an educational disability, but who was not listed as needing a Staff Assistant, and it became questionable during the conference whether the youth had the communication skills to effectively advocate his own needs. When discussed, the youth was not aware of what a Staff Assistant was, and the case carrier admitted that such an accommodation would likely be warranted in this instance.

Staff and youth's self-referrals underwent major changes three years ago, with the facilities transitioning from the previous Request for Sick Call (YA 8.229) form to the "Disability Referral/Evaluation Form" (DJJ 8.288). It is now somewhat common (but also occasionally sporadic) for the DJJ 8.288 form to be used by both staff for staff-referrals and wards for self-referrals. Previously, WDP and Education Headquarters staff 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 absence of a facility WDP Coordinator at the two new reception centers caused a significant degree of confusion on the part of both educational and mental health clinicians as to when and how to use these forms. The use of the DJJ 8.288 form for Education referrals and adherence to the WDP Remedial Plan's requirement to use the SCT process (or alternatively, the SEAT 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) still needs special attention at the reception centers. See audit items numbers 12, 46, 88-90 & 99 in the detailed Audit Instrument included as Attachment 1.

Recommendations:

(1) Conduct the recommended Departmental evaluation process to (1) provide written guidelines to medical and mental health practitioners on ADA and State regulations and statutes on disability identification procedures, and (2) establish a multi-disciplinary approach to the identification of DJJ WDP status for all youth. The product of this task could either be: (1) drafted by the WDP Expert, as has been offered for the past three years (note that current scope of services does not include this task,) in consultation with DJJ medical and mental health representatives, or (2) drafted by DJJ medical and mental health representatives for review by the Disabilities Expert.

(2) Implement the identification process as described in (1) above during the intake process prior to next year's facility audits.

(3) Review the previous identification process for selected youth currently in DJJ (not intended to mean ***all*** *youth, but those youth who might likely be subject to such a re-evaluation, such as those youth in ITP's, and those with known health issues such as asthma or diabetes).*

(4) Use the case conference and/or IEP processes to review existing or potential accommodations, including the provision of a Staff Assistant.

(5) Continue to fine tune the processes and forms related to staff-referrals and youth self-referrals.

3. Use of Force (Crisis Prevention and Management) for Youth with Disabilities (Audit Item 53)

This area continues to be a major stumbling block for assuring "protection for wards with disabilities from…abuse related to or resulting from their disability" (quoted from the Consent Decree). Issues related to use of force on youth with disabilities have been well documented in past WDP Comprehensive Reports, as well as Safety and Welfare Comprehensive Reports, and several special study reports authored by DJJ staff and/or *Farrell* experts, and summarizing all of those herein would be too time-consuming. Nevertheless, over the past year, disability audits have revealed no realistic improvements in this area for youth with disabilities, as documented

not only in the detailed Audit Instrument included as Attachment 1, but also in separate reports for each facility provided to the Safety and Welfare Expert (providing the collaboration as requested by the Special Master).

In February, 2012, DJJ issued its revised draft policy on Use of Force (actually entitled "Crisis Prevention and Management"), with training and subsequent implementation of this policy scheduled for late summer, 2012. I did not submit any official comments on the draft policy for several reasons, including (1) I had previously submitted my detailed comments at the time of the initial DJJ report (also submitted by OSM to DJJ and the Court as an Appendix to OSM 18), (2) Dr. Krisberg and I have been singular in our opinions on use of force, and I felt comfortable abiding by his comments, and (3) while I doubt that my comments would have caused any significant delays, the three years it took to get to this stage seemed long enough. I feel that the draft policy has many positive elements. My two major concerns are: (1) curbing use of force in single-youth incidents is not delineated enough to prescribe the types of interventions required by the WDP Remedial Plan, thus potentially hindering eventual substantial compliance on Audit Item 53 related to this topic, and (2) the failure to include youth with disabilities (a protected class under both Federal and State statutes) in specific prohibitions related to use of force, while other non-protected groups are included, could be in direct violation of those statutes (a subject more appropriate for the attorneys to decide than me).

With respect to the first item in the sentence above, there are several elements related to use of force that are prescribed within the WDP Remedial Plan on which the new Use of Force policy is silent, but also does not contradict; therefore, I would maintain that these elements of the WDP Remedial Plan are still in effect and applicable. These elements have been the main cause for the lack of substantial compliance in this area (it should be noted that DJJ's Use of Force study team also found problems and a lack of compliance in these same areas), and these are best described as follows:

(1) The very first requirement of the WDP Remedial Plan regarding use of force on youth with disabilities is that security staff must be aware of the accommodations to be provided to youth with disabilities prior to the use of force. While this requirement does not literally delineate any differences between major multiple-youth incidents vs. single-youth incidents, I have agreed (both during audits and at the September 29, 2011, meeting) that for auditing purposes, this would only be applied to single-youth incidents or similar incidents where it is possible to isolate youth with disabilities. During this year's audits, I saw few if any Use of Force Reports (or for that matter, any follow-up IFRC or DFRC review forms) that contained any information whatsoever about whether or not a youth involved had a disability, much less what the required accommodation might be.

(2) Use of Force Reports reviewed during audits contained little if any information about how the usage of "prolonged dialogue and verbal instructions" or other de-escalation techniques for youth with disabilities were used (a situation corroborated by the DJJ UOF study team), and the situations that were described in UOF Reports made it clear that these requirements were not considered in the application of force.

(3) Security staff continued to use force that was not "the minimum force necessary to ensure the safety of others" (another situation corroborated by the DJJ study team).

(4) Other issues best described in Dr. Krisberg's and my report, "Use of Force Findings and Recommendations", submitted as an Appendix to OSM 18.

As mentioned above, the Special Master asked me to coordinate all findings and opinions regarding use of force as discovered during audits with the Safety and Welfare Expert, and I have done so. Dr. Krisberg summarized the current status in his last reports, stating, "The DJJ task force report essentially validated most, if not all, of the findings of the Court Experts' preliminary analysis. Some of the specific issues raised include lack of clarity in the UOF policy, staff ill-equipped to understand and respond to youth behavior issues, flawed UOF review processes at the facility and at the division level, poor documentation, and inadequate and unreliable data. The UOF issue was discussed extensively in OSM 18th and OSM 19th and during the ensuing case management conferences. DJJ has formed an implementation team to make improvements to the system and the processes and I understand the parties are in the process of entering into a stipulated agreement on the corrective action to be taken to address the myriad of issues. Reducing the amount of UOF remains as a key organizational concern for DJJ." The WDP audits found that these conditions and concerns still exist, and in addition, that youth with disabilities are still statistically and proportionally more likely to be negatively affected by these conditions. While these requirements have been discussed with Chiefs of Security for several years of audits, the past year indicated no significant increase and a possible decline in compliance (although the actual rating stayed the same "PC").

Recommendations:

(1) Issue a "clarification memorandum issued pertaining to the Use of Force", as allowed and discussed on Page 1 of the new "Crisis Prevention and Management" policy, to reinforce the additional requirements of the WDP Remedial Plan" as they relate to youth with disabilities.

(2) Reinforce the four elements outlined above to security personnel during forthcoming training.

(3) Reinforce the concept of "immediate" force actually being a range of potential actions, rather than being absolute and applicable in all situations (a concept postured by Dr. Krisberg's and my previous report, and by the DJJ UOF Study Team's report, both only minimally covered in the new "Crisis Prevention and Management" policy).

(4) Train staff on methods to better document de-escalation techniques and accommodations in Use of Force Reports.

4. Disability Training for Staff (Audit Items 23 &25)

For this year, the OACC Audit Report for Headquarters reported a less than substantial compliance rating for this item. During the Expert's Headquarters audit, the data provided showed another dramatic decrease in disability-related training for staff. Training rosters were not reviewed in as great a detail as in prior years, since Headquarters staff indicated that block training (for which the disability training was to be a part) had not been presented sufficiently during the year due to fiscal deficiencies and the inability the schedule staff. General reviews of the data indicated a percentage below 50%, and since DJJ admitted that the item was not in substantial compliance, the need to compute an exact percentage seemed irrelevant. (This exact percentage could be calculated by me upon further auditing of the training logs, if requested by either party.)

Last year's WDP Comprehensive Report for FY 2010-11 also described some decreases in meeting requirements for annual disability training for all staff, including new hires. Training statistics reviewed in detail for that time period clearly indicated that the percentage of staff attending the approved training fell far short of that required for a substantial compliance rating, and that the percentage had actually been substantially less than the year before. DJJ responded that other records for block training showed a higher percentage, and OSM 19 stated that "there may be a misunderstanding or miscommunication between the expert and the defendant on this issue". Actually, the data reviewed was absolute and clearly showed a reduction in staff disability training from the year before.

This situation is of significant concern, not only due to the specific inability of DJJ to provide the prescribed staff training, but on a larger scale, the intrusion of budgetary issues into overall compliance with *Farrell* and the WDP Remedial Plan. Indications are that neither block training or individual disability training on specific topics will not be able to meet desired goals for the coming fiscal year, due to increasing budget concerns, staffing volatility, and the need to provide additional training to staff on the revised Use of Force (i.e., "Crisis Prevention and Management") policy. While it is agreed that Use of Force training is critical, it cannot be justified that one prescribed training would take precedence over another (unless there can be a mutual merging of curricula, as discussed in the *Recommendations* section below).

From a qualitative viewpoint, the decrease of disability training has become more evident during facility audits over the last two years. As the auditing has proceeded, I have attempted to visit more living units to interview youth and talk informally with staff (an audit "method" required by the Audit Instrument"). CDCR/DJJ has raised some objections in the past to my having discussions with staff, but I have not used informal discussions with staff to effect compliance ratings as included in the Audit Instrument. On the other hand, these interfaces can help to see how remedial plan requirements are affecting youth services, and at this level, it is now more common to encounter staff who are unfamiliar with the WDP program than before.

Recommendations:

(1) Assure that all staff (those who interface with youth in any way) receive annual disability training as required by the WDP Remedial Plan. An analysis of the current conditions should occur to evaluate how limited budgetary conditions or tightened staff schedules can be best optimized to provide the required training.

(2) Evaluate whether block training or separate disability training is more advantageous in meeting the annual disability training requirements, and if the former, assess how the disability training is merged into the block training. If curricula or presentation methods are revised from what has been previously approved by the Disability Expert, submit new information (via the PoP procedure) for approval.

(3) Improve either computerized or written (rosters with signatures) methods for documenting staff attendance at trainings. (Note: Such a statement on my part has led to a mis-interpretation of my findings by some in the past. Past documentation has been quite adequate to assess compliance. However, if DJJ is to counter that other documentation that is not presented to me at audits shows a higher degree of compliance, such documentation must be clear and be provided at audits.)

(4) If indeed Use of Force training is deemed by DJJ to be a higher priority than disability training for the next fiscal year, DJJ may want to consider integrating a portion of the required disability training into it. This would require integration of WDP Remedial Plan's Use of Force requirements into the proposed policy "Crisis Prevention and Management" training; note that this would include additional curricula, since that proposed policy does not itself speak to disability per se.

5. Disability-related Grievances and Due Process for Youth with Disabilities (Audit Items 72-85)

During this year's audits, a more detailed review of current grievance and complaint procedures for youth with disabilities, as specifically required of me in the *Farrell* Consent Decree (Par. 15.f., "Disability Related Grievances") and in the WDP Remedial Plan (Section XII), has again indicated that these youth have serious difficulties in accessing the grievance system and are often not provided with a Staff Assistant or with the other types of accommodations specifically outlined in the WDP Remedial Plan. Many of the WDP Audit Instrument items were transferred to OACC two years ago because problems in this area were not evident at that time, but the current situation requires a re-evaluation of how the new grievance policies implemented about two years ago are impacting overall treatment programs (of which the WDP Remedial Plan states grievances are to be a part) for youth with disabilities.

Specific concerns involving violations of the WDP Audit Instrument and other procedures that do not afford these youth with a prompt and equitable resolution of complaints, often directly related to their disability or lack of accommodations, are included below. It should be noted that the Grievance Policy does not specifically prohibit any of these issues, and all could be resolved within the framework of the current policy.

(1) Many youth are not provided with Staff Assistants at the time of initial "filing" (that is, the first action of putting their complaint in writing and officially submitting it to the DJJ Grievance Coordinator or other staff), nor do Staff Assistants that are provided continue their assistance throughout the entire process (i.e., during and beyond informal resolution discussions with staff). Any confusion over this issue is unwarranted, as it should be obvious that such an accommodation at the earliest stage is the whole purpose of the Staff Assistant process in the first place.

(2) Youth are not provided with any other accommodations that may also be required in the official WDP accommodation lists (separate from or in addition to a Staff Assistant) as they often need to access the grievance system on their own.

(3) There is no evidence that time frames are altered as a reasonable accommodation for youth with disabilities in any way, as required by both the WDP Remedial Plan (Section XII.F.) and Audit Instrument (Item 85).

(4) Many of the normal grievance procedures do not include providing youth with written documents or copies of applicable regulations (both as required by the WDP Remedial Plan, Section XII.), and documentation (either through a youth's signature or other means) of the youth's involvement and understanding of the resolution is often sketchy, and sometimes non-existent.

(5) No effective process exists to determine if a grievance filed by a youth with a disability is related their disability or the need of an accommodation (thus requiring the additional protections included in the WDP Remedial Plan).
(6) Youth with disabilities are rarely provided the opportunity to appeal a decision, often made informally by an involved staff member, in opposition to ADA guidelines.
(7) Qualitative evidence obtained through confidential interviews has indicated that youth are sometimes improperly dissuaded from filing a grievance, and many youth express hesitancy to access the system even when they feel it is warranted.
(8) Staff misconduct grievances are often inappropriately dismissed due to an alleged failure to resolve via the informal resolution process, even though such dismissal is not allowed by the new grievance policy.
(9) other issues as described in the WDP Audit Instrument and supplemental reports (see below).

In last year's WDP Comprehensive Report, I raised the issue of grievances and due process for youth with disabilities. The Special Master, in OSM 19, suggested that I coordinate these issues with Dr. Krisberg, and I have consulted and communicated my on-going concerns with him throughout the year (usually through separate facility reports that have not been made a part of this comprehensive report due to the confidential nature of several youth's names and conversations, but samples of which have been made available to the parties). My involvement in this topic relates only to youth with disabilities and their ability to access an equitable system of due process as it may relate to grievances concerning their disability, and not necessarily in the overall Youth Grievance System as it relates to the entire youth population. However, beyond those definitive stipulations of involvement within *Farrell*, I feel that due to my experience and expertise in this field (past experience over thirty years in drafting and implementing grievance procedures for numerous public entities is not included herein, but will be provided upon request), I am professionally obligated to assess and advise DJJ and the parties on adherence to the requirements of the Americans with Disabilities Act.

The ADA contains some very basic statutory requirements regarding the implementation of a grievance process, with the most basic statement included in the regulations being that "grievance procedures must provide for prompt and equitable resolution of complaints alleging any action that would be prohibited by this part" (of the legislation). Beyond that, DOJ and other regulatory agencies have more detailed guidelines that delineate how these should be undertaken, and many of those guidelines describe procedures that are not being followed by the DJJ system. It is possible that unless serious deficiencies in the grievance system for youth with disabilities are corrected, compliance with specific ADA requirements (irrespective of proactive youth policies to be implemented under Farrell) could be called into question.

<u>*Recommendations:*</u>

(1) Assure that a Staff Assistant (one who is unknowledgeable about the specific grievance and unrelated to the situation involved) is assigned and made available to all youth with disabilities at the initial point of filing, as well as throughout the entire grievance process, including any informal resolution talks.

(2) Provide accommodations other than a Staff Assistant, including potential time frame extensions, particularly when such accommodations are listed for the youth in the WDP Accommodations List.

(3) Provide written forms describing the procedures, determinations, and resolutions to youth with disabilities, and require signatures from youth or other methods to document the youth's understanding of the resolution, per the WDP Remedial Plan, Section XII.

(4) Provide written policies that relate to the subject of a grievance to all youth with disabilities who request them, per the WDP Remedial Plan, Section XII.

(5) The Facility WDP Coordinator should review all grievances for youth with disabilities to determine if the grievance relates to the determination of a disability or the provision of a reasonable accommodation.

(6) Effect an appeals process (even if informal resolution discussions are unproductive), in keeping with normal ADA guidelines.

6. Education for Youth with Disabilities (Audit Item 48, 49, 51, 55, & 56)

Overall educational programs and educational accommodations for wards with disabilities at O.H. Close reached a substantial compliance level, only the second time a facility has met the applicable requirements of the WDP Remedial Plan. 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, although still a work-in-progress and somewhat confusing to Education staff, (3) improvements in the IEP process, including "pre-IEP" advocacy meetings with youth, and (4) increased involvement on the part of the interim facility WDP Coordinator present at the time of the audit (although she has since left).

However, at the same time, overall educational programs and educational accommodations for wards with disabilities at N. A. Chaderjian regressed from the previous substantial compliance level to only partial compliance, generally for lack of progress and compliance in the first three areas listed in the paragraph above.

There is overlap between the requirements of the WDP Remedial Plan and the Education Remedial Plan, particularly in the area of services for youth with disabilities enrolled in special education programs. Because of this, I have maintained communication with Dr. O'Rourke and Dr. Gordon on specific issues at the facilities, as requested by the Special Master in OSM 19, and a close review of both Educational and Disability facility reports will show a consistency in remaining issues and compliance ratings. Since many youth with disabilities are housed in special treatment or restrictive programs at Chaderjian and Ventura, the difficulties of providing complete services at these units tend 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 youth, 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.

Recommendations:

(1) Continue to improve the educational referral process at the reception centers, particularly for those youth who do not arrive with a record of Special Education or an IEP. Given the typical history of poor attendance, poor academic performance, and larger behavioral issues at prior public schools (as well as the inability to properly identify and serve these youth in many under-performing school districts, an statement made unapologetically since I have worked for several of them), it is unreasonable to expect identification accuracy for these entering youth.

(2) Continue to improve the methods for using either the SEAT and/or the SCT processes as the mechanisms for providing assessments and evaluations

(3) Implement appropriate remedial strategies to improve the number of hours of direct and integrated instruction for these youth at special-purpose and restricted living units, including T.I.P's, as well as the provision of compensatory services.

(4) Document the required involvement of staff advocates prior to and during IEP meetings. The recommended method is to have youth sign the Special Education file log indicating that a "pre-meeting" occurred on a date prior to the IEP meeting.

7. Youth Orientation on Disability Programs (Audit Item 96)

The single-line audit item regarding the disability module of the orientation process is still a high priority item needing both resolution and effective implementation. The WDP Remedial Plan (Section III.J.) and Audit Instrument (Item 96) are both quite cursory and do little to accurately define what is required for auditing purposes. Indeed, a literal reading of the descriptions only states that a module covering four basic topics needs to be prepared, and that a youth must complete an orientation process (presumably, but not specifically stated, that contains it). My interpretation is that the Remedial Plan and Audi Instrument imply that such a disability orientation module and process must be effectively presented to all youth with disabilities. What this entails has been the subject of several meetings with DJJ and OSM, with no definitive resolution.

The current situation has actually shown some progress during the last year, yet inaccurate record-keeping and the lack of clarity on exactly how the orientations were provided to ***all*** youth during the past fiscal year caused less than substantial compliance ratings in this area. These ratings were also confirmed with numerous interviews with youth with disabilities. Since the progress that was made was at the very end of the audit cycle with no clear evidence that those procedures will be continued, particular attention needs to be paid to following through with the procedures discussed, but not verified, during these latter-year audits. The "Comments" given within the WDP Audit Instrument, Attachment 1, Item 96 are quite extensive, and for simplicity, they will not be repeated or summarized herein. The *Recommendations* below should give an indication of remaining issues.

Recommendations:

(1) Hold the group orientation session at each reception center at a fixed time (such as the weekly orientation recently instituted at Chaderjian). Assure that all new entrants to DJJ attend.

(2) If a youth enters DJJ at O.H. Close, transport the youth to Chaderjian to attend, or if an orientation is to be provided at O.H. Close, provide documentation of the orientation' activities.

(Since DJJ does not consider OH Close a "reception center", auditing was not requested or provided at that facility during the last audits).

(3) Utilize the Power Point presentation that includes the previously-approved Disability Module. Update and improve the module as time goes on.

(4) Have the facility WDP Coordinator present to present the disability module and answer questions authoritatively. (Note: if unavailable on periodic occasions, the Coordinator can check in with youth later).

*(5) Document the need or absence of accommodations **before** the presentation, not after.*

8. Monitoring of Psychotropic Medications (Audit Item 9)

The WDP Remedial Plan and Audit Instrument both contain references to the need for a disability perspective in the prescription and monitoring of psychotropic medications. From the very beginning, plaintiffs' attorneys cited a concern regarding a general propensity within institutional contexts of over-medication to "control" certain disabilities, as well as the need to assure that the individual's rights of self-determination of medications were not violated. Both the OACC and Expert audits found that monitoring timelines for youth prescribed with certain psychotropic medications, as required in current DJJ policy, were routinely missed, and that counseling was sporadic. Furthermore, youth interviews continue to pinpoint some confusion among these youth about the reason and nature of their prescriptions.

At the September 29, 2011, meeting, it was relayed by DJJ and OSM that the Mental Health Experts were working with DJJ staff on revisions and clarifications to current policy, and that this information would be sent to me for review and input. I have only recently learned that this task has finally been completed, but since I have not reviewed this new information (it is not due for my review until after this report was to be submitted), I will do so in the near future. I welcome coordination with the Mental Health Experts on this topic, and it is expected that such collaboration will help to resolve compliance issues.

Recommendations:

(1) Transmit any new or revised Psychopharmicological Policy and related information after the Disabilities Expert input for review and input.

(2) Meet the 30-day psychotropic medication monitoring requirement contained in current policy.

9. Self-monitoring (Audit Item 10)

At the request of the Special Master and DJJ, a process was implemented during the 2010-11 fiscal year to transfer a significant amount of WDP auditing to CDCR's Office of Audits and Court Compliance (OACC). The Farrell Experts and I supported this approach because it would serve two purposes. First, it would help DJJ to sustain reform by developing its own internal quality assurance system for self-monitoring. Second, it would enable the Farrell Experts to focus on the more targeted issues (such as those focused on in this report) to expedite reform efforts. 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. OACC was assigned the primary auditing responsibility for from 54 to 64 of the audit items contained in the WDP audit instrument (depending on the facility), and that office prepared compliance reviews at all three facilities and Headquarters.

While there was a basic degree of training for OACC Auditors during mid-2010 in anticipation of upcoming audits, the first year of auditing in 2010-11 was intended to be largely educational. My comprehensive report for last year generally described the auditing as a "work in progress". I offered to provide an additional training for this year's audits, focusing mainly on what the parties had agreed to in terms of compliance issues (although there were still some that had not been determined), but that was not accepted.

A summary of this year's OACC audits is that the results were less than satisfactory. Of the audit items turned over to OACC for auditing, five were later changed to a lower compliance rating by me. While this is not a particularly large number, it must be realized that within my two-day audits (OACC's audits were for five days), there was little time to re-evaluate OACC's ratings, and the changes usually stemmed from fairly obvious situations that showed a lack of understanding of the relevant issues. But for the vast majority of these items, there was no Expert review or follow-up available (although it should be noted that many of those items are relatively low priority, or already completed).

Of greater concern are many of the OACC ratings for items that were **not** turned over to OACC. There was an unacceptable discrepancy between the relatively large number of these audited items rated differently. While DJJ and OACC have repeatedly stated that the Expert's ratings were all that matters for these items, the reality is that the facilities take OACC's ratings to heart and often refer to them as being valid, and this confuses the most complicated compliance issues. More importantly, such discrepancies signal potential future problems of trust and objectivity if and when these more critical audit items are to be turned over for self-monitoring.

It would be too time-consuming to go over the rating discrepancies individually; this can be more easily accomplished by reviewing the differences between my Attachment 1 and the OACC reports. A separate meeting would most likely be the best way to discuss these. Nevertheless, I will give two examples.

First, the OACC audit rated Ventura as substantially complaint for all audit items. My audit listed a total of 13 items with less than a substantial compliance rating, with about six others with data being "not available", and many of these items represented the major issues required for overall reform. Many of the problems at Ventura for this year were well-documented in other documents and other Expert's reports, and the effect of those issues would undoubtedly affect youth with disabilities to a significant extent.

Second, one particular example, Item 72, might best show the problems involved. The question of when a Staff Assistant must be provided to a youth wanting to file a grievance arose in audits during 2010-11 and was discussed extensively. It was made clear that the WDP Remedial Plan and Audit Instrument required a Staff Assistant at the point of filing and throughout the entire process, and that a later rejection of a formal grievance (whether valid or invalid) would not preclude the need for a Staff Assistant during the initial filing. It is clear that those types of collaborations needed to word the grievance and to communicate with staff who were involved in the incident were the exact reason for there being a Staff Assistant necessary in the first place.

DJJ has stated that the OACC was to follow the Expert's instructions on such issues, yet what some staff claimed to be the Department's position on this item was accepted, and the item was rated as being substantially compliant.

Recommendations:

(1) Have the Expert provide additional training to OACC prior to next year's audits.

(2) Retain all existing Expert-audited items to be Expert-audited for the next audit cycle. Review OACC-audited items for possible transfer back to Expert.

(3) Add one extra day to Expert's audits (as was requested for this past year, but denied).

Report respectfully submitted,

Logan Hopper, Disabilities Expert and Auditor

cc: Sid Wolinsky, Disability Rights Advocates
Stuart Seaborn, Disability Rights Advocates
Nancy Campbell, Special Master
John Chen, Deputy Special Master

State of California Department of Corrections and Rehabilitation

Memorandum

Date : June 8, 2012

To : Michael Minor
Director
Division of Juvenile Justice

Subject : **OFFICE OF AUDITS AND COURT COMPLIANCE 2011-2012 COMPREHENSIVE REPORT OF EDUCATION SERVICES**

From November 2011 to February 2012 the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB), conducted reviews of the Education Services Remedial Plan at each Division of Juvenile Justice (DJJ) facility.

Attached, please find the 2011-2012 Education Services Comprehensive Report.

Please direct any questions or concerns to John Blackwell, Captain, JCCB, at (916) 255-2829.

BRYAN B. BEYER
Deputy Director
Office of Audits and Court Compliance

Attachment: OACC Annual Report

cc: Nancy Campbell, Special Master
Sara Norman, Prison Law Office
Van Kamberian, Deputy Attorney General
Dr. Tom O'Rourke, Education Services Expert
Dr. Bob Gordon, Education Services Expert
Dorene Nylund, DJJ
Tami McKee-Sani, DJJ
Doug Ugarkovich, DJJ
Susan Harrower, DJJ
Julian Martinez, OACC
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California Department of Corrections and Rehabilitation

Office of Audits and Court Compliance

Juvenile Court Compliance Branch

OFFICE OF AUDITS AND COURT COMPLIANCE
JUVENILE COURT COMPLIANCE BRANCH

EDUCATION SERVICES
ANNUAL REPORT
2011 - 2012

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Executive Summary

In December 2010, the Office of Audits and Court Compliance (OACC), Juvenile Court Compliance Branch (JCCB) assumed responsibility to conduct *Farrell* Remedial Plan line item reviews. Line items deemed appropriate by court appointed Experts were released for self monitoring. All remedial plan line items are reviewed by OACC in advance of the court Expert audits to offer the Division of Juvenile Justice (DJJ) preliminary findings and recommendations to correct identified deficiencies. The goal of OACC is to ensure standards are maintained and a continuum of quality youth services are provided. To date, OACC has completed two rounds of Education Services Remedial Plan line item reviews.

This annual report will serve as a summary of the 2011-2012 audit round. Listed below is an overview of identified accomplishments and areas remaining less than substantially compliant as identified by OACC. Recommendations for corrective action plans have been identified in the audit reports specific to each site reviewed.

Accomplishments

The DJJ has made notable progress in several areas during this review period. Areas of improvement include, but are not limited to: N.A. Chaderjian High School (NACHS), Johanna Boss High School (JBHS) and Mary B. Perry High School (MBPHS) increasing in overall compliance, the hiring of a Language, Speech and Hearing (LSH) Specialist at NACHS and JBHS, the increase of vocational classes offered at MBPHS and placement of students including high school graduates into vocational classes. Furthermore, Student Consultation Team (SCT) meetings are occurring regularly and being documented at all three schools.

- **Overall Compliance Ratings**

All three DJJ schools increased overall compliance percentages from the 2010-2011 audit round to the 2011-2012 audit round. NACHS increased Substantial Compliance (SC) ratings from 84.48% to 89%, JBHS increased SC ratings from 77.06 to 92% and MBPHS increased SC ratings from 81% to 92%. JBHS showed the greatest improvement for an overall augment of 19.39% from the previous year.

- **LSH Specialist**

LSH services are mandated by federal law and reflected in eight remedial plan line items. During the 2010-2011 audit round, due to the LSH Specialist vacancy at JBHS and NACHS, both schools were Non-Compliant (NC) on each of the eight related remedial plan line items. This negatively affected the overall compliance rating. The 2011-2012 audit round showed significant improvement due to the hiring of an LSH Specialist who ensures mandated services are delivered in accordance with students' Individual Education Plan(s).

- **Vocational classes**

During the OACC 2010-2011 audit round, it was noted that the number of vocational classes at MBPHS was inadequate. However, proof of practice presented during the 2011-2012 audit round indicated the number of vocational classes had increased. Currently, four vocational programs are offered at MBPHS to non-high school graduates, to include: building maintenance, computer repair, janitorial and keyboarding.

- **SCT meetings**

During the 2010-2011 school year, SCT Coordinators at JBHS and MBPHS received limited training on the SCT process. Consequently, both schools received NC ratings on remedial plan line items specific to SCT meetings.

The SCT Coordinator duties at JBHS and MBPHS are being fulfilled by different staff members from the 2010-2011 audit round. The SCT meetings are occurring on a regular basis, being attended by required participants (including youth) and documented appropriately. The SCT process is reviewed in six different remedial plan line items. Corrections in this area have dramatically increased compliance ratings during the 2011-2012 audit round.

Areas Requiring Additional Correction

Of the 115 remedial plan line items reviewed, eight areas were identified as less than SC in two or more of the three DJJ schools. These items included: High School Graduation Plan (HSGP) six month progress reviews are not completed and filed correctly at JBHS and NACHS, a lack of documentation supporting Trade Advisory Committee (TAC) quarterly meetings occurring at JBHS and NACHS, vacant positions at JBHS and MBPHS exceeding 45 days and excessive absenteeism is occurring at all three DJJ schools. Students are not receiving a full day of school instruction on the Behavioral Treatment Programs (BTP) at MBPHS and NACHS, compensatory services are not adequately provided on a consistent basis at MBPHS and NACHS, observations of teachers by administrators are not conducted quarterly at JBHS and NACHS and all three DJJ schools fell out of compliance in the area of Stakeholder Committee meetings not being held in one of the four quarters.

- **HSGP six month progress reviews**

HSGP six month progress reviews at NACHS and JBHS need to be completed and filed appropriately. The purpose of the HSGP is to track student progress in completing required courses toward high school graduation. A HSGP is one component helping to ensure DJJ students will successfully transition back into their respective communities.

- **TAC quarterly meetings**

TAC meetings at NACHS and JBHS should occur on a quarterly basis to provide appropriate programming and liaison between DJJ, the community and potential employers. No evidence was provided during the 2011-2012 audit round to substantiate TAC quarterly meetings are occurring and being documented.

- **Vacancies**

A streamlined process to fill vacancies within 45 days continues to be an area of concern. Associated discrepancies were particularly noted at JBHS and MBPHS. Several factors are negatively impacting the timely filling of vacancies, to include: a continuance of state hiring freezes that were suspended for teachers in July 2011, ongoing Departmental downsizing processes and staff placement protocols affecting site administrators ability to advertize and fill vacancies pending department placements of affected employees, limited availability of resources for LSH Specialists and departmental hiring timelines that exceed 45 days once an applicant has accepted a position.

- **Excessive absenteeism**

During the 2011-2012 audit round, the absence rate at all three DJJ schools exceeded 20%. This is well above the acceptable compliance threshold. The month of October 2011 was reviewed at NACHS and the absence factor was reported at 21.6%. During the month of October 2011, the absence factor at JBHS was 20.9%. MBPHS reported an absence factor of 34% for the month of December 2011. Students continue to be held back from school for reasons other than medical emergencies and safety and security issues. Additionally, students are refusing to attend school and remain on the living units. Both issues need to be addressed by staff.

Farrell mandates require DJJ schools to maintain an absence rate of 7% or less. This standard is lower than requirements for public schools and has been problematic for DJJ to obtain. DJJ is currently gathering information to determine the comparability of absence reporting at DJJ schools versus that of public school districts and the impact of high school graduate attendance patterns with the overall absence rates. Once this research is complete, DJJ may want to consider discussing obtainable compliance thresholds, alternative absence reporting methods and/or alternative absenteeism reduction solutions with the Education Court Experts.

- **BTP**

A full day of Education services on the restricted units at MBPHS and NACHS were not being provided to all enrolled students. At Ventura Youth Correctional Facility (VYCF), the modular units were in place and operative as of January 2012. However, several structural deficiencies have resulted in safety concerns, to include: rocks on either side of the cement sidewalks, breakable glass windows, the student desks are not secured to each other or to the floor, lack of sufficient razor wire enclosing the perimeter and concerns that the walls separating the classrooms could be penetrable.

Difficulties continue to persist at VYCF with some youth opting to fight when scheduled to attend school together. As a result of programming issues and safety concerns, one scheduled classroom per period is often cancelled. As a result, the modular classrooms are not being utilized to their full capacity.

- **Compensatory Services**

Compensatory special education services are not being provided to students at MBPHS and NACHS when a significant gap of missed services occurs. Additionally, a standardized system for tracking and providing compensatory service hours must be maintained.

- **Teacher Observations**

Quarterly observations at JBHS and NACHS were not conducted. In an on-going effort to assist teachers in becoming more effective educational instructors, administrators must conduct and communicate observations to their staff on a quarterly basis.

- **Stakeholder Committee Meetings**

The Stakeholder Committee Meeting did not occur for the month of September 2011. This negatively impacted compliance ratings at all DJJ schools. To ensure the exchange information regarding education programs, obtain parental/community input to improve DJJ schools and act in an advisory capacity to the Superintendent and Executive Team, the Stakeholder Committee needs to meet quarterly.

Cumulative Audit Results

The charts below are reflective of SC items for the Education Services 2011-2012 OACC audit schedule.

N.A. Chaderjian Youth Correctional Facility				
CATEGORY	Round 2 - 2011-2012	Items Compliant	Total Items	Percentage
	Overview, Philosophy and Program Policy	5	7	71.00%
	Staffing	9	11	82.00%
	Student Access and Attendance	35	40	88.00%
	Curriculum	22	24	92.00%
	Special Education	23	25	92.00%
	California High School Exit Exam	8	8	100.00%
	Totals	**102**	**115**	**89.00%**

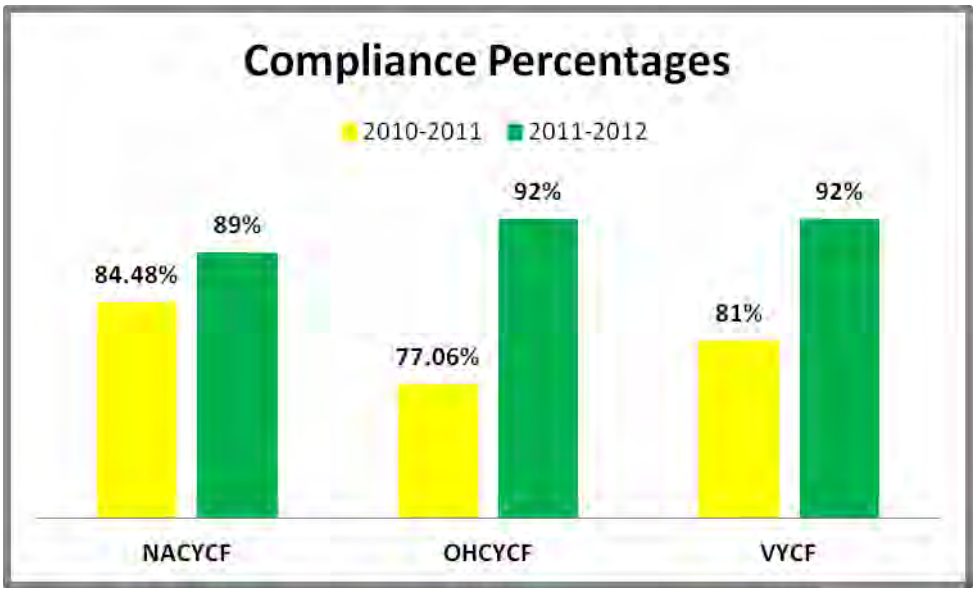
O.H. Close Youth Correctional Facility				
CATEGORY	Round 2 - 2011-2012	Items Compliant	Total Items	Percentage
	Overview, Philosophy and Program Policy	5	7	71.00%
	Staffing	10	11	91.00%
	Student Access and Attendance	37	40	93.00%
	Curriculum	22	24	92.00%
	Special Education	24	25	96.00%
	California High School Exit Exam	8	8	100.00%
	Totals	**106**	**115**	**92.00%**

Ventura Youth Correctional Facility				
CATEGORY	Round 2 - 2011-2012	Items Compliant	Total Items	Percentage
	Overview, Philosophy and Program Policy	6	7	86.00%
	Staffing	10	11	91.00%
	Student Access and Attendance	37	40	93.00%
	Curriculum	24	24	100.00%
	Special Education	21	25	84.00%
	California High School Exit Exam	8	8	100.00%
	Totals	**106**	**115**	**92.00%**

Cumulative Audit Results

The below listed chart and graph demonstrate the increase in compliance from the 2010-2011 round to the 2011-2012 round of the OACC audit schedule.

Percentage of Substantial Compliance				
DJJ FACILITY	*Column A* Round 1 2010-11	*Column B* Round 2 2011-12	*Column C* Increase/Decrease by Percentage Points (Column B-A)	*Column D* Increase/Decrease by Percentage (Column C/A)
N.A. Chaderjian Youth Correctional Facility	84.48%	89%	+ 4.52	+ 5.35%
O.H. Close Youth Correctional Facility	77.06%	92%	+ 14.94	+ 19.39%
Ventura Youth Correctional Facility	81%	92%	+ 11.00	+ 13.58%
Average Increase by Percentage Points			+ 10.15	



1: I. OVERVIEW, PHILOSOPHY AND PROGRAM POLICY	JBHS	MBPHS	NACHS
1.1: (1) Verify Western Association of School and Colleges (WASC) accreditation status at all school sites. Review WASC records at each site. (Education Remedial Plan Criteria-page 2)	SC	SC	SC
1.2: (2) The California Youth Authority (YA) will provide written verification that their courses are California Education Standards driven and that they meet state curriculum standards. (Education Remedial Plan Criteria-page 2)	SC	SC	SC
1.3: (3) Review ten or ten percent, whichever is greater, of the student records at each site to determine the presence of a High School Graduation Plan. (Education Remedial Plan Criteria-page 2)	SC	SC	PC
1.4: (4) Verify whether semi-annual reviews have been conducted. (Education Remedial Plan Criteria-page 2)	PC	SC	PC
1.5/6: (5) Review 10 or 10 percent, whichever is greater, of student records at each site to determine whether progress is being made in meeting high school diploma requirements. (Education Remedial Plan Criteria-page 2)	PC	SC	SC
1.7: (7) Review 10 or 10 percent, whichever is greater, of student files for students with a primary language other than English to verify the provision of English Learner services. (Education Remedial Plan Criteria-page 3)	SC	SC	SC
1.8: (8) Review all files of students within 90 days prior to release to verify that transition planning is being provided to students. (Education Remedial Plan Criteria-page 2)	SC	PC	SC
2: II. STAFFING			
2.1: (1) Review all teaching certificates and teaching schedules of personnel. (Education Remedial Plan Criteria-Page 24)	SC	SC	PC

	JBHS	MBPHS	NACHS
2.2: (2) Review courses offered at each high school to determine if there are enough courses offered to prepare students for graduation, including the following: English, math, life science, physical science, history, economics, government, art or foreign language, physical education and career-technical. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC
2.3: (3) Review and evaluate the written recruitment plan and the qualifications and use of the two recruiters. (Education Remedial Plan Criteria-Page 24)	SC	SC	SC
2.4: (4) Determine the length of time that positions are vacant and the length of time required to recruit and hire replacement teachers during the monitoring period. (Education Remedial Plan Criteria-Page 24)	PC	PC	SC
2.5: (5) Determine whether there is a pool of trained substitute teachers and specialists at each site which represents 15 percent of the permanent teaching staff. (Education Remedial Plan Criteria-Page 6)	SC	SC	PC
2.6: (6) Document class cancellations due to teacher absences that are not covered by substitute teachers. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC
2.7: (7) Verify the use of an in-field teacher for any teacher vacancy which exceeds 45 consecutive days. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC
2.8: (8) Verify that each facility has a psychologist and related service providers available to ensure psychologist participation in the development of Individual Education Program (IEP), administration of psycho-social assessments, and consultation with teachers and staff. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC

	JBHS	MBPHS	NACHS
2.9: (9) Use a sample of 10 or 10 percent, whichever is greater, of special education (SE) students referred for testing during the monitoring period; determine how long it was from referral to testing and report. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC
2.10: (10) Use a sample of 10 or 10 percent, whichever is greater, of SE students referred for related services during the monitoring period; determine how long it was from referral to service provision. (Education Remedial Plan Criteria-Page 6)	SC	SC	SC
2.11: (11) Verify employment of 2 school psychologists at schools with restricted programs.	SC	SC	SC
3: III. STUDENT ACCESS AND ATTENDANCE			
3.1: (1) Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.2: (2) Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.3: (3) Review 10 or 10 percent of student files, whichever is greater, to document enrollment in appropriate education programs within 4 school days of arrival for students entering during the monitoring period. (Education Remedial Plan Criteria-Page 26)	SC	SC	SC
3.4: (4) Verify that high school registrars request transcripts from any prior school within 4 school days of the student's arrival at the facility for students entering during the monitoring period. (Education Remedial Plan Criteria-Page 27)	PC	SC	SC

	JBHS	MBPHS	NACHS
3.5: (5) Review 10 or 10 percent of student files, whichever is greater, to verify that students meeting criteria for General Education Diploma (GED) preparation are provided the opportunity for classes to prepare for GED testing. (Education Remedial Plan Criteria-Page 26)	SC	SC	SC
3.6: (6) Verify School Consultation Team (SCT) committee make up and function. Interview SCT committee members. Interview 10 or 10 percent of student, whichever is greater, who have been the subject of the SCT team meetings to verify the provision of SCT developed instructional services. (Education Remedial Plan Criteria-Page 27)	SC	SC	NC
3.7: (7) Review SCT minutes and records for planned interventions and referral to supplement service providers. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.8: (8) Review 10 or 10 percent, whichever is greater, of files of students not making minimal progress to determine if referrals have been made to SCT (general education students), the Special Education Team (SE students) and/or the Case Conference Team (all students) for evaluation and possible intervention plans. (Education Remedial Plan Criteria-Page 27)	SC	SC	PC
3.9: (9) Verify development of the tracking system by April 2005. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.10: (10) Review 10 or 10 percent, whichever is greater, of files of students having SCT Intervention Plans for documentation of on-going progress reviews. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.11: (11) Review the SCT log at each site for proper documentation and follow-through with students that should be referred for eligibility testing. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC

	JBHS	MBPHS	NACHS
3.12: (12) Review each individual student's file that has been referred from SCT for special education evaluation in last 30 days to verify that SE evaluation has been conducted. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.13: (13) Review in-service training including the outline of topics, the schedule and the dates. Verify attendance at staff training. (Education Remedial Plan Criteria-Page 27)	SC	SC	SC
3.14: (14) Note the procedure for security and/or dorm personnel to inform teachers of missing student's whereabouts. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC
3.15: (15) Review 10 or 10 percent, whichever is greater, of student files to document school attendance for the last 30 school days. (Education Remedial Plan Criteria-Page 28)	NC	NC	NC
3.16: (16) Review the cooperative agreements to ensure students' access and attendance in the school program. Interview staff and students to verify implementation of the agreements. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.17: (17) Verify quarterly reviews of school attendance reports by Executive Team. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.18: (18) Review and evaluate April 2005 plans to remediate deficient attendance/access. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.19: (19) Review and evaluate quarterly corrective action plans for sites that have an absence rate of more than 5 percent. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC

	JBHS	MBPHS	NACHS
3.20: (20) Review school schedules for the last 30 days. Review Ward Information Network (WIN) Data and verify individual class cancellations at each site. Interview teachers, other staff, and students. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.21: (21) Review attendance records of a minimum of 5 teachers to verify that the location of missing students is identified. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.22: (22) Review exclusion from school forms at each site for 10 days out of the previous month for completeness of data recorded. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.23: (23) Observe any students being pulled from class, held back on housing unit, or held over after meals to perform work details. (Education Remedial Plan Criteria-Page 29)	SC	NC	SC
3.24: (24) Verify existence and accuracy of WIN attendance information for the last 10 consecutive schools days. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC
3.25: (25) Review logs and minutes documenting the management team's monthly review of instructional time requirements. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC
3.26: (26) Review and evaluate performance expectations on attendance developed in July 2005. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC
3.27: (27) Review and evaluate training plan, outline of topics and schedule. Verify staff attendance at the training. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC

	JBHS	MBPHS	NACHS
3.28: (28) Review and evaluate final implementation of attendance policies and procedures in December 2005. Review and evaluate revised policy and procedure in July 2006. (Education Remedial Plan Criteria-Page 28)	SC	SC	SC
3.29: (29) Verify the development of incentives for increased school attendance. (Education Remedial Plan Criteria-Page 29)	PC	SC	SC
3.30: (30) Review and evaluate annual school calendar. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.31: (31) Review scheduling and utilization of the 44 student advising/case conference days per year. (Education Remedial Plan Criteria-Page 29)	SC	SC	SC
3.32: (32) Review number and size of classrooms and CYA study of instructional space in May 2005. Monitor progress in meeting proposed classroom construction and renovation schedule. (Education Remedial Plan Criteria-Page 30)	SC	SC	SC
3.33: (33) Verify the implementation of the behavior management system in the classrooms at each site. (Education Remedial Plan Criteria-Page 30)	SC	SC	SC
3.34: (34) Verify the use of the alternative behavior management classroom at each site. (Education Remedial Plan Criteria-Page 30)	SC	SC	SC
3.35: (35) Review and evaluate staff training outline, schedule and attendance. (Education Remedial Plan Criteria-Page 30)	SC	SC	SC
3.36: (36) Review behavioral goals in IEPs of all special education students placed in restricted programs. Interview IEP team members, psychologist and related service providers.	SC	SC	SC

	JBHS	MBPHS	NACHS
3.37: (37) Verify existence of classrooms in restricted settings. Verify that all classrooms meet minimum CDOE size standards. Report the number of students in restricted settings served in small classrooms and the number not being served.	SC	NC	PC
3.38: (38) Review current and previous 30 school days' class rolls for all restricted programs to determine staffing pattern. Verify teachers' credentials. Review high school graduation plans, IEPs and other documents to document assignment/instructional match.	SC	SC	PC
3.39: (39) Verify instructional program on restricted units by reviewing school schedule, education progress reports and school transcripts. Conduct direct observation of instructional program. Interview site administrators. Interview teachers, custodial staff and students.	SC	SC	SC
3.40: (40) Verify staff training and technical assistance are being provided	SC	SC	SC
4: IV. CURRICULUM			
4.1: (1) Verify with written documentation that the CYA curriculum meets the Content Standards and Curriculum Frameworks for the California Public Schools. (Education Remedial Plan Criteria-Page 32)	SC	SC	SC
4.2: (2) Verify with written documentation that there is a process in place to coordinate curriculum revisions and develop curriculum guides on a cyclical basis. (Education Remedial Plan Criteria-Page 32)	SC	SC	SC

	JBHS	MBPHS	NACHS
4.3: (3) Verify that Curriculum Guides with content, performance standards and process for instruction exist for all core area courses (English/Language Arts, Science, Mathematics, Social Studies) and vocational education courses taught in the CYA Schools. (Education Remedial Plan Criteria-Page 32)	SC	SC	SC
4.4: (4) Verify that the core academic guides are available to all staff electronically in December 2005. (Education Remedial Plan Criteria-Page 33)	SC	SC	SC
4.5: (5) Compare the number of textbooks and library books at each site with applicable standards. (Education Remedial Plan Criteria-Page 33)	SC	SC	SC
4.6: (6) Verify in August 2005 that the annual inventory and needs assessment has been conducted. (Education Remedial Plan Criteria-Page 33)	SC	SC	SC
4.7: (7) Observe whether adequate supplies and materials are available at each site to support the curriculum offerings. Verify the availability of textbooks and library materials to students in classrooms. (Education Remedial Plan Criteria-Page 33)	SC	SC	SC
4.8: (8) Verify availability of core books in the mini-libraries on the living units according to the inventory prepared by the school librarian. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.9: (9) Verify the implementation of the State Development Plan for leadership personnel. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.10: (10) Verify in-service schedule including dates and outline of topics. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC

	JBHS	MBPHS	NACHS
4.11: (11) Verify staff attendance at training through inspection of in-service roll information and review of Principal's Monthly Report. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.12: (12) Verify the formation of advisory committees at each site by May 2005 and their quarterly meetings. (Education Remedial Plan Criteria-Page 34)	NC	SC	PC
4.13: (13) Verify the use of annual surveys to provide vocational course planning by July 2005. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.14: (14) Verify the use of annual Career Technical job studies to determine the effectiveness of Career Technical Education (CTE) programs. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.15: (15) Verify the existence of the use of technology at each site by June 2005. (Education Remedial Plan Criteria-Page 34)	SC	SC	SC
4.16: (16) Verify that distance learning course content meets Content Standards. (Education Remedial Plan Criteria-Page 35)	SC	SC	SC
4.17: (17) Verify implementation and use of Global Classrooms distance learning. (Education Remedial Plan Criteria-Page 35)	SC	SC	SC
4.18 Verify use of distance learning in restricted settings by direct observation, lesson plan and transcript review.	SC	SC	SC
4.19: (19) Verify implementation and use of the automated library system. (Education Remedial Plan Criteria-Page 35)	SC	SC	SC

	JBHS	MBPHS	NACHS
4.20: (20) Verify through teacher observation evidence of the use of course syllabi, units of instruction and lesson plans. Interview teachers, students, and administrators for evidence of the use of lesson plans, course syllabi and units of instruction. (Education Remedial Plan Criteria-Page 35)	SC	SC	SC
4.21: (21) Verify the practice of quarterly teacher observations by administrators using the revised rubric for Classroom Observation. (Education Remedial Plan Criteria-Page 35)	PC	SC	NC
4.22: (22) Verify that the strategic plan and reading initiative are being implemented at each site. (Education Remedial Plan Criteria-Page 36)	SC	SC	SC
4.23: (23) Verify that policies have been revised to reflect changes in operations. (Education Remedial Plan Criteria-Page 37)	SC	SC	SC
4.24: (24) Verify that policies are made available to staff electronically by June 2006. (Education Remedial Plan Criteria-Page 37)	SC	SC	SC
5: V. SPECIAL EDUCATION			
5.1: (1) Verify that the manual is complete and made available to staff by September 2005. Verify that Special Education Manual meets all relevant State and Federal rules and guidelines. (Education Remedial Plan Criteria-Page 42)	SC	SC	SC
5.2: (2) Review 10 or 10 percent, whichever is greater, of newly transferred student files at each site to verify that completed SE files are transferred to the receiving CYA facility and fully implemented within 4 school days of student's arrival. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC

	JBHS	MBPHS	NACHS
5.3: (3) Review 10 or 10 percent, whichever is greater, of newly transferred student files at each site to verify that CYA SE screening procedures are being followed and that students are being referred for psychological testing as needed for new identification. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.4: (4) Interview teachers to review informal procedures used to identify SE students in classrooms. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.5: (5) Review 10 or 10 percent, whichever is greater, of SE student files at each site to verify that students are being referred for psychological testing as needed to update expired eligibility reports. In the same sample, determine whether psychological testing and reports are done in a reasonable time period and if reports are completed and useful. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.6: (6) During site visits and staff interviews, determine whether each CYA facility provides a continuum of placement options, including the full range of time, frequency and duration within each option. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.7: (7) During site visits and through staff interviews, determine whether the continuum of available SE services is provided to all eligible students including those assigned to restricted settings. (Education Remedial Plan Criteria-Page 39)	SC	PC	SC
5.8: (8) Review 10 or 10 percent, whichever is greater, of SE student files at each site to verify that eligible students are receiving the required number of segments and full instructional day. Interview SE students to verify that services listed in IEPs are being provided. (Education Remedial Plan Criteria-Page 40)	SC	PC	SC

	JBHS	MBPHS	NACHS
5.9: (9) Determine completeness and accuracy of SE data collection system (includes type of disability, number and type of segments, etc). (Education Remedial Plan Criteria-Page 41)	SC	SC	SC
5.10: (10) Verify that the revised standards are established and that the timelines are being met. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.11: (11) Verify that in-service training on assessments is provided. Review monthly reports of assessment completions. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.12: (12) Verify whether the revised assessment procedures, including county inmate processes, have been implemented. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.13: (13) Verify existence of collaborative agreements. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.14: (14) Verify established procedures that enforce requirements. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.15: (15) Review 10 or 10 percent, whichever is greater, of SE files at each site to verify that students were provided services according to requirements of pre-existing valid IEPs. (Education Remedial Plan Criteria-Page 38)	SC	SC	SC
5.16: (16) Review 10 or 10 percent, whichever is greater, of SE files to verify that any changes in an IEP are documented with the rationale stated. (Education Remedial Plan Criteria-Page 38-39)	SC	SC	SC

	JBHS	MBPHS	NACHS
5.17: (17) Review 10 or 10 percent, whichever is greater, of SE files to verify that the eligibility determination is made prior to holding IEP meeting. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.18: (18) In same files, verify that IEP meetings are held within prescribed timeframe and if not, that proper documentation exists as to the reason. In same files, verify that IEP notices are sent as required and that required participants are present. If regular education teachers are not there, ensure that they are made aware of IEP provisions. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.19: (19) Review 10 or 10 percent, whichever is greater, of SE files at each site for consideration of need for related services and/or transition planning. Interview teachers regarding consideration of related services and transition planning. (Education Remedial Plan Criteria-Page 39)	SC	SC	SC
5.20: (20) Verify in-service training schedule including dates and outline of topics. Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly report. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.21: (21) Verify that SE staff is provided with standardized formats for documentation of review. Review or 10 or 10 percent, whichever is greater, of SE files to verity that progress reviews meet the IEP schedule. Interview SE teachers regarding progress reviews. (Education Remedial Plan Criteria-Page 41)	SC	SC	SC
5.22: (22) Review Administrator's Compensatory Services Plan. Through teacher and student interviews verify that compensatory services are provided to students when required. (Education Remedial Plan Criteria-Page 41)	SC	NC	NC

	JBHS	MBPHS	NACHS
5.23: (23) Review formal minutes of Stakeholder's meetings including dates, agenda, membership, and recommendations. (Education Remedial Plan Criteria-Page 41)	PC	NC	PC
5.24: (24) Verify in-services schedule including date and topics. Verify staff attendance through inspection of in-service roll information and review of Principal's Monthly Report. Verify schedule using CYA Master Calendar. (Education Remedial Plan Criteria-Page 40)	SC	SC	SC
5.25: (25) Review quarterly site review reports. (Education Remedial Plan Criteria-Page 42)	SC	SC	SC
6: VI. CALIFORNIA HIGH SCHOOL EXIT EXAM			
6.1: (1) Verify the use of the state mandated testing schedule through observation and interviews. Through student interviews and file reviews, verify access of eligible students to the state mandated exam. (Education Remedial Plan Criteria-Page 43)	SC	SC	SC
6.2: (2) The CYA will provide written verification that the content of its curriculum guides in English-language arts and mathematics is related to items on the California Graduation Test. (Education Remedial Plan Criteria-Page 43)	SC	SC	SC
6.3: (3) Through student interviews and file reviews, verify that eligible students have appropriate opportunities to pass the state mandated exam. (Education Remedial Plan Criteria-Page 43)	SC	SC	SC
6.4: (4) Verify by records review of students taking state mandated exams that appropriate accommodations, modifications or variations were provided as a part of testing procedures (in accord with CDOE guidelines). (Education Remedial Plan Criteria-Page 44)	SC	SC	SC

	JBHS	MBPHS	NACHS
6.5: (5) 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 CDOE guidelines). (Education Remedial Plan Criteria-Page 44)	SC	SC	SC
6.6: (6) Verify by records review of students taking the test that students failing at least one part of the exam were provided specific remediation related to test items. (Education Remedial Plan Criteria-Page 44)	SC	SC	SC
6.7: (7) Review and evaluate data on student achievement on the California High School Exit Exam to determine whether school improvement plans are based on test achievement data. (Education Remedial Plan Criteria-Page 44)	SC	SC	SC
6.8: (8) Review and evaluate data on students to determine whether they are being provided the full range of alternatives available (diplomas, equivalency tests, certificates of completion). (Education Remedial Plan Criteria-Page 45)	SC	SC	SC

BTP	Behavioral Treatment Program
DJJ	Division of Juvenile Justice
HSGP	High School Graduation Plan
JBHS	Johanna Boss High School
LSH	Language, Speech and Hearing
MBPHS	Mary B. Perry High School
NACHS	N.A. Chaderjian High School
NC	Non-compliance
OACC	Office of Audits and Court Compliance
SC	Substantial Compliance
SCT	School Consultation Team
TAC	Trade Advisory Committee
VYCF	Ventura Youth Correctional Facility

California Department of Corrections and Rehabilitation

Office of Audits and Court Compliance

Juvenile Court Compliance Branch

OFFICE OF AUDITS AND COURT COMPLIANCE
JUVENILE COURT COMPLIANCE BRANCH

WARDS WITH DISABILITIES PROGRAM
FARRELL REMEDIAL PLAN
ANNUAL REPORT
2011 - 2012

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Executive Summary

In December 2010, the Office of Audit and Court Compliance (OACC), Juvenile Court Compliance Branch assumed responsibility to conduct *Farrell* Remedial Plan line item reviews. Line items deemed appropriate by court appointed Experts were released for self monitoring. All remedial plan line items are reviewed by OACC in advance of the court Expert audits to offer the Division of Juvenile Justice (DJJ) preliminary findings and recommendations to correct identified deficiencies. The goal of OACC is to ensure standards are maintained and a continuum of quality youth services are provided. To date, OACC has completed two rounds of Wards with Disabilities Program (WDP) Remedial Plan line item reviews.

This annual report will serve as a summary of the 2011-2012 audit round. Listed below is an overview of identified accomplishments and areas remaining less than substantially complaint as identified by OACC. Recommendations for corrective action plans have been identified in the audit reports specific to each site reviewed.

Accomplishments

DJJ has made notable progress in several areas during this review period. Areas of improvement include, but are not limited to: all three facilities achieved a substantial compliance rating in the area of identifying youth with developmental disabilities and the implementation of the New Youth Orientation presentation. In addition, the Departmental WDP Coordinator is making continued progress to improve the disability programs at all facilities. With the development of the Initial Case Review (ICR) Guidelines and the ICR Compliance Review form, the facility WDP Coordinator monitors' ICRs with youth and complete a quarterly compliance review.

- **Developmental Disabilities**

All three DJJ facilities improved their compliance ratings by ensuring all youth were given the Kaufman Brief Intelligence Test or other intelligence measuring assessments. The results were documented in the youth's Unified Health Record (UHR) and in the Ward Information Network (WIN). A standardized form entitled "Cognitive Testing Summary" was developed and is now being used at each facility to document youth assessment scores.

- **New Youth Orientation**

The New Youth Orientation Presentation has been completed and implemented at all three DJJ facilities. The New Youth Orientation is presented to all new intakes. This presentation contains a complete WDP module which has been approved by the court appointed WDP Expert.

- **ICR Guidelines**

The ICR Guidelines were developed to ensure youth who have a disability requiring an accommodation are properly documented and receive their required accommodation during the ICR. These guidelines also ensure the participation of the appropriate staff, when warranted. Staff documents additional accommodations identified during the ICR in WIN.

- **ICR Compliance Review form**

The Departmental WDP Coordinator developed an ICR Compliance Monitoring Tool. The facility WDP Coordinator at each facility uses this monitoring tool to document compliance with ICR Guidelines. This quarterly review will identify deficiencies involving the use of the ICR Guidelines and any youth not receiving accommodations during the ICR.

Areas Requiring Additional Correction

Areas requiring additional corrections as identified by OACC include: monitoring the use of psychotropic prescriptions and medications, implementation of annual staff disability training, the reporting of WDP youth placed in an alternative program, and scheduling procedures for School Consultation Team (SCT) referrals.

- **Psychotropic prescription and medication monitoring**

DJJ has a "Psychopharmacological Treatment, Mental Health System" policy signed January 20, 2009, outlining how psychotropic prescriptions and medications are to be monitored. To date, none of the facilities have a standardized monitoring process in place. This headquarters (HQ) item is currently being reviewed by the DJJ Senior Psychiatrist (Supervisory).

- **Staff Disability Awareness Training**

DJJ failed to provide Disability Awareness Training to all staff during the 2011-2012 fiscal year resulting from budget constraints and the subsequent cancellation of in-service training in September 2011. This training is required in the WDP Remedial Plan. This is a HQ item in which deficiencies occurred due to staffing issues at N.A. Chaderjian Youth Correctional Facility (NACYCF). Budget issues caused deficiencies at the remaining two DJJ facilities and HQ.

- **WDP Youth Placed in Alternative Programs**

The Superintendent or designee is required to review a copy of the "WDP Youth Daily Alternative Program Report" to ensure that any accommodation required by a youth has been documented. The facility WDP Coordinator is required to provide the Superintendent with a copy of the WDP Youth Daily Alternative Program Report within 24 hours of youth being placed in an alternative program. Documentation presented indicated this process is not being adhered to at both NACYCF and Ventura Youth Correctional Facility (VYCF).

- **SCT Referrals**

Within five days of receipt, the SCT Coordinator is required to schedule SCT referrals for an SCT meeting. The SCT Coordinators at NACYFC and O.H. Close Youth Correctional Facility (OHCYCF) are not scheduling SCT meetings within the five day time frame.

Cumulative Audit Results

The charts below are reflective of items in substantial compliance from OACC's findings from the 2011-2012 round of audits.

CATEGORY	DJJ Headquarters			
	Compliance Percentages	Items Compliant	Total Items	Percentage
	Directorate	1	1	100%
	Departmental Ward Disability Coordinator & Functions	10	11	91%
	Headquarters Policies	14	15	93%
	Headquarters Programs/Screening	4	4	100%
	Totals	**29**	**31**	**94%**

CATEGORY	N.A. Chaderjian Youth Correctional Facility			
	Compliance Percentages	Items Compliant	Total Items	Percentage
	Superintendent	4	4	100%
	Facility's Ward with Disabilities Coordinator	5	5	100%
	Facility's Policies	21	25	84%
	Disciplinary Decision Making System	5	5	100%
	Grievance Procedures	14	14	100%
	Reception Center and Clinic Functions	10	12	83%
	Residential Programs	12	16	75%
	Developmental Disabilities	2	2	100%
	Removal of Architectural Barriers	6	6	100%
	Totals	**79**	**89**	**89%**

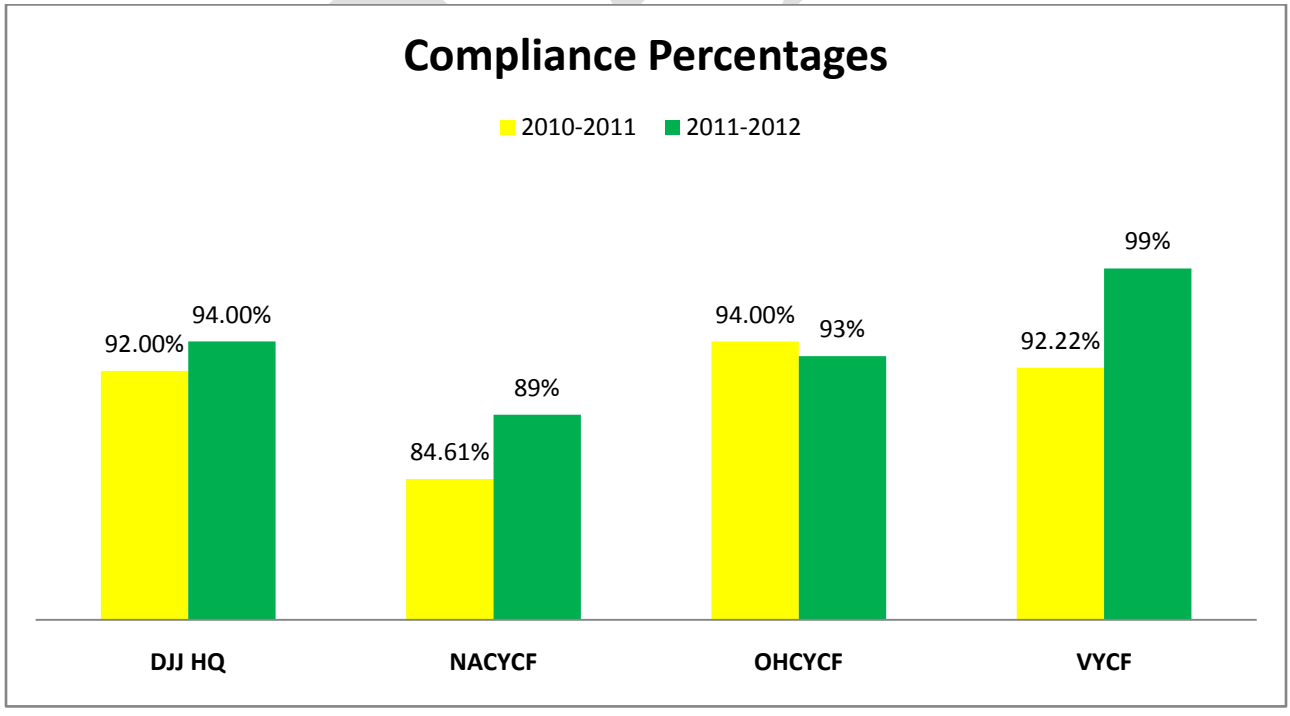
CATEGORY	O.H. Close Youth Correctional Facility			
	Compliance Percentages	Items Compliant	Total Items	Percentage
	Superintendent	4	4	100%
	Facility's Ward with Disabilities Coordinator	5	5	100%
	Facility's Policies	23	23	100%
	Disciplinary Decision Making System	3	5	60%
	Grievance Procedures	12	14	86%
	Residential Programs	15	16	94%
	Developmental Disabilities	2	2	100%
	Removal of Architectural Barriers	6	6	100%
	Totals	**70**	**75**	**93%**

CATEGORY	Ventura Youth Correctional Facility			
	Compliance Percentages	Items Compliant	Total Items	Percentage
	Superintendent	4	4	100%
	Facility's Ward with Disabilities Coordinator	5	5	100%
	Facility's Policies	21	22	95%
	Disciplinary Decision Making System	5	5	100%
	Grievance Procedures	14	14	100%
	Reception Center and Clinic Functions	12	12	100%
	Residential Programs	16	16	100%
	Developmental Disabilities	2	2	100%
	Removal of Architectural Barriers	6	6	100%
	Totals	**85**	**86**	**99%**

Cumulative Audit Results

The below listed chart and graph demonstrate the increase/decrease in compliance from OACC's findings from the first round (2010-2011) to the second round (2011-2012).

Percentage of Substantial Compliance				
DJJ FACILITY	*Column A Round 1 2010-2011*	*Column B* Round 2 2011-2012	*Column C* Increase/ Decrease by Percentage Points (Colunm B-A)	*Column D* Increase/ Decrease by Percentage (Column C/A)
DJJ Headquarters	92%	94%	+2	2%
N. A. Chaderjian Youth Correctional Facility	85%	89%	+4	5%
O.H. Close Youth Correctional Facility	94%	93%	-1	-1%
Ventura Youth Correctional Facility	92%	99%	+6	7%
Average Increase by Percentage Points			+3	



Headquarters **A. Directorate**	NACYCF	OHCYCF	VYCF	HQ
*1.01: (1) A. DIRECTORATE- Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director's office.	NA	NA	NA	SC
B. Departmental Ward Disability Coordinator & Functions				
1.02: (2) B. DEPARTMENTENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- 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 Disability Access program. (Reference: Remedial Plan-Page 5)	NA	NA	NA	SC
1.03: (3) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- Ensure duty statement encompasses all Departmental WDP Coordinator duties as defined in the WDP Remedial Plan. (Reference: Remedial Plan-Page 4)	NA	NA	NA	SC
1.04: (4) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan. (Reference: Remedial Plan-Page 4)	NA	NA	NA	SC
1.05: (5) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS-Establish and maintain full-time WDP Coordinators at each facility by February 2006. Reference: (Remedial Plan-Page 5)	NA	NA	NA	SC
1.06: (6) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- The Departmental WDP Coordinator will develop a standardized emergency announcement protocol by December 2005. Reference: (Remedial Plan-Page 37)	NA	NA	NA	SC
1.07: (7) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- The Departmental WDP Coordinator shall ensure that a WDP report is completed monthly, quarterly and annually for each site. Reference: (Remedial Plan-Page 57)	NA	NA	NA	SC

	NACYCF	OHCYCF	VYCF	HQ
1:08: (8) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, (1) 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. (Reference: Remedial Plan-Page 14)	NA	NA	NA	SC
1:09: (9) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- 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 prescription and medications including SSRI's for wards under the age of 20. (Reference: Remedial Plan-Page 15)	NA	NA	NA	PC
1.10: (10) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- 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 reevaluate the level of staffing and training needed to comply with the Remedial Plan, commencing in the 2006 calendar year. (Reference: Remedial Plan-Page 58)	NA	NA	NA	SC
1.11: (11) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- 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. (Reference: Remedial Plan-Page 57)	NA	NA	NA	SC
1.12: (12) B. DEPARTMENTAL WARD DISABILITY COORDINATOR & FUNCTIONS- Develop the Disability Health Services Referral Form.	NA	NA	NA	SC

	NACYCF	OHCYCF	VYCF	HQ
C. Headquarters Policies				
*1.13: (13) C. HEADQUARTER'S POLICIES- The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006. (Reference: Remedial Plan-Page 44)	NA	NA	NA	SC
1.14: (14) C. HEADQUARTER'S POLICIES - By July 2006, the Department shall develop and maintain a system that documents the mental and physical impairments of wards with disabilities and any reasonable accommodations. (Reference: Remedial Plan-Page 8)	NA	NA	NA	SC
1.15: (15) C. HEADQUARTER'S POLICIES - 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. (Reference: Remedial Plan-Page 2)	NA	NA	NA	SC
1.16: (16) C. HEADQUARTER'S POLICIES - 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. (Reference: Remedial Plan-Page 2)	NA	NA	NA	SC
1.17: (17) C. HEADQUARTER'S POLICIES - 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 upon manifestations of that disability. (Reference: Remedial Plan-Pages 37-40)	NA	NA	NA	SC
*1.18: (18) C. HEADQUARTER'S POLICIES -) 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. (Reference: Remedial Plan-Page 34)	NA	NA	NA	SC

	NACYCF	OHCYCF	VYCF	HQ
*1.19: (19) C. HEADQUARTER'S POLICIES - 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 Department to provide such means.) (Reference: Remedial Plan-Page 34)	NA	NA	NA	SC
*1.20: (20) C. HEADQUARTER'S POLICIES -) The Education Branch working committee shall also study the need to include a wider variety of individualized accommodations in IEP's. (Reference: Remedial Plan-Page 34)	NA	NA	NA	SC
1.21: (21) C. HEADQUARTER'S POLICIES - 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 Program Remedial Plan is filed with the court. (Reference: Remedial Plan-Page 26)	NA	NA	NA	SC
*1.22: (22) C. HEADQUARTER'S POLICIES - The new visiting facility at Ventura YCF is currently under construction and will be fully operational by January 2006. The new facility at Preston YCF will be fully operational and safe for all wards, visitors and staff by July 2006. The CYA will confer with the Disability Expert to explore and implement, as reasonably appropriate, interim solutions to address architectural barriers at the existing Preston YCF visiting area until the new facility is opened by July 2006. (Reference: Remedial Plan-Page 36 & Appendix C)	NA	NA	NA	SC
1.23: (23) C. HEADQUARTER'S POLICIES - 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, and in consultation with the Disability Expert, by June 2006. (Reference: Remedial Plan-Page 56)	NA	NA	NA	SC
1.24: (24) C. HEADQUARTER'S POLICIES - The CYA shall develop a screening tool to assess the current ward population in order to identify any developmentally disabled wards who may not have been previously identified. The CYA shall complete this assessment by December 2006. (Reference: Remedial Plan-Page 29)	NA	NA	NA	SC

	NACYCF	OHCYCF	VYCF	HQ
1.25: (25) C. HEADQUARTER'S POLICIES - Within 12 months of the court approval and adoption of this 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 disabilities sensitivity, awareness and harassment. This training will be provided to all staff on an annual basis. Additionally, until such time as disability sensitivity, awareness and harassment training is incorporated in the basic training academy curriculum, this training will be provided to all new hires within 90 days of their placement in the facility. (Reference: Remedial Plan-Page 57)	NA	NA	NA	PC
1.26: (26) C. HEADQUARTER'S POLICIES - 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. (Reference: Remedial Plan-Page 35)	NA	NA	NA	SC
*1.27: (27) C. HEADQUARTER'S POLICIES - The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005.(Reference: Remedial Plan-Page 5)	NA	NA	NA	SC
*1.28: (28) D. HEADQUARTERS PROGRAMS/SCREENING- Maintain a contract for sign language interpreter services, as well as a record of use of this service. (Reference Remedial Plan-Page 4 & 13)	NA	NA	NA	SC
1.29: (29) D. HEADQUARTERS PROGRAMS/SCREENING - 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. (Reference: Remedial Plan-Page 5)	NA	NA	NA	SC
1.30: (30) D. HEADQUARTERS PROGRAMS/SCREENING - 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. (Reference: Remedial Plan-Page 5)	NA	NA	NA	SC
1.31: (31) D. HEADQUARTERS PROGRAMS/SCREENING - 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. (Reference: Remedial Plan-Page 5)	NA	NA	NA	SC

2: FACILITY ADMINISTRATION	NACYCF	OHCYCF	VYCF	HQ
A. Superintendent				
*2.32: (32) A. SUPERINTENDENT-Maintain a current copy of the Wards with Disabilities Program Remedial Plan retained in the Superintendent's office.	SC	SC	SC	NA
*2.33: (33) A. SUPERINTENDENT-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. (Reference: Remedial Plan-Page 33)	SC	SC	SC	NA
2.34: (34) A. SUPERINTENDENT-The Superintendents shall report to the Deputy Director, within 24 hours, when a ward with a disability that requires accommodations is placed in a restrictive setting, i.e., Temporary Detention or lockdown. (Reference: Remedial Plan-Page 39)	SC	SC	SC	NA
2.35: (35) A. SUPERINTENDENT-The Superintendent shall be responsible for ensuring that due process and equal access occurs for wards with disabilities who require accommodations during institutional Youth Authority Board hearings. (Reference: Remedial Plan-Page 52)	SC	SC	SC	NA
B. Facility's Ward Disability Coordinator				
2.36: (36) B. FACILITY'S WARD DISABILITIES COORDINATOR-Maintain WDP Coordinators at each facility. (Reference: Remedial Plan-Page 4)	SC	SC	SC	NA
*2.37: (37) B. FACILITY'S WARD DISABILITIES COORDINATOR-Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan. (Reference: Remedial Plan-Page 3)	SC	SC	SC	NA
2.38: (38) B. FACILITY'S WARD DISABILITIES COORDINATOR-The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan. (Reference: Remedial Plan-Page 4)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.39: (39) B. FACILITY'S WARD DISABILITIES COORDINATOR-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. (Reference: Remedial Plan-Page 57)	SC	SC	SC	NA
2.40: (40) B. FACILITY'S WARD DISABILITIES COORDINATOR-The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator. (Reference: Remedial Plan-Page 57)	SC	SC	SC	NA
C. Facility's Policies				
2.41: (41) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 19)	SC	SC	SC	NA
*2.42: (42) C. FACILITY'S POLICIES-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 devise is no longer medically necessary or appropriate. (Reference: Remedial Plan-Page 16)	SC	SC	SC	NA
*2.43: (43) C. FACILITY'S POLICIES-Wards with hearing disabilities shall be provided use of a Telecommunications Devices for the Deaf (TDD). (Reference: Remedial Plan-Page 18)	SC	SC	SC	NA
*2.44: (44) C. FACILITY'S POLICIES-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 in use. (Reference: Remedial Plan-Page 18)	NC	SC	SC	NA
*2.45: (45) C. FACILITY'S POLICIES-Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities. (Reference: Remedial Plan-Page. 18)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
2.46: (46) C. FACILITY'S POLICIES-A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her assigned Parole Agent, Casework Specialist or by completing the Referral for Sick Call form (RSC). A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her Education Advisor by completing the Self-Referral to the School Consultation Team (SRSCT) form. (Reference: Remedial Plan-Page 20)	SC	SC	SC	NA
*2.47: (47) C. FACILITY'S POLICIES-The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment. (Reference: Remedial Plan-Page 33)	SC	SC	SC	NA
2.48: (48) C. FACILITY'S POLICIES-Students who take the California High School Exit Exam 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 State Board of Equalization process and policy.	SC	NA	NA	NA
2.49: (49) C. FACILITY'S POLICIES-Each ward with a disability shall have a High School Graduation Plan. (Reference: Remedial Plan-Page 31)	SC	SC	SC	NA
*2.50: (50) C. FACILITY'S POLICIES- Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan. (Reference: Remedial Plan-Page 31)	SC	SC	NA	NA
2.51: (51) C. FACILITY'S POLICIES-The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities. (Reference: Remedial Plan-Page 31)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
2.52: (52) C. FACILITY'S POLICIES-Non-emergency verbal announcements, in living units where wards with hearing and 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. (Reference: Remedial Plan-Page 37)	SC	SC	SC	NA
2.53: (53) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 40)	SC	SC	SC	NA
*2.54: (54) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 39)	PC	SC	PC	NA
2.55: (55) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 34)	PC	SC	SC	NA
2.56: (56) C. FACILITY'S POLICIES-All individuals who serve as surrogate parents will receive annual training in the role and responsibilities of a surrogate as identified by the State Department of Education. Student Advocacy will be addressed in part of the training and the training will also encourage active participation. (Reference: Remedial Plan-Page 34)	NC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.57: (57) C. FACILITY'S POLICIES-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. Such assistive devices may include interpreters, readers, taped texts, canes, crutches, wheelchairs, hearing aids, corrective lenses, teletypewriters (TTYs), and telecommunication devices for deaf persons (TDDs), assistive listening headsets, television captioning and decoders, Braille materials, video text displays, and large print materials. (Reference: Remedial Plan-Page 11)	SC	SC	SC	NA
*2.58: (58) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 13)	SC	SC	SC	NA
2.59: (59) C. FACILITY'S POLICIES-Qualified sign language interpreters shall be provided as necessary to ensure effective communication and at a minimum for all due process functions, medical consultations, videoconferencing and special programs. (Reference: Remedial Plan-Pages 11 and 12)	SC	SC	SC	NA
*2.60: (60) C. FACILITY'S POLICIES-Reasonable accommodations may only be denied if the accommodation 1) poses a direct threat to the Health and Safety of others, 2) constitutes and undue burden, or 3) if there is equally effective means of providing access to a program, service, or activity. A request for a specific accommodation may be denied if equally effective access to a program, service, or activity may be afforded 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. (Reference: Remedial Plan-Pages 13 and 14)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.61: (61) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 51)	SC	SC	SC	NA
*2.62: (62) C. FACILITY'S POLICIES-Department staff shall ensure that wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans and in the completion of required forms. (Reference: Remedial Plan-Page 51)	SC	SC	SC	NA
2.63: (63) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 30)	SC	NA	NA	NA
2.64: (64) C. FACILITY'S POLICIES-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. (Reference: Remedial Plan-Page 30)	NA	NA	NA	NA
2.65: (65) C. FACILITY'S POLICIES-The IIPA/Casework Specialist shall complete and forward the Case Report Transmittal Form, along with all supporting documents on the issue of a disability, to the Parole Agent III or Supervising Casework Specialist II, when scheduling a YAB hearing. Parole Agent I/Casework Specialist shall be responsible for requesting accommodations for wards with disabilities during YAB hearing when a ward requests an accommodation, or when the Parole Agent I/Casework Specialist is aware of a disability or should have been aware of a disability. (Reference: Remedial Plan-Page 51)	SC	SC	SC	NA
*2.66: (66) C. FACILITY'S POLICIES-The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings. (Reference: Remedial Plan pg. 52)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
1. Disciplinary Decision Making System				
2.67: (67) C. FACILITY'S POLICIES-1. DISCIPLINARY DECISION MAKING SYSTEM-To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct,) all wards with disabilities who require an accommodation shall be assigned a Staff Assistant (SA) from the facility SA team. (Reference: Remedial Plan-Page 45)	SC	SC	SC	NA
*2.68: (68) C. FACILITY'S POLICIES-1. DISCIPLINARY DECISION MAKING SYSTEM-Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education. (Reference: Remedial Plan-Page 45)	SC	NC	SC	NA
*2.69: (69) C. FACILITY'S POLICIES-1. DISCIPLINARY DECISION MAKING SYSTEM-Disposition chairperson shall be trained to communicate with wards that have disabilities. (Reference: Remedial Plan-Page 46)	SC	SC	SC	NA
*2.70: (70) C. FACILITY'S POLICIES-1. DISCIPLINARY DECISION MAKING SYSTEM-The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive and emotional disabilities and present an overview of the Disciplinary Decision-Making System (DDMS) process. (Reference: Remedial Plan-Page 46)	SC	SC	SC	NA
2.71: (71) C. FACILITY'S POLICIES-1. DISCIPLINARY DECISION MAKING SYSTEM-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. (Reference: Remedial Plan-Page 46)	SC	PC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
1. Grievance Procedures				
2.72: (72) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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. (Reference: Remedial Plan-Page 47)	SC	SC	SC	NA
*2.73: (73) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-All grievance respondents shall be trained to communicate with wards that have disabilities. (Reference: Remedial Plan-Page 48)	SC	SC	SC	NA
*2.74: (74) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental and physical disabilities and present an overview of the grievance process. (Reference: Remedial Plan-Page 47)	SC	SC	SC	NA
*2.75: (75) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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. (Reference: Remedial Plan-Page 48)	SC	PC	SC	NA
2.76: (76) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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.	SC	PC	SC	NA
*2.77: (77) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-The grievance screening process for accommodations, including the medical verification process for accommodations, should be completed in a timely manner and interim accommodation shall be provided to the extent necessary. (Reference: Remedial Plan-Page 49)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.78: (78) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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 with department WDP policy; Allegation of discrimination based on a disability under WDP; Denial of access to a program, service or activity based on disability. (Reference: Remedial Plan-Page 49)	SC	SC	SC	NA
*2.79: (79) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-The Wards Rights Coordinator shall forward the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 40 hours of receipt. (Reference: Remedial Plan-Page 49)	SC	SC	SC	NA
*2.80: (80) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-Grievances referred to the Chief Medical Officer 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. (Reference: Remedial Plan-Page 49)	SC	SC	SC	NA
*2.81: (81) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-If medical verification is not available in the Unified Health Record (UHR), and medical staff determines that a referral to an expert consultant, external to the department, is required, an appointment 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 the disability and any limitations that exist on a Youth Authority grievance form, and in the UHR of a ward. (Reference: Remedial Plan-Page 50)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.82: (82) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-After consultant verification of a disability, medical staff shall return the grievance, with all required documentation, to the Wards Rights Coordinator. The Wards Rights Coordinator shall forward to the Office of the Superintendent all grievances that meet criteria for review and response within 48 hours of receipt from Health Care Services Staff. (Reference: Remedial Plan-Page 50)	SC	SC	SC	NA
*2.83: (83) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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 with timeframes. (Reference: Remedial Plan-Page 50)	SC	SC	SC	NA
*2.84: (84) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-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. (Reference: Remedial Plan-Page 52)	SC	SC	SC	NA
2.85: (85) C. FACILITY'S POLICIES-2. GRIEVANCE PROCEDURES-Wards with disabilities shall be granted reasonable accommodations with respect to timeframes, consistent with the Ward Safety and Welfare Plan, for processing of grievances. (Reference: Remedial Plan-Page 51)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
D. Programs				
1. Reception Center & Clinic				
2.86: (86) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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 Americans with Disabilities Act (ADA) and/or may make them eligible to receive services from a Regional Center. (Reference: Remedial Plan-Page 3)	SC	NA	SC	NA
2.87: (87) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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 advisement. (Reference: Remedial Plan-Page 5)	SC	NA	SC	NA
2.88: (88) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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. (Reference: Remedial Plan-Page 6)	SC	NA	SC	NA
2.89: (89) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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. (Reference: Remedial Plan-Page 6)	SC	NA	SC	NA
2.90: (90) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-Assigned Casework Specialist 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. (Reference: Remedial Plan-Page 6)	SC	NA	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
2.91: (91) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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. (Reference: Remedial Plan-Page 7)	SC	NA	SC	NA
2.92: (92) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan. (Reference: Remedial Plan-Page 7)	SC	NA	SC	NA
2.93: (93) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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. (Reference: Remedial Plan-Page 7)	SC	NA	SC	NA
2.94: (94) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-Credentialed Education Staff shall complete educational assessment within 50 calendar days. (Reference: Remedial Plan-Page 7)	NC	NA	SC	NA
2.95: (95) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-If it is determined prior to or during the Initial Case Review 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. (Reference: Remedial Plan-Page 8)	SC	NA	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
2.96: (96) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-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 Individuals with Disabilities Education Act 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. (Reference: Remedial Plan-Page 10)	SC	NA	SC	NA
2.97: (97) D. PROGRAMS-1. RECEPTION CENTER AND CLINIC FUNCTIONS-Presenters of ward orientation program shall make the reasonable accommodations or modifications necessary for wards with disabilities who require accommodations during the orientation. (Reference: Remedial Plan-Page 10)	SC	NA	SC	NA
2. Residential Programs				
2.98: (98) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 30)	SC	SC	SC	NA
2.99: (99) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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 already documented and verified. (Reference: Remedial Plan-Page 20)	SC	SC	SC	NA
*2.100: (100) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-Within five days of receipt, the Medical Technical Assistant or Registered Nurse shall forward Referral for Sick Call referrals to the appropriate licensed mental health professionals or medical personnel for screening. (Reference: Remedial Plan-Page 20)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
2.101: (101) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-Within five days of receipt, the SCT Coordinator shall forward SCT referrals to the appropriate credentialed education staff for screening. (Reference: Remedial Plan-Page 20)	PC	PC	SC	NA
*2.102: (102) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 21)	SC	SC	SC	NA
2.103: (103) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan. (Reference: Remedial Plan-Page 22)	SC	SC	SC	NA
*2.104: (104) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 21)	SC	SC	SC	NA
*2.105: (105) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-Credentialed Education Staff shall complete educational assessment within 50 calendar days. (Reference: Remedial Plan-Page 22)	SC	SC	SC	NA
2.106: (106) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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 Parole Agent/Casework Specialist conducts a special case conference. (Reference: Remedial Plan-Page 22)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.107: (107) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-The Parole Agent/Casework Specialist shall document on the Individual Change Plan (ICP) form the following information: Impairment; Accommodations; Current level of care; Classification code. (Reference: Remedial Plan-Page 23)	SC	SC	SC	NA
*2.108: (108) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-The Parole Agent or Casework Specialist shall ensure that copies of the changes in the status of a ward with a disability documented on the ICP form 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. (Reference: Remedial Plan-Page 23)	PC	SC	SC	NA
*2.109: (109) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 24)	SC	SC	SC	NA
*2.110: (110) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-The Superintendent shall ensure that the following data is documented for all wards with a disability: Name, age, Youth Authority number; Location by facility, living unit, or parole office; Specific impairment; Impairments that substantially limit a major life activity; Impairments that substantially limit a major life activity and require accommodations; Specific accommodations required; Need for a Staff Assistant; Level of care designation (i.e.: GPOP, ITP, SCP, SBTP); Classification Code. (Reference: Remedial Plan-Page 25)	SC	SC	SC	NA
*2.111: (111) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 35)	SC	SC	SC	NA
*2.112: (112) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-The Program Manager shall ensure that a SA is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions. (Reference: Remedial Plan-Page 35)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.113: (113) D. PROGRAMS-2. RESIDENTIAL PROGRAMS-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. (Reference: Remedial Plan-Page 35)	SC	SC	SC	NA
3. Developmental Disabilities				
*2.114: (114) D. PROGRAMS-3. DEVELOPMENTAL DISABILITIES-No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program. (Reference: Remedial Plan-Page 26)	SC	SC	SC	NA
2.115: (115) D. PROGRAMS-3. DEVELOPMENTAL DISABILITIES-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. (Reference: Remedial Plan-Page 26)	SC	SC	SC	NA
4. Removal of Architectural Barriers				
*2.116: (116) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-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. (Reference: Remedial Plan-Page 52)	SC	SC	SC	NA
*2.117: (117) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-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. Presently, the schedule includes nine areas to be completed by FY 2005/06 and eight areas in FY 2006/07. (Reference: Remedial Plan-Page 53)	SC	SC	SC	NA

	NACYCF	OHCYCF	VYCF	HQ
*2.118: (118) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-The Department committed to the removal of critical disability related structural barriers projects that will be completed by 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. (Reference: Remedial Plan-Page 53 and 54)	SC	SC	SC	NA
*2.119: (119) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-The Department committed to analyze the 3000 additional barriers identified in the report prepared by Access Unlimited and provides a report that would categorize the barriers into three distinct areas. The three categories would be: 1) Projects that could be fixed in a short period of time with minimum of cost; 2) Projects that will require substantial funding; and 3) Projects that have been identified but are not specifically required for ward programmatic access and are not part of the plan. This report is due July 15, 2005 and will be filed at Appedix C to the Disability Remedial Plan. (Reference: Remedial Plan-Page 55)	SC	SC	SC	NA
*2.120: (120) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-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. (Reference: Remedial Plan-Page 56)	SC	SC	SC	NA
*2.121: (121) D. PROGRAMS-4. REMOVAL OF ARCHITECTURAL BARRIERS-The second category of projects, which involve projects that will require substantial funding, will be completed by September 30, 2008. (Reference: Remedial Plan-Page 56)	SC	SC	SC	NA

ADA	Americans with Disabilities Act
CYA	California Youth Authority
DJJ	Division of Juvenile Justice
HQ	Headquarters
ICR	Initial Case Review
IEP	Individual Education Program
NACYF	N.A. Chaderjian Youth Correctional Facility
OACC	Office of Audits and Court Compliance
OHCYCF	O.H. Close Youth Correctional Facility
SCT	School Consultation Team
SELPA	Special Education Local Plan Area
SRSCT	Self-Referral to the School Consultation Team
SSRI	Selective Serotonin Re-uptake Inhibitor
TDD	Telecommunications Devices for the Deaf
UHR	Unified Health Record
VYCF	Ventura Youth Correctional Facility
WDP	Wards with Disabilities Program
WIN	Ward Information Network

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CALIFORNIA DIVISION OF JUVENILE JUSTICE

UNIVERSITY OF CINCINNATI QUARTERLY REPORT

April 30, 2012

Submitted by: Lori Lovins, MSW, LISW-S

Project Description

The University of Cincinnati Corrections Institute (UCCI) is working with the California Division of Juvenile Justice (DJJ) in the implementation of evidence-based cognitive behavioral programming. UCCI's involvement with DJJ began with assisting them to develop an implementation plan for the Integrated Behavioral Treatment Model (IBTM), which was to be submitted by October 1, 2010. The IBTM is critical to the six remedial plans submitted to the courts in response to the Farrell lawsuit. Monitors appointed by the court are overseeing implementation of the IBTM, as well as the six remedial plans. While several components of the IBTM had been implemented prior to October 1, 2010, other components had not or had been implemented with limited fidelity. The IBTM Implementation Plan specifies what components are in place and what components will be addressed with the assistance of UCCI.

Two facility units housing high risk youth at OH Close Youth Correctional Facility (OHCYCF) in Stockton, CA were selected by DJJ as the initial implementation sites. Eventually, the program components successfully implemented at these sites will be implemented DJJ wide. This will allow for program adaptations to be made before wide-scale implementation occurs. Likewise, these sites can serve as model training units for DJJ. The development and implementation of evidence-based programming involves a collaborative effort between DJJ headquarters, OHCYCF unit staff, and UCCI. A multidisciplinary implementation team (MIT) was developed, as well as subcommittees charged with addressing programming deficiencies. IBTM deliverables were identified for each subcommittee, which are outlined in the IBTM Implementation Plan. Subcommittees met regularly during the design/development phase to address program needs and ensure deliverables were being met. Now that implementation is well underway, the subcommittees meet as needed, and the MIT continues to meet regularly to oversee the implementation process.

The following report represents a summary of services rendered by UCCI within the last quarter (February 1, 2012—April 30, 2012). The report will specify progress being made toward meeting IBTM goals, continued areas of need, as well as upcoming tasks.

Progress in Implementation of the IBTM

DJJ established a multidisciplinary implementation headquarters team, as well as 4 subcommittees: *1) Assessment and Case Planning; 2) Treatment/ Scheduling; 3) Behavior Management; and 4) Quality Assurance*. Both DJJ headquarters staff and unit staff are represented on these committees to develop strategies for program implementation. The IBTM is currently working on extension of program implementation beyond the initial IBTM units. Currently, IBTM programming and

coaching is being conducted on the following OH Close units: Butte, Amador (formally Glenn), Calaveras and Del Norte. Expansion has also begun to the sexual behavior treatment and BTP units. Some staff at NA Chaderjian Youth Correctional Facility and Ventura Youth Correctional Facility have also been given an IBTM overview, and have participated in training on the core programming. While initially Ventura was selected as the next facility for IBTM expansion, DJJ made the decision to instead focus expansion efforts at Chaderjian before moving to Ventura. The proximity to OH Close as well as use of the IBTM staff that were involved in program development should help to expedite the expansion efforts.

The IBTM completed the IBTM Implementation Plan Deliverables work for the period Oct 1, 2011 - March 31, 2012. This covered month 13 through 18 of the IBTM plan. All deliverables across nine implementation areas were sent to UCCI for review. The IBTM team has also developed a timeline for expansion of IBTM initiatives to additional facilities and specialty units. This timeline is tentative, so may require modification.

***Assessment/Case Management Committee*:** The long-awaited integration of the CA-YASI with the WIN electronic system is ready for implementation (scheduled May 1). This was the primary outstanding implementation component for this subcommittee. This integration will support staff focus on criminogenic targets from the CA-YASI during both case planning and case review. The IBTM is also working to structure the process for case conferences to further support these efforts.

Treatment/Scheduling Committee: In addition to core programming (CounterPoint and AIT), skill of the Week groups are being conducted on all OH Close units. Training and coaching have been provided by the IBTM for effective delivery of these sessions. Concentration is now being placed on expansion of the Pre-treatment and Advanced Practice sessions, which were completed last quarter. Some modifications in the protocol for entry into Advanced Practice have been discussed; but the protocol is currently being piloted as written. Staff were initially trained on these components by UCCI, but IBTM staff have been permitted, and are in the process of developing a plan for continued training on these ancillary treatment groups.

Attention this past quarter has been on development of programming for the Behavior Treatment Program (BTP). While, initially the OH Close BTP was attempting to conduct AIT training on the unit, the variable length of stay and appropriate objective on integrating youth back to general population as soon as suitable made implementation of a lengthy curriculum difficult. It was therefore decided that the 7 pre-treatment sessions, each which use motivational or cognitive-behavioral strategies, could be adapted as stand-alone ongoing sessions for youth on the unit. In addition, several additional social skills were selected for sessions that may be more pertinent to aggression or poor decision making, as these problems are what typically leads to youth placement on these units. The compilation of sessions can therefore be conducted in an open format, so that youth rotate into sessions upon placement on the unit, and receive a CBT-based treatment group daily. While youth are taught some similar lessons in pre-treatment, these lessons are being adapted to use the CBT technique taught in pre-treatment to focus on the problems that lead to placement in the BTP. In the course of these lessons, youth also learn coping strategies they can use to integrate back to core unit programming. Development of a detailed BTP curriculum is underway, with piloting of the new sessions to begin by June, 2012.

Attention is also being drawn to expansion of the Youth Assistant program. The IBTM will provide the protocol for the selection of youth on the non-pilot units. The IBTM will also assist in training youth on their role as a Youth Assistant. Discussion has also ensued as to the adaptation of the protocol for selection of youth on specialty or non-high core units. Youth at nearly all units should have the opportunity to serve as youth assistants, since this gives youth doing well at DJJ an important leadership and mentoring opportunity.

The Quality Assurance Committee: A body of IBTM and unit staff from each of the three DJJ facilities was trained as trainers this quarter in AIT. This was an intensive 10 day training whereby the first week was spent training the staff on delivery of an AIT training. The second week was used for quality assurance so that the UCCI trainer could monitor the newly trained trainers as they delivered an AIT training to a body of DJJ staff. The UCCI trainer could then provide feedback on training delivery and ultimately certify qualifying staff as AIT trainers. With this training, DJJ now has the internal capacity to continue use of core CBT programming (CounterPoint and AIT).

IBTM staff has continued to spend more time on the OH Close units, training and coaching staff outside of the pilots on IBTM initiatives. IBTM staff are also working with unit supervisors to expand the job of group observation and coaching beyond IBTM. As IBTM staff begin expansion to Chaderjian, less attention will be provided to OH Close by IBTM staff, but quality assurance initiatives need to be maintained. Therefore, unit supervisors will have to play a more active role in implementing the group observation protocol and providing general coaching to staff on CBT-based strategies.

The Behavior Management Committee: The draft Positive Reinforcement System (PRS) was finalized based on suggestions from Dr. Bruce Gage (mental health expert) and UCCI. This system has been implemented on the pilot units for a brief piloting period prior to wide-scale adaptation. Block training was also started for all DJJ staff related to core correctional practices and the Positive Reinforcement System. This training is aimed at not only training staff on the new reinforcement system, but also improving general interactions between youth and staff. Staff skills such as effective reinforcement, disapproval, use of authority and relationships skills were integrated. DJJ expects to complete block training by the end of July, with implementation of the PRS across DJJ to follow.

The IBTM is encouraged to systematically review implementation of the PRS on the pilot units with staff via focus groups or other structured feedback mechanisms. This will allow minor adaptations to be made to the written PRS prior to DJJ wide application. A brief review of the adaptations can then be provided to staff prior to implementation across units.

Areas of Need/Concern

As DJJ moves toward expansion of the IBTM Plan to Chad, IBTM staff will be need to divert attention to expansion facilities. As mentioned above, this will require that quality assurance tasks at OH Close, as they relate to the IBTM, be expanded to unit supervisors and designees. Limiting QA practices at OH Close will result in program drift. A unit supervisor from a pilot unit has adopted the role of conducting the monthly IBTM meetings, which shows willingness by unit staff in taking

on this role. Likewise, DJJ is in the process of hiring one to two additional IBTM staff to replace the several positions recently lost. This indicates a commitment by the department to continue the IBTM plan efforts, which are again, essential in both continuing and maintaining the progress that has been made.

Although DJJ is in the process of securing an additional IBTM position(s), with what has been an increasingly limited body of IBTM staff, expansion of some secondary or ancillary treatment interventions (e.g., pre-treatment, advanced practice, Peer Assistant) has been limited. While staff were only trained on this intervention last quarter, the timeline requires that IBTM efforts move to the second facility, which will limit oversight and coaching on these interventions at OH Close. DJJ should be mindful of fidelity to these initiatives and how oversight and coaching will be conducted.

DJJ is currently exploring options for incorporating substance abuse treatment. While DJJ has decided to be trained on the UCCI substance abuse curriculum, the plan for training is still being formalized. DJJ also has to determine what staff will be conducting this treatment, and what qualifications such staff will need. An implementation plan should be put into place before training is provided.

Since DJJ wide adoption of the Positive Reinforcement System will occur next quarter, the IBTM should develop a feedback mechanism for units so that barriers to implementation can be addressed. This mechanism should include regular feedback by all units on strengths and limitations to the new system. Likewise, application of reinforcers should apply to all youth, regardless of whether they are placed on core or on specialty units. Hence, like the DDMS, the PRS should be adopted on all units, although it may require some modification for specialty units.

Upcoming Tasks

Assessment/Case Planning: Develop or review the protocol for case conferences.

Treatment/Scheduling: Continue to identify staff capacity for delivering the full spectrum of interventions. Pilot the BTP program at OH Close once complete. Continue expansion of the use of advanced practice and pre-treatment.

Behavior Management System: Systematically review the pilot of the Positive Reinforcement System. Make adjustments to the PRS description prior to wide-scale adoption. Develop a strategy for monitoring implementation of the PRS across DJJ once implemented.

Quality Assurance: Provide continued fidelity monitoring of new and core interventions.

Consultation/Training/Coaching

Contact Type/ Deliverable	**Purpose**	**Name**	**Date**	**Time**
On-site Training **Task 3b**	AIT Training of Trainers	Jenn Luther	2/1 thru 2/3/12 2/6 thru 2/10/12	80 hours

Consultation Call **Task 5d**	Call with Special Master and experts	Lori Lovins Ed Latessa	2/8/12	1.5 hours
Conference Call **Task 2b**	Call with QA subcommittee	Lori Lovins	3/7/12	2 hours
Conference Call **Task 2b**	Call with IBTM—status update	Lori Lovins	3/8/12	2 hours
Consultation Call **Task 2b**	Call with IBTM member	Lori Lovins	4/26/12	1.5 hours

UCCI Off-Site Development/Planning Work

Name	**Hours**	**Deliverable**
Lori Lovins	30—includes written feedback on PRS, BTP curriculum, and preparation for conference calls	**Task 2a**

Summary

The MIT and subcommittees, along with unit staff continue to work diligently to meet the IBTM deliverables. Due to the hard work of the IBTM and unit staff, all deliverables were satisfied for the 13 to 18 month timeline period. The IBTM will begin to move to Chaderjian, which has already implemented some of the IBTM initiatives, but who will expand to use the full spectrum of IBTM strategies.