SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. JAMES TILTON, Defendant.	)	CASE NO. RG03079344

FIFTH REPORT OF SPECIAL MASTER

Donna Brorby, Special Master
Cathleen Beltz, Monitor
605 Market Street, Ninth Floor
San Francisco, California 94105
(415) 348-0853
(415) 495-7204 (facs.)
lodb@earthlink.net

TABLE OF CONTENTS

I. INTRODUCTION

This report first addresses what have been identified as potential systemic obstacles to compliance with the remedial plans in this case. It also presents monitor and expert reports in the areas of youth safety and welfare, health services, sexual behavior treatment, and physical and programmatic access for youth with disabilities. The reports are appended. Pursuant to the procedures that the parties, experts and special master developed to guide the monitoring and reporting, the special master provided a draft of this report and the appended monitor's and experts' reports for the parties' comments. The special master, monitor and experts submit these final reports after consideration of the parties' comments.

II. SYSTEMIC OBSTACLES TO COMPLIANCE WITH THE REMEDIAL PLANS

As the court has observed, DJJ's leadership repeatedly affirms its commitment to comply with the consent decree and remedial plans in this case. At the same time, as the special master's reports and experts' reports document, DJJ's progress is halting and well behind the schedule set forth in the remedial plans. The special master has reported on several systemic problems that appear to be obstacles to progress, in the areas of policy development and implementation, staff vacancies and hiring delays, contracting and information technology support. At the August 6, 2007 case management conference, the court ordered that the parties meet and confer over the source and nature of these obstacles to compliance and propose what, if any, further judicial relief would be an appropriate response to them.

As a result of the Court's order and the OSM's responsibility to continue to report on DJJ's progress, the special master requested that DJJ provide information and evidence relevant to the identified obstacles. DJJ provided most of the documentary information

requested, and made four key managers available to respond to the special master's questions. The special master asked the managers about the apparent systemic obstacles in their areas and pressed them to explain their strategies for overcoming the obstacles and the basis for their belief that their strategies would be successful. The special master also has reviewed DJJ's case management conference statement, which is generally consistent with what DJJ's management staff reported to the special master.

A. Policy Development and Promulgation

One of the basic tenets of the safety and welfare plan is that DJJ's central office must guide the implementation of the remedial plans and govern conditions and practices throughout DJJ facilities by promulgating and enforcing written system wide policies.[1] In any institutional setting, written policies are the primary mechanism for establishing the duties and responsibilities of employees and thereby regulating employee practices. DJJ will need to develop many new policies, and revise many existing ones, if it is to change troubled custodial facilities into juvenile correctional facilities that meet the requirements of the remedial plans.[2]

To date, almost three years after entry of the consent decree, DJJ has not demonstrated the capacity to develop and promulgate adequate written policy within a reasonable time. DJJ, for example, has yet to promulgate most of the initial policies required by the mental health and safety and welfare plans, which are long overdue.[3] DJJ has not

[1] *See*, Safety and Welfare Remedial Plan, p. 8.
[2] *See*, Appendix A, Krisberg, *DJJ Progress on the Standards and Criteria of the Safety and Welfare Remedial Plan*, pp. 16-18. According to its counsel, DJJ estimates that "over 800 policies remain to be developed." Defendant's Amended Case Management Conference Statement, p. 15.
[3] *See*, Appendix A (Krisberg report), pp. 12, 13, and 16-18; Appendix B, Beltz, Monitor's *Report: Selected Safety and Welfare and Mental Health Plan Audit Items: Report of Findings*, pp. 13, 16, and 20. *See also, Fourth Report of the Special Master*, p. 10-11, and 15-18. In August 2007, the mental health experts and the special master requested drafts of mental health policies that were due to be completed by then; DJJ has not yet provided any of them. Subject areas of delinquent policies include suicide observation and watch, mental health

finalized the policy intended to operationalize the Ward With Disabilities Program Remedial Plan, thereby impeding the implementation of that program.[4] Since late 2005, the sexual behavior treatment expert has stressed the importance of standardized written policies for the sexual behavior treatment program but none have been written.[5] The medical experts report also expresses concern about the slow pace of development and implementation of necessary health services policies.[6] DJJ still has not finalized the policies related to database modifications that are necessary for compliance with remedial plans in this case; and, until those policies are finalized, the overdue database modifications cannot be implemented.[7] It reports that it needs to develop and implement over 800 new policies, and that it promulgated just over twenty policies last fiscal year.[8]

There are at least two stages where policies are delayed for prolonged periods: (1) in the development and writing and (2) between formal adoption by DJJ's central office and its promulgation of them as official policies. The sexual behavior treatment program and several of the mental health policies noted in the previous paragraph, for example, are stalled at the writing stage. But, for a different kind of example, 26 of the 29 medical policies that DJJ reports it has just distributed to DJJ's facilities as official policy were formally adopted as temporary departmental orders a full year ago.[9]

---

levels of care, transfers of youth for long-term inpatient psychiatric care, and discipline and time-adds. The policy to operationalize the safety and welfare plan provisions concerning grievances was distributed to facilities as official policy on October 10, 2007. Those plan provisions were due to be implemented March 31, 2007. Safety and Welfare Remedial Plan, Standards/Criteria, Master Audit Checklist, 8.5.

[4] See Section VII, below.

[5] See Section VI, below.

[6] See Section V., below.

[7] *See* Section II.D, below.

[8] Defendant's Amended Case Management Conference Statement, pp. 15 and 18. (145% divided into 31 policies just distributed would be 21 policies distributed in fiscal 2006-2007.)

[9] *See*, Amended Case Management Conference Statement, p. 18 (distribution of 29 policies in September 2007), TDOs 06-40 through 06-69, and *Third Report of the Special Master*, p. 13 (26 of them formally adopted by September 2006 and three more by November 2006). The disabilities TDO that has not been finalized, TDO # 06-71, also was signed in September 2006.

DJJ has identified two sources of delay between development and promulgation of policies: (1) evaluation of labor impact and any necessary labor negotiations and (2) the actual transmission of the policies to facilities.[10] It reports it has solved the transmission problem with a new electronic distribution system.[11] DJJ has not elucidated the steps for identifying and resolving collective bargaining issues. Since this is done by a CDCR group, it may be that there have been dysfunctions at CDCR or in the matrix between CDCR and DJJ to delay official promulgation of policy. DJJ has not yet explained the yearlong delays in official promulgation of numerous signed TDOs.[12] Thus, it is not possible to determine whether improved management may locate and eliminate most of the sources of these delays.[13]

DJJ has not had a sufficient system for planning and tracking its development and promulgation of policy. DJJ has not, for example, prepared the table of contents for its manual of policies that is long overdue under the safety and welfare plan.[14] Nor does it have an adequate list of policies that it has scheduled for development or modification.[15] It has not prepared the table of contents for mental health policies that was due by March 1, 2007 under the mental health plan.[16] This is all part and parcel of DJJ's failure to develop and

[10] DJJ reports that there also has been a delay between official promulgation and implementation at facilities because training curricula were not distributed with the policies. Defendant's Case Management Conference Statement, p. 17.
[11] Defendant's Amended Case Management Conference Statement, p. 18.
[12] *See*, *e.g.*, n. 9, above.
[13] In their case management statements, DJJ contends that the labor process takes up to 90 days and plaintiff contends it need take no more than 30 days. DJJ management has told the special master that it has a good relationship with labor, in which case it should be able to work with labor to ensure that it collective bargaining processes do not unduly delay implementation of policy.
[14] See, Safety and Welfare Remedial Plan, Master Schedule/Audit Checklist Item 2.1.4a. The table of contents was due by January 15, 2007, with a master schedule.
[15] It provided the special master with a list but the list did not include several policies related to the WIN medications discussed in Section II.D below. The list did not show the steps in policy development or the status of any of the policies vis a vis the necessary steps.
[16] Statements of staff in meeting of mental health experts, special master, DJJ mental health staff and CDCR counsel, August 30, 2007. The list of 22 policies mental health policies to which DJJ refers in its case

promulgate policy. DJJ reports that it is addressing planning and tracking now, which might improve its ability to develop and promulgate policy.[17]

Pursuant to the Safety and Welfare Remedial Plan, by November 21, 2007, DJJ is required to have "sufficient and appropriate dedicated staffing for developing and maintaining polices for juvenile corrections based on contemporary standards of care and practice."[18] Towards this end, DJJ has employed five or six dedicated policy developers for some time.[19] It does not intend to increase this number.[20] It contends that the management capabilities of the new director of administration and operations, plus the reorganization of central office staff into three new work groups (assessment/classification, program, and re-entry) with one policy writer embedded in each, will make it possible for DJJ to develop and promulgate necessary policies within a time frame that supports the timely implementation of the remedial plans in this case.[21] It will rely on its leadership and management to ensure that all policies are based on contemporary standards of care and practice.[22] Further, under the new administration and operations director, DJJ has again empowered various DJJ

---

management conference statement (p. 17) apparently is to the list of 22 subject areas for policy at pp. 62-63 of the mental health remedial plan.

[17] *See*, Defendant's Amended Case Management Conference Statement, p. 16, 17 and 19. DJJ confronted a similar problem beginning in late 2006 with respect to staff vacancies and hiring delays, when it did not maintain an accurate list of authorized, filled and vacant positions. Over a period of six months, it was able to reconcile staff against budgeted positions and to develop an accurate and trackable list/database. As a result, DJJ now is able to identify the reasons for staff vacancies and hiring delays and take steps to address them. See Section II.B, below.

[18] Safety and Welfare Remedial Plan, pp. 12, 21 and Action Item 2.1.4a.

[19] Susan Sonoyama Jenkins, then the manager responsible for policy development, described this staffing to Monitor Cathleen Beltz during the latter's central office site visit May 30, 2007. Brigid Hanson, Director of Administration and Operations for Juvenile Justice described the same staffing to the special master during a central office site visit on September 26, 2007. As DJJ staff have explained generally, the policy developers draft policy based on input from subject area staff, ensuring consistency with other policy and with formal requirements. They shepherd policy drafts through the process of review and approval and labor clearance.

[20] Statement of staff and counsel during meeting with the special master on September 26, 2007. There is not any evidence at this time that an increase in the number of policy writers is necessary.

[21] Statements of DJJ staff and counsel during October 3, 2007 monthly meeting and "meet and confer" session. When the special master has pressed DJJ staff and counsel to disclose the facts and analysis that convinces them that the improved management and realignment of central office staff will solve the problems that have been blocking policy development, they say that they are not authorized to say more.

[22] Statements of DJJ staff and counsel during September 26, 2007 conference with the special master.

programmatic units to draft proposed policies and procedures that they think are necessary for their programs. The drafts will ultimately be completed and processed by policy unit staff (either the embedded policy writers or the two or three other policy writers), but program groups with staff who have policy drafting skills will be able to push their key policies forward by putting them in writing.[23] The director of administration and operations is developing a tool to track policies through development and formal promulgation.[24]

Given the degree of DJJ's failure to develop and promulgate written policy for more than a year, its rather general representations about management, realignments of staff and streamlining of processes are insufficient to demonstrate that it has a grasp of all of the relevant facts and a realistic strategy for developing and implementing necessary policy within a reasonable time. The special master is impressed by the drive and apparent competence of DJJ's new Director of Administration and Operations, Brigid Hanson. DJJ fairly observes that Hanson, who has been in her position for approximately two months, has not had enough time to fully assess and address this very complex problem. Still, in the two months since her appointment, DJJ apparently has disseminated more official policy than it disseminated in all of fiscal year 2006-2007.[25] Enough DJJ central office staff speak positively of the new approach using interdisciplinary teams that the special master is hopeful that it will help enable DJJ to develop and promulgate policy. If DJJ develops a good tool for tracking policy development and promulgation, it will reveal the stages and

[23] This is might improve DJJ's ability to get policies into writing. Key medical policies were written by medical department staff, in consultation and with substantial help from the *Farrell* medical experts. Statements of Madeleine LaMarre 2006. Sexual behavior treatment and mental health staff were working on policy until July 2006 when they were directed to stop and leave initiation of policies and procedures to the policy unit. *See*, sections V. and VI, below. As the experience with DJJ's first medical policies proves, getting policies into written form is only the first major step towards promulgation and implementation of new or revised policies. *See*, n. 9, above.

[24] Defendant's Amended Case Management Conference Statement, p. 19.

[25] Defendant's Amended Case Management Conference Statement, p. 18.

delays in the process and supply a basis for evaluating DJJ's actions and strategies. But, DJJ has not yet revealed enough to show that it knows why it has been unable to develop and promulgate a reasonable amount of policy over the course of the past two years and that it is addressing all the significant problems.

Unless and until the Court directs an alternate course, the special master intends to document DJJ's progress in planning, tracking, developing and promulgating policy in the immediate future. The special master additionally intends to press DJJ to determine and disclose any and all impediments to timely development and promulgation of policy and a realistic strategy to confront them.

B. Central Office Vacancies, Other Vacancies and Related Personnel Issues

Plaintiff's counsel raised the issue of high staff vacancy rates and impediments to hiring in late 2006.[26] One major problem was that the compensation for a number of DJJ positions was lower than the compensation that was being offered for the same positions with the adult prison system. Beyond that, the CDCR and DJJ central offices did not seem to be identifying and addressing the causes of the persistent vacancies. Since late 2006, "pay parity" has been achieved[27] and CDCR and DJJ have identified and have begun to address some crucial systems issues.

With the 2005 reorganization, DJJ became a part of CDCR and largely dependent on the CDCR "matrix" for many business processes, including personnel processes.[28] DJJ lost dedicated central office personnel positions because it lost responsibility for most personnel

[26] As a result, in January 2007, the Court ordered that DJJ begin tracking its vacancies so that the issue could be considered more fully. Case Management Conference Order, January 24, 2007.
[27] *See*, Appendix C (LaMarre/Goldenson report), p. 7; *Fourth Report of the Special Master,* p. 19.
[28] The special master's fourth report discusses DJJ's dependence on the CDCR matrix for contracting and information technology support, at pp. 4-9. DJJ's operations support office personnel specialist, Gregory O'Brien, described the CDCR/DJJ relationship and system for personnel processes during conversations with the special master on September 26 and October 5, 2007. DJJ depends on CDCR for legal review of its policies.

functions. DJJ now acknowledges that, from 2005 through the first half of 2007, the CDCR matrix did not work very well for DJJ. DJJ was largely disabled from taking effective actions to address impediments to and delays in hiring. It could only make requests to CDCR's personnel unit. Those requests did not result in effective action.[29]

In May 2007, under the pressure of the Court's scrutiny, CDCR detailed a team to DJJ to address DJJ systems issues and its place in the CDCR matrix. That team included CDCR business office personnel staff. As a result of the work of that team, DJJ reduced the number of DJJ staff responsible for central office hiring and related recruitment activities and located them DJJ's newly created operations support unit. These personnel staff also are responsible for monitoring facility vacancies, the actions facilities take to fill them and whether the CDCR personnel unit is appropriately responsive to facilities' requests. DJJ's operations support unit staff member who is primarily responsible for personnel matters credibly claims to have a good working relationship with the CDCR "matrix" personnel staff. He says that they came to know each other and understand each other's institutional needs when the CDCR staff were detailed to DJJ on the Spring 2007 matrix team.[30]

As DJJ attempted to address the questions raised by plaintiff's counsel about vacancies and hiring, it quickly became apparent that DJJ did not have an accurate electronic system for tracking authorized, filled and vacant positions and related information. As of the special master's last report in June 2007, DJJ had only just created an accurate electronic staffing database.[31] The operations support staff member who is responsible for personnel

[29] Statements of Gregory O'Brien, DJJ Operations Support, September 26 and October 5, 2007.
[30] Statements of Gregory O'Brien, Operations Support during October 5, 2007 telephone conference with DJJ counsel and the special master.
[31] Statements of Gregory O'Brien, Operations Support, to the special master, during meeting with Director of Operations Support Brigid Hanson and CDCR counsel on September 26, 2007. The "vacancy report" attached to the *Fourth Report of the Special Master* as Appendix E was derived from that database. The database

matters says that DJJ is beginning to use the database to shape efforts to fill positions.[32] The database shows that facility vacancy rates have declined significantly since the special master's last report. Now, six facilities have five percent or lower vacancy rates, two have seven percent rates, and two have fourteen percent rates. The vacancy rate for DJJ's central office has increased slightly, however, to twenty percent.[33]

The central office vacancies include the program director position that has been vacant since DJJ's inception more than 2 years ago. Since February 2007, DJJ has not had the plan-required designated project coordinator for the development of operational and facilities master plans.[34] On the other hand, the *Farrell* project manager position has been filled, as has the position of director of administration and operations for juvenile justice. The latter position is at the same level as the director of programs position and was recently created. The filling of these two positions with two apparently able and motivated individuals is a significant positive development. Additionally, the director of juvenile facilities who joined DJJ in late 2006 has substantial program expertise. Nonetheless, the twenty percent vacancy rate in DJJ's central office is very troublesome. Whether or not

---

produces more useful reports, by individual position, how long positions have been vacant and employees have been in positions. *Ibid.*

[32] During the September 26 meeting with the special master, Gregory O'Brien of DJJ central office Operations Support impressively described analyses of vacancies against lists, plans to administer exams when lists were insufficient, and plans for job fairs at each facility with recruiting directed at the positions vacant at the particular facility. We did not discuss central office vacancies.

[33] Based on the June and September vacancy reports, using the "total authorized positions line" (which counts temporary as well as permanent employees), the special master calculates that there are lower vacancy rates at all locations except Pine Grove and DJJ's central office: the vacancy rate decreased from 12 to 7 percent at SYRCC, 23 to 14 percent at NCYCC, 7 to -2 percent at OHC, 8 to 3 percent at DWN, 14 to 3 percent at NAC, 17 to 5 percent at Paso, 12 to 3 percent at Preston, 23 to 7 percent at HGS, and 17 to 14 percent at Ventura. The rate held steady at 4 percent at Pine Grove, and increased from 17 percent to 20 percent at central office. That increase appears to be due to new positions reported as if they came on line as of July 1, well before the state budget was approved.

[34] See, Appendix A (Krisberg report) p. 6 and Appendix B (Beltz report), p. 21. Another central office vacancy, Clinical Records Administrator for health care services, is discussed in Section V., below.

every central office employee is productive or every position is vital, DJJ clearly needs a strong central office to plan, track and manage the reform to which it has committed.

DJJ has not had a system in place to track the hiring process. It is implementing one this month, involving monthly reports on the status of all positions and actions taken to fill vacancies. The operations support staff member who is responsible for personnel issues says that he will review the reports monthly and take action with respect to any vacancies where the recruitment and hiring processes is not proceeding appropriately. He has been involved in devising the tracking report and seems to be eager to put it to use.[35]

Without the benefit of tracking information, the "live scan" process has previously been identified as a major cause of delay and loss of candidates. New hires must be fingerprinted and cleared by the Department of Justice and the FBI before they are permitted to start work.[36] The process has been taking two to three months for candidates whose fingerprints clear without question. The operations support staff member who is responsible for personnel issues credibly represents that DJJ has analyzed and resolved the "live scan" problems and that the two or three months delay will soon be reduced to no more than two weeks for most candidates (*i.e.*, those who are cleared without questions).[37]

The actions DJJ taken has taken – centralizing its personnel function, tracking vacancies and the efforts to fill them, and addressing delays in the live scan process -- should continue to reduce vacancy rates and enable DJJ to identify additional impediments to hiring

[35] Statements of Gregory O'Brien September 26 and October 5, 2007 during a meeting and a teleconference with the special master and DJJ counsel.
[36] Per CDCR counsel, adult system new hires can work after their fingerprints are taken, pending clearance, and they are dismissed if they cannot get clearance. DJJ is subject to special rules intended to protect school children from pedophiles, the "Montoya" law. New hires cannot work until they are cleared.
[37] During the September 26, 2007 meeting, Gregory O'Brien, Operations Support, and Brigid Hanson, Director of Operations Support, were impressive in their description of the steps taken to determine and solve problems at individual facility sites, including miscoding of forms and machine malfunction. See also Defendant's Amended Case Management Statement, pp. 10-11.

that will then need to be addressed. DJJ has not yet responded to the special master's request for detailed information on central office and facility vacancies, including the length of time that positions remain vacant, reasons for prolonged vacancies and the impact of each vacancy on DJJ's efforts to implement the remedial plans. DJJ has not demonstrated that it has analyzed its central office vacancies and that it has developed a strategy to fill necessary positions. Unless and until the Court directs an alternate course, the special master intends to pursue this information from DJJ and to report further.

Finally, DJJ notes that it cannot fill certain positions until it knows which of its facilities will be closed in the wake of the law that took effect September 1, 2007 that is anticipated to reduce its population by 40%.[38] It does not disclose any facts relevant to how and when that decision will be made or who will make it. On September 11, 2007, DJJ represented that the decision would be made before the end of September.[39] The continuing uncertainty is crippling to DJJ.

C. Contracting

As a part of the reorganization effective July 1, 2005, CDCR absorbed DJJ's central office contracts staff and took responsibility for DJJ's contracts. By the summer of 2006, the medical experts observed that DJJ was not able to secure necessary contracts for medical services due to the non-responsiveness of the CDCR contracts unit.[40] The parties and the special master brought this to the attention of defendant CDCR Secretary Tilton in October

[38] Defendant's Amended Case Management Conference Statement, pp. 12, 14.
[39] Statements DJJ management at monthly meeting of Farrell parties and the special master, September 11, 2007.
[40] See, *Third Report of the Special Master*, pp. 14-15. Before the reorganization, DJJ was relatively successful in contracting for necessary goods and services though there were a number of issues that would have required attention and adjustments. *Ibid.* DJJ's system was largely automated. Statements of Joseph Watkins, current manager of the CDCR contracts group responsible for DJJ contracts and a DJJ contracts analyst before the reorganization.

2006 and he promised to take appropriate action.[41] In April 2007, the parties and the special master met with CDCR Undersecretary Kingston Prunty concerning DJJ vacancies and delays in the CDCR hiring process; the special master also raised DJJ's continuing problems with respect to contracting. He promised that CDCR and DJJ would determine the reasons for the vacancies and delays and develop a strategy to address them.[42] Apparently as a result, in May 2007, CDCR detailed the team mentioned above to review DJJ systems issues and its interface with the CDCR matrix. This CDCR team included a very experienced and apparently capable contracts manager who has remained at DJJ in its new operations support unit. Among other things, he is developing a system for tracking DJJ's contract requests and their progress as they are processed.[43] He seems well suited to serve as DJJ's interface with CDCR for purposes of contracts. He has a contract analyst working under his direction.[44]

The problems that DJJ has encountered in relation to its contracts requests, however, which are described in the last report of the special master, [45] are not simply the result of an inadequate interface with CDCR. According to numerous experienced CDCR and DJJ contracts managers and staff, CDCR's contracting process is not working well and it has not worked well for many, many years.[46] In their view, both the adult prison system and DJJ suffer the same lack of communication, delays and uneven success in securing needed

[41] Secretary Tilton met with counsel for both parties and the special master on October 20, 2006.
[42] See, *Fourth Report of the Special Master*, p. 10.
[43] The special master has seen at least two drafts of the document in the course of medical contracts meetings and interviews of the manager, David Hale. See also, Defendant's Amended Case Management Conference Statement, p. 8.
[44] Statements of David Hale, October 3, 2007.
[45] *Fourth Report of the Special Master*, pp. 4-6, 20-21.
[46] On October 3 and 9, 2007, the special master spoke to numerous credible managers and staff responsible for the processing of contract requests, including: Joseph Watkins, supervisor of the CDCR juvenile services contracts unit and formerly contracts analyst for DJJ; David Hale, DJJ operations support contracts manager; Debra Jones, CDCR institution service contracts section manager; and Steve Alston, CDCR Deputy Director, Office of Business Services. The special master observed and listened staff in medical contracts meetings in June and August 2007. The staff were close to unanimous in their observations and opinions on the points reported here.

contracts. CDCR contracts unit staff do a tremendous amount of unnecessary, tedious, labor-intensive clerical work.[47] Generally, there is a backlog of work and individual contracts projects are not moved along until they are urgent. For example, the responsible CDCR manager informed the special master, approximately 23 of 68 current DJJ contract requests have been pending for 120 days or longer. As a result, so many of the requests are urgent that the urgent matters will monopolize staff attention. That means that everything else will languish unless and until it is considered urgent. As long as the backlog is not resolved, the constant state of crisis and months-long delays in the processing of most requests will be perpetuated. Even the managers who should be identifying and solving system problems are swamped by the need to deal with immediate issues involving what are considered particularly urgent contracts. The obviously deficient systems and constant state of urgency makes for an unpleasant work environment and a high level of turnover and vacancies.[48]

CDCR reports that it has taken and is taking action to address the problems that plague its contracting unit. This past summer, CDCR contracted with IBM and SAP for the development of an automated system for all of its business services, including contracting. According to CDCR's Deputy Director, Office of Business Services, Steven Alston, the system ("BIS") is scheduled to be operational for CDCR's fiscal functions by July 1, 2008, for contract and procurement functions in October 2008 and, for human resources functions after that.[49] In order to deal with the immediate crisis, CDCR is attempting to procure additional staff on a temporary basis to work through the backlog by inter-agency contract

[47] They prepare contracts manually; for example, they have to repeatedly enter the same information again and again throughout contract documents, such as the name of the contractor. They do the same things over and over again, for each contract they work on; none of the repetitive steps are automated. Unanimous statements of contracts managers and staff, October 3, 2007.
[48] Statements of Debra Jones and David Hale, October 3, 2007. According to Ms. Jones, twelve of sixty-two positions were vacant on October 3.
[49] Statements of Steven Alston, October 3, 2007

with the Department of General Services ("DGS"). It also has requested recruitment and retention bonuses for contracts analysts, in an attempt to lower turnover and vacancy rates.[50] It is rather intensively training staff in contracting procedures.[51]

The medical experts again have highlighted the importance of health services contracts to enable DJJ to provide necessary medical and mental health services.[52] DJJ has experienced particular difficulties trying to secure health services contracts.[53] The CDCR and DJJ contracts managers explain that, until January 2005, CDCR and DJJ health services contracts were exempt from bid procedures, as is appropriate for health services contracts for a number of reasons.[54] As the result of irregularities documented by an audit of CDCR, the Department of General Services ("DGS") substantially tightened up the rules for gaining exemptions from competitive bidding requirements. Unlike other state agencies, CDCR has not yet gotten an exemption from these more stringent rules for its health services contracts.[55] CDCR recently retained a consultant to evaluate DJJ's medical contracting needs and to develop a credible strategy for meeting them by April 2008.[56]

---

[50] Statements of Debra Jones, October 3, 2007.
[51] Defendant's Amended Case Management Conference Statement, p. 8-9; statements of Debra Jones and Steve Alston, October 3, 2007.
[52] LaMarre/Goldenson, *First Report By Consent Decree Medical Experts*, p. 10. The report is attached as Appendix C.
[53] *Fourth Report of the Special Master*, p. 20-21.
[54] Contractors need to be near the individual facilities where services will be rendered; most hospital and individual providers will not bid in response to complicated state requests for proposals. Among other things, they do not are not willing to retain the lawyers and contracts experts that they would need to negotiate the process.
[55] The constant state of urgency pressures staff to use emergency rather than regular procedures. This contributes to tension with "control agencies" that enforce contract regulations. The new DGS rules are stated in "Management Memo 504."
[56] Medical expert Madeleine LaMarre is supportive of the examination of DJJ's medical contract needs. It does not appear to her that the current contracts are as effective and efficient as they might be. Statements of Ms. LaMarre to the special master during teleconference, September 2006. The special master talked to the consultant, Deborah Dietz, who appears to have the appropriate expertise to help DJJ with medical contracting issues.

The continuing difficulty with medical contracts is and illustrative of the enormity of the systemic contracting problems. Despite a great deal of effort, including specially assigned staff and monthly CDCR/DJJ medical contracts meetings, progress in actually resolving issues and executing contracts has been excruciatingly slow.[57]

CDCR/DJJ have taken and are taking important steps towards addressing contracting systems issues and they seem to have motivated and capable managers and staff trying to improve DJJ's ability to enter into necessary contracts. Nonetheless, as in every area of apparent systemic deficiency, the agencies have not demonstrated that they have made a reasonable effort to identify all of the major reasons for the current dysfunction with respect to contracting and to address each of those reasons. Unless and until the Court directs an alternate course, the special master intends to require CDCR and DJJ to produce information until it appears that they have determined and disclosed all of the significant reasons for their inability to execute and consummate contracts in a timely fashion and they demonstrate that the have a realistic strategy to confront each of those problems.

D. Accounting

As the special master previously has reported, DJJ repeatedly fails to pay its contractors' bills within a reasonable time.[58] It is very likely that CDCR's accounting unit is every bit as dysfunctional as its contracts unit and that the dysfunctions reinforce each other. Again, successful automation would likely improve functionality, but its not clear that

[57] The DJJ staff member whose principal function is to make and track medical contract requests noted more than a year ago, for example, that some "boilerplate" CDCR contract document language was not legally appropriate for DJJ. He proposed modifications to CDCR, for example, language that would identify the correct office for appeals related to contract issues. The proposed modifications have been pending for more than a year. They currently are under review by CDCR's legal services unit. Statements CDCR and DJJ contracts staff, medical contracts meeting September 5, 2007. The special master's office has been tracking progress since June 2007 by attending the DJJ/CDCR medical contracts working meetings and receiving copies of a document that tracks individual contracts requests. For documentation of the facts as of June 2007, *see* Appendix C (LaMarre/Goldenson report), pp. 10, 17, 19 and *Fourth Report of the Special Master*, pp. 20-21.
[58] See, *Fourth Report of the Special Master*, p. 6.

automation by itself will be sufficient so that CDCR and DJJ will be able to conduct business well enough for DJJ to succeed in the implementation of its remedial plans in this case.

E. Information Technology

The special master's last report detailed the importance of the two-plus year old project to modify and improve DJJ's primary database, the Ward Information Network or WIN. The "WIN Exchange" will enable staff to compile and have access to complete DJJ records for every youth from every facility where he has lived. The modified and new WIN features are necessary for the implementation of new policies and procedures required by the *Farrell* remedial plans. The safety and welfare remedial plan requires that the WIN improvements to be operational by January 2007. Although DJJ has projected two or three completion dates between then and now,[59] the WIN improvements are still not operational.[60] The CDCR-EIS WIN senior programmer responsible for previous projections and for managing the project says that he now believes that this WIN project may be completed by the end of 2007.[61]

As the special master reported a few months ago, some of the delays in completing the WIN Exchange and Farrell-related WIN modifications are attributable to the time it took to hire and train new programmers and the inevitable vagaries of software development.[62]

---

[59] *See, Fourth Report of the Special Master*, pp. 7-9.

[60] See Appendix A (Krisberg report) p. 8 and Appendix B (Beltz report) p. 2. Features such as use of force tracking may have been developed and even deployed at O.H. Close where DJJ is "beta-testing" WIN-Exchange, but they have not been deployed throughout DJJ. *Cf.*, Defendant's Amended Case Management Conference Statement, pp. 19-20.

[61] Statements of Bob Eden, WIN senior programmer, to special master during conference September 26, 2007. The senior programmer responsible for many of the projections said the Safety and Welfare Plan's January 2007 deadline was unrealistic when the plan was filed in July 2006 and that he tends to be optimistic in projecting IT project completion dates. The estimate was based on his long experience with DJJ and facts that he felt he could not share with the special master. DJJ has so much invested in the WIN project that it does seem certain that it will be brought on line.

[62] *Fourth Report of the Special Master*, p. 8. The WIN senior programmer says that he is about to fill the last vacant position in his group of five programmers and that several of his programmers have been with the group

Since then, the WIN senior programmer has been informed that the policies related to the modifications are still being finalized; he has informed the special master that the modifications cannot be implemented until the policies are finalized.[63] Also, the budget for this fiscal year that was finalized in August 2007 does not provide funding for contract programming for the WIN project, in contrast to the budgets for each of the last two years.[64] The senior programmer does not believe that CDCR/DJJ can implement WIN Exchange without contract programming assistance. To date, because of the lack of funding, DJJ has not submitted a contract request to secure that assistance. Asserting the governor's deliberative process privilege as to matters involving funding, DJJ will not disclose what, if any, attempt it is making to secure funding.[65] Once it has funding, there may be delays in the process of securing an appropriate contract.

Obviously, CDCR/DJJ need to complete the pending WIN Exchange project as quickly as it can be completed. Once that is done, the question is whether the EIS WIN support group will be sufficient to maintain WIN and develop more features that will be necessary to the implementation of *Farrell* remedial plans. The WIN senior programmer

---

long enough to be proficient in WIN. Apparently, there is a steep learning curve for new programmers entering the group, as they tend not to be familiar with 4D, the language in which WIN is written.

[63] The policies concern wards with disabilities, restricted and alternative program and HRO/suicide watch, according to the senior programmer. They are all signed TDOs (## 06-71 and 07-82 through 07-86), which means that DJJ's management formally adopted them. "Finalized" means cleared for official dissemination to DJJ facilities. The senior programmer believes that the policies will be finalized in a form that is consistent with the current version of the new WIN features; he does not believe that the draft policies will be changed in a way that requires further programming. Statements of Bob Eden October 5, 2007. DJJ touts that it has almost entirely resolved the policy issues that have delayed the WIN Exchange deployment. But, the WIN senior programmer only learned of those policy issues after June 2007. Statements of Bob Eden, October 5, 2007 (he had thought that the policies were finalized).

[64] DJJ says that it did not know until the budget was approved that the WIN contractor was not funded. Statements of Bob Eden and counsel October 5, 2007.

[65] The CDCR-EIS WIN senior programmer told that special master that "beta testing" shows that the WIN Exchange is technically sound. With the contract programming assistance, the WIN team will be able to work out the last inevitable "bugs" that appear during full implementation. Statements of Bob Eden during teleconference October 5, 2007. The special master could not fully the senior programmer's technical explanation, but his demeanor and the level of detail he provided were convincing.

credibly asserts that CDCR and DJJ are taking the right steps now, specifically in creating a management level IT steering committee to determine and specify DJJ's data needs. Once the needs are specified, then the WIN support team can determine its capability to meet those needs. The past experience with the WIN Exchange project is not necessarily predictive, especially because the "exchange" improvement to WIN is bigger and more complicated than designing new WIN features.

The safety and welfare expert has observed substantial discrepancies between WIN data and other records. His report highlights the need for an audit/quality process to ensure accurate data.[66]

F. Uncertain Organizational Structure

Like some previous expert reports, the most recent reports of the safety and welfare, medical and sex behavior treatment experts refer to staff uncertainty about their place in DJJ's organizational structure and their reporting relationships.[67] The most recent report of the disability expert comments on the way that the DJJ organizational structure places various programs and activities under separate departments that are not necessarily coordinated.[68] The difficulty DJJ is having in finalizing its central office and facility organization charts fosters this uncertainty. After the reorganization more than two years ago, DJJ still could not produce a finalized organizational chart in early October 2007.[69] As the expert reports illustrate, the uncertainty diffuses responsibility for actions required by policies and the remedial plans and interferes with accountability. Some staff may not have

[66] See, Appendix A (Krisberg report), p. 9.
[67] See sections V. (medical) and VI. (sexual behavior treatment), below. See also, Appendix A (Krisberg report), pp. 6-7.
[68] See Appendix E (Hopper report), p. 2.
[69] The special master repeatedly asked for a copy of the charts and was told that it was not available. She last asked in early-October 2007. DJJ filed an unofficial central office organization chart with the joint case management conference statement in March 2007.

the organizational power to discharge what seem to be their responsibilities.[70] The Court ordered that DJJ file an organizational chart before the case management conference set for October 25, 2007 and DJJ has just now filed one. The special master has no information about whether the new organization chart has allayed uncertainty.

III. SAFETY AND WELFARE

The safety and welfare expert conferred with DJJ central office staff and made site visits to three facilities for his report on compliance with those requirements of the safety and welfare plan that were effective as of June 30, 2006. His report is attached as Appendix A.

Monitor Cathleen Beltz conferred with DJJ central office staff and made site visits to all eight DJJ facilities from May through August 2007. She also monitored compliance with the requirements of the safety and welfare plan that were effective by the end of fiscal year 2006-2007. She monitored only the issues that the safety and welfare plan designates for monitoring by the special master's office. Her report is attached as Appendix B.

The reports of the safety and welfare expert and the monitor show that DJJ is taking some steps forward along the course charted by the safety and welfare plan, but that it is greatly hampered by the systems deficiencies discussed above. Some of the specific areas reviewed in the reports are discussed below. Most of these areas have been subject of prior expert, monitor and special master reports, and some progress is noted.

A. Risk Classification

DJJ complied with the requirements of the safety and welfare plan for "interim classification" separating highest and lowest risk (to harm others) youth by January 2007. It has not complied with the permanent risk classification requirements, which became

[70] *See, e.g.,* Appendix E (Hopper report), p. 2 (WDP coordinators) and Appendix D (Schwartz report), p. 3 and 9 (sexual behavior treatment program coordinator).

effective in June 2007. This is due, at least in part, to the fact that the necessary written policies and procedures have not been finalized and the WIN Exchange and modifications have not been implemented.[71]

B. Violence Reduction and Conversion of Facilities to the Rehabilitative Treatment Model

Under the Safety and Welfare Plan, beginning in April 2007, DJJ was due to convert the Chaderjian facility to a specialized treatment facility with mental health and other residential treatment programs. It was due to begin to convert the Stark facility to its new rehabilitative model – even while the model was being developed – beginning in January 2007.[72] These conversions are on hold, in part due to systemic incapacities and in part due to legislation limiting DJJ's population, requiring closure of one or more DJJ facilities.[73] Nonetheless, DJJ has reduced living unit populations at Chaderjian and Stark, meeting the safety and welfare plan's population reduction requirements in a majority of living units.[74]

Though Chaderjian has fewer residential treatment units than it was slated to have by this time, DJJ has transformed it from one of the system's most violent to a relatively safe facility, largely by population reductions and improved staff to youth ratios.[75] However, the other two facilities that the safety and welfare expert visited, Stark and Preston, continue to be characterized by high levels of violence among youth.[76]

///

[71] *See*, Appendix A (Krisberg report), pp. 11-16.
[72] See, Safety and Welfare Remedial Plan, Standards and Criteria Item 6.1.b.
[73] Appendix A (Krisberg report), p. 31. The legislation that recently passed that reallocates responsibility for juvenile offenders between the state and the counties originally was proposed in January 2007. By late 2006, DJJ disclosed that it would not be able to meet the schedule for the conversions of the Chaderjian and Stark facilities, or even to set a schedule for the conversions. Statements of DJJ management staff to the special master December 2006.
[74] *See*, Appendix B (Beltz report), p. 2
[75] *See*, Appendix A (Krisberg report), p. 29.
[76] *See*, Appendix A (Krisberg report), pp. 24-27.

C. Implementation of PbS

Performance-based Standards ("PbS") is a nationally recognized system for tracking data relevant to conditions and practices in juvenile correctional facilities. The data is reported and the numerous state systems that participate can compare themselves to each other. The safety and welfare plan requires DJJ to implement PbS, beginning in October 2006. DJJ has proceeded with implementation, according to the schedule set in the plan. One of the WIN system modifications that DJJ is poised to implement will produce comprehensive data on incidents of violence and use of force in DJJ, based on PbS criteria.[77]

IV. MENTAL HEALTH CARE

DJJ has not provided the mental health experts with a significant amount of the information they requested in early August 2007 for purposes of preparing a report on issues under the mental health care plan with deadlines through the end of last fiscal year. DJJ has indicated that the information will be forthcoming by October 26, 2007. Monitor Beltz's report covers mental health plan issues through the end of the last fiscal year that the plan designates to be monitored by the OSM.[78]

In December 2007, the mental health and education experts will meet with DJJ mental health, other treatment and education staff to help them consider (1) how DJJ can provide required education (240 minutes/day) and treatment services by joint programming during the traditional school day at the school site and (2) DJJ's options for consistent behavior management techniques to be applied throughout DJJ facilities and programs (including at school sites). The education plan requires a formal behavior management system at DJJ's schools, and DJJ's treatment programs will be directed in part at the

[77] *See*, Appendix A (Krisberg report), pp. 7-8; Appendix B (Beltz report), p. 2.
[78] *See*, Appendix B, pp. 22-32.

management of disruptive or destructive behavior. The education and mental health experts agree that education and treatment services must be harmonized in order for youth to receive the services required by the mental health, safety and welfare and education remedial plans.

V. MEDICAL CARE

The special master's previous reports have reflected the medical experts' work before they initiated their first round of monitoring last fall. These experts have devoted many hours to assisting DJJ with the development of the remedial plan, including the standards and criteria for measuring compliance, and 32 key medical policies.[79] The experts' report of their first round of monitoring is attached as Appendix C.[80] They have reviewed and approve this section of the special master's report.

DJJ has taken significant steps to address the most pressing health services issues identified by the medical experts' 2003 report that became the basis for the consent decree provisions concerning medical care. DJJ has greatly strengthened administrative and medical leadership and central office management,[81] which the experts reported in 2003 were DJJ's most important task related to medical care.[82] Dr. Morris has continued to serve as Medical Director and most of the necessary central office positions have been established and filled. The quarterly statewide health services meetings that Dr. Morris instituted are very

[79] *See, Third Report of the Special Master*, pp. 12-13 and *Fourth Report of the Special Master*, pp. 19-20. References to the medical experts are to Michael Puisis, M.D. and Madeline LaMarre, M.N., A.P.R.N., B.C. through June 30, 2006. After Dr. Puisis' resignation, in consultation with Ms. LaMarre, the parties retained Dr. Joe Goldenson to serve as physician expert.

[80] During this initial round they were "field-testing" their audit tool/standards/criteria for monitoring. They did not record and report as much information as they will in succeeding rounds. The report sets a new benchmark for measuring future progress.

[81] See, *First Report of the Special Master*, p. 33-34; Appendix C (LaMarre/Goldenson report), pp. 5-10; statements of Madeleine LaMarre to special master during telephone conference September 24, 2007.

[82] Puisis and LaMarre, *Review of Health Care Services in the California Youth Authority* (August 22, 2003), p. 6.

valuable.[83] Dr. Morris has medical autonomy over the health services program, i.e., final authority over clinical matters.[84] Twenty-nine of the 32 key medical policies had been developed and formally adopted as signed temporary departmental orders ("TDOs") by November 2006[85] and they were disseminated as official policy in September 2007.[86] DJJ has initiated a chronic care program that is in the early stages of implementation at the facility level.[87] It has brought the pharmaceutical inventory and medication administration under appropriate control and management and is beginning to implement its new medication policies and procedures at the facility level.[88] It is very close to having a separate central health services budget with all non-health related expenditures excluded; generally, health service expenditures are tracked and controlled by health services' management.[89] With the exception of quality assurance, peer review and nursing sick call, DJJ had, as of early 2007, addressed each area of the systemic deficiencies that the medical experts highlighted in their executive summary of their 2003 report.[90] DJJ reports that it has commenced peer review recently.[91]

Still, as the medical experts reviewed individual health care records documenting care provided to youth with potentially serious medical problems, they found poor medical care in

[83] Appendix C, (LaMarre/Goldenson report), pp.7-9.
[84] Appendix C (LaMarre/Goldenson report), pp. 7; LaMarre statements to the special master during telephone conference September 24, 2007.
[85] *See*, *Third Report of the Special Master*, p. 13; Appendix C, (LaMarre/Goldenson report), p. 7, 9; *see also*, DJJ quarterly report, October 2006, health care services section, p. 1. These key medical policies and procedures were developed in consultation with the medical experts before DJJ centralized the policy development process and located it in the policy unit.
[86] Defendant's Amended Case Management Conference Statement, p. 18.
[87] Appendix C, (LaMarre/Goldenson report), p. 9, 24-25; LaMarre statements to the special master during telephone conference September 24, 2007.
[88] Appendix C (LaMarre/Goldenson report), p. 26-27; LaMarre statements to the special master during telephone conference September 24, 2007.
[89] Appendix C (LaMarre/Goldenson report), p. 8.
[90] Puisis and LaMarre, *Review of Health Care Services in the California Youth Authority* (August 22, 2003), p. 6.
[91] Correspondence of Michelle Angus to the special master dated October 24, 2007.

a disturbing number of cases. Because of the potential consequences of poor care, it is urgent that DJJ address the issues that are slowing the implementation of the health services remedial plan. Youth in DJJ who require health care services for serious medical problems currently face an unacceptable risk of receiving substandard care.[92]

Progress in implementation of the health services remedial plan has been hampered by DJJ's systemic problems discussed above in Section II. The lack of clarity concerning organizational relationships is evidenced by the divisions between facility custody and health services staff, and among health services (medical, mental health and dental) staff. These divisions impede the implementation of new policies and procedures and threaten medical autonomy.[93] Until last month, progress in the development and implementation of new policies halted almost a year ago, after DJJ's impressive accomplishment in formally adopting 29 of 32 key medical policies as TDOs. As noted above, DJJ disseminated the 29 TDOs to the facilities as official policy.[94] The last three of the key medical policies – on peer review, credentialing and organizational structure -- have been under review since July 2006.[95] Since July 2006, DJJ has repeatedly reported that the policies would be implemented through local operating procedures yet to be finalized. It has also repeatedly reported that it would identify and develop additional necessary policies and procedures, without following through and doing so. Although DJJ and CDCR staff have been meeting monthly to try to work through the problems that have interfered with DJJ's attempts to contract with health services providers for necessary services, progress has been limited and slow.[96] It appears

[92] Appendix C (LaMarre/Goldenson report), pp. 21-25 and 29-31; statements of Ms. LaMarre to the Special Master during a teleconference on October 8, 2007.
[93] Appendix C (LaMarre/Goldenson report), pp. 6, 14-16, 18.
[94] See nn. 9 and 86, above.
[95] Appendix C, p. 9; DJJ quarterly reports, July 2006 – July 2007, health services section, pp. 1-3. The review is by CDCR's legal unit, which raises the question of a possible "matrix" issue.
[96] See n. 57 above and accompanying text.

that DJJ has achieved pay parity with the adult system for its health services positions, but delays in the hiring process have perpetuated vacancies.[97] The experts highlight these systems issues in their recommendations.[98]

DJJ has been without a Clinical Records Administrator for more than a year now, since September 2006. DJJ repeatedly reports that this is a difficult position to fill statewide for all state agencies, that there is no list of eligible candidates and that it is attempting to fill the position by contract in the interim. DJJ/CDCR efforts to fill the position or cover it by contract have been inconsistent and ineffectual. The responsibility for securing the clinical records administrator is diffuse, between the several DJJ and CDCR staff involved in retaining contractors, and between the staff involved in recruiting permanent employees and the staff involved in getting contracts in place to cover vacant positions. It is not clear that DJJ knows what it likely would take to employ or contract with a qualified Clinical Records Administrator, or that it has a strategy to fill the position. However, a consultant with expertise in medical staffing and contracting is now focused on the issue, which is a hopeful development.[99]

VI. SEXUAL BEHAVIOR TREATMENT PROGRAM

In May and July 2007, Dr. Barbara Schwartz, the *Farrell* sexual behavior treatment expert, completed her second round of compliance audits at the four DJJ institutions with residential sexual behavior treatment units. Her first round of compliance audits was completed in late 2005. In the interim, due to the slow pace of DJJ's progress in the area of sexual behavior treatment, she limited herself to telephone conferences with DJJ staff and

[97] Appendix C (LaMarre/Goldenson report), pp. 11, 17.
[98] Appendix C (LaMarre/Goldenson report), p. 34.
[99] The special consultant for health services contracts believes that the salary for the position may be non-competitive, but that there may be an alternate state classification that would be adequate for the position. Statements of Deborah Dietz October 3, 2007.

attending some of the meetings of the sexual behavior treatment task force. Dr. Schwartz's report is attached as Appendix D. She has reviewed and approved this section of the special master's report.

Dr. Schwartz's current report includes a number of positive observations, some of which the special master previously has reported. Since 2005, the Sexual Behavior Treatment Task Force has continued to meet on at least a quarterly basis.[100] In November 2006, DJJ hired Dr. Frederick Martin to fill the long vacant sexual behavior treatment program coordinator position.[101] In May 2007, salaries for DJJ psychologists were increased when CDCR brought them into parity with the adult prison system's psychologist salaries.[102] It is to be hoped that DJJ now will be able to fill the substantial number of psychologist vacancies that have dogged its sexual behavior treatment program.[103] Also in May 2007, DJJ sent approximately 60 sexual behavior treatment staff members to the statewide conference of the California Coalition on Sexual Offending, thereby demonstrating what Dr. Schwartz characterizes as "exceptional support for training."[104] Within the last few months, Dr. Robert Prentky trained staff on the use of the J-SOAP assessment tool. Finally, as she did in 2005,

---

[100] DJJ quarterly report, July 2007, sexual behavior treatment plan section; Dr. Schwartz September 8, 2007 email to special master.

[101] *See*, DJJ quarterly report, January 2007, sexual behavior treatment plan section. Dr. Schwartz has frequently referred to her communications with Dr. Martin in her telephone and email communication with the special master's office.

[102] There was a several month delay in achieving pay parity, which gave the adult system a competitive advantage for those months. Statements DJJ management staff; see also, Appendix C (LaMarre/Goldenson report) pp. 11 and 15. What had been DJJ's flagship residential sexual behavior treatment program at the O.H. Close facility was reduced to a marginal program as of May 2007, largely due to psychologist vacancies. See Appendix D (Schwartz report), p. 11.

[103] *See*, Appendix D (Schwartz report), pp. 5. At this point, there has been an influx of applicants and DJJ apparently has made a number of job offers. The special master will monitor whether DJJ is able to complete the hiring process and put new employees in place in a timely fashion.

[104] Appendix D (Schwartz report), p.2. DJJ sent only 1 staff member to the previous year's conference. DJJ *Farrell* Quarterly Report, July 2006, Sexual Behavior Treatment Remedial Plan section. Nonetheless, DJJ still does not have a written training plan for the initial and annual continuing in-service training required by the sexual behavior treatment remedial plan. Sending staff to national or statewide conferences cannot substitute for all training in a year. Appendix D, p. 9.

Dr. Schwartz observed numerous staff treat youth in a caring and professional manner again in 2007.[105]

Still, DJJ has not made significant progress towards development of a standardized sexual behavior treatment program, the object of the sexual behavior treatment remedial plan that was filed more than two years ago.[106] One reason for the lack of progress is that responsibility and authority over DJJ's sexual behavior treatment program is diffuse. Since 2005, when DJJ began drafting its mental health and safety and welfare remedial plans, staff have expressed confusion and dissension over the relationship between the mental health and all other treatment programs, including the sex behavior treatment programs. DJJ's continuing failure to promulgate a definitive organizational chart has served to prolong this confusion and dissension.[107] Dr. Martin's role and authority as sexual behavior treatment program coordinator have yet to be clarified. He is a "senior psychologist" -- not a "chief psychologist" -- and he was not even consulted earlier this year when a number of psychologists from the sexual behavior treatment program were redirected to treatment programs for mentally ill youth under the supervision of chief psychologists. Until recently, he was not involved in the hiring of psychologists for the sexual behavior treatment program. His reporting relationships are unclear. As he began his tenure as sexual behavior treatment program coordinator, he had relatively limited experience in the field of sexual behavior

[105] *See*, Appendix D (Schwartz report), pp. 4, 5, 6 and 11. Dr. Schwartz continues to observe that the "post and bid" process results in turnover of correctional counselors without regard to their suitability and desire to provide sexual behavior treatment. Appendix D, p. 3.
[106] *See*, Appendix D generally and especially pp. 10-11.
[107] *See*, Appendix D (Schwartz report), p. 2. As DJJ staff have explained, DJJ has and will have mental health programs for mentally ill youth and treatment/rehabilitation programs for youth who are not mentally ill. It is clear that the mental health program management and clinical staff are responsible for the mental health programs for mentally ill youth. It has not been clear what role the mental health program management and clinical staff would play in the development and management of the other psychologically based treatment programs such as those involving the treatment of sexual behavior problems. Mental health clinicians will have to be involved in the other treatment programs. The question is whether mental health staff will be separated between different program "silos." DJJ staff have recently reported to the special master that the sexual behavior treatment program has been brought within the mental health department.

treatment so he did not have the power and authority of a great deal of subject matter expertise.[108]

The sexual behavior treatment plan provides for comprehensive written policies and procedures and comprehensive curricula to describe the treatment program and guide the treatment.[109] DJJ cannot have a coherent, evidence-based program for sexual behavior treatment without written policies and procedures and curricula that standardize treatment.[110] Yet, to date, there has been no discernible progress towards the preparation of these written policies and procedures and only modest progress towards the development of the needed curricula. This is a second reason that DJJ's sexual behavior treatment program is not yet coming together.

The sexual behavior treatment task force originally planned to complete the development of the needed program policies and procedures by mid-2006.[111] Task force members took responsibility for drafts, which were reviewed at regular task force meetings. Dr. Schwartz was supportive of the task force effort though she did not review their work product and cannot comment on its quality. In mid-2006, DJJ assigned a writer from its policy unit to take over production of the policies. The task force members were told that the policy unit would write all policies in order to ensure consistency among them. They were instructed to discontinue their efforts, to give their drafts to the policy writer and to wait for the policy writer to prepare policies in the proper form. For more than a year, the DJJ policy writer has attended task force meetings but has yet to report any progress on the policies.[112]

---

[108] *See*, Appendix D (Schwartz report), pp. 3,7 and 8; statements of Dr. Schwartz during telephone conferences with the special master.
[109] Remedial Plan, Sexual Behavior Treatment Program, p. 11.
[110] *See*, Appendix D (Schwartz report), p. 11.
[111] *See*, *Second Report of the Special Master*, p. 14.
[112] Dr. Schwartz' statements to the special master during telephone conference September 18, 2007 and Appendix D (Schwartz report), p. 2; see also, DJJ *Farrell* Quarterly Reports, October 2006, January 2007, April

Now, as reported above, DJJ has withdrawn the injunction to program staff against policy writing and the task force may return to the task of writing policy.

As for the lack of curricula, the Special Master has previously reported that Dr. Cellini's curriculum development work was disrupted from April 2006 through April 2007 because the funds in his initial contract were exhausted and it took CDCR/DJJ a year to execute a successor contract.[113] After he resumed work for DJJ in May 2007, CDCR failed to pay his bills in a timely fashion, which he says hampered his work by delaying his ability to replace the staff that he let go a few months after his initial contract lapsed.[114] In the meantime, he has lost the confidence of some key DJJ staff by the length of time it is taking him to deliver the first of the three curricula he was retained to develop. The first curriculum, Healthy Living, supposedly was near completion when he was told to stop work in April 2006 because his contract was exhausted.[115] He now expects to deliver it by mid-

---

2007 and July 2007, Sexual Behavior Treatment Remedial Plan sections. In the July 2007 report, DJJ reported that the policies were "at various stages of planning and development." In October 2006, DJJ staff responsible for the sexual behavior treatment programs were prioritizing development of a policy for tracking each youth's treatment progress. Towards this end, they sent a proposed a tracking form to DJJ's policy unit for review. DJJ *Farrell* Quarterly Report (October 2006), Sexual Behavior Treatment section. As of August 2007, DJJ had no standard form to track progress in sexual behavior treatment. Yet, such tracking is critical to individualizing treatment and determining a youth's readiness for safe return to his or her community. See, Appendix D, p. 2, 5, 10 and 11.

[113] *See, Third Report of the Special Master*, p. 16; DJJ *Farrell* quarterly reports, October 2006, January 2007 and April 2007, Sexual Behavior Treatment Remedial Plan sections. It is difficult to parse out the factors in contract problems such as this one. Renewal of the consultants' contract raised issues of state law related to non-competitive bid or sole source contracts. Obviously, DJJ and CDCR need to follow state law. But nothing material changed during the 12 months it took for CDCR and DGS to permit DJJ to contract with its sexual behavior treatment consultant. The delay in renewing the contract reflects dysfunction in government that DJJ, CDCR and DGS need to solve.

[114] Dr. Cellini told the Special Master that he hired those staff near the end of September 2007.

[115] *Second Report of the Special Master*, p. 13. The Healthy Living program is conceived as the first step in sexual behavior treatment, administered on regular living units ("outpatient" treatment). The program will prepare youth for more intensive treatment and allow staff to continue to assess youth's treatment needs. Most of the youth who complete the Healthy Living program will then move into a residential sexual behavior treatment program. Dr. Barbara Schwartz' September 8, 2007 email to the Special Master. Dr. Schwartz informed the special master by email and telephone conference on October 9 that sections provided to Dr. Cellini by Task Force members still needed substantial work as of April 2006. When Dr. Cellini resumed work under a new contract in approximately May 2007, he had to update the curriculum due to the year delay in publication, and he had to complete and format the Task Force sections.

October 2007.[116] He is under contract to develop the residential curriculum and additional outpatient curriculum materials before July 1, 2008.[117]

The current system for record-keeping is not conducive to a standardized sexual behavior treatment program. Clinicians and counselors still record their notes in different records. As a result, they have incomplete information as they provide treatment services and there is no coherent, complete treatment record for quality assurance review or any other purpose.[118] Dr. Schwarz has been recommending a unified treatment record since 2005.[119]

Reflecting how little progress has been made in the last two years, Dr. Schwartz continues to press almost all of the same recommendations she has been making since 2005: promulgation of an organizational chart that clarifies reporting relationships for sexual behavior treatment program staff; completion of comprehensive program curricula and written policies; implementation of evidence based assessment;[120] a unified program treatment record used by all staff for charting treatment and progress; regular tracking of treatment progress based on clearly delineated criteria; systematic training that builds skills of clinician and counselor staff; and, assignment of counselor staff based on training, aptitude and program preference (instead of straight "post and bid").[121] She recommends also that

---

[116] Dr. Cellini statements to the special master September 21, 2007.

[117] Dr. Schwartz recommends that the residential curriculum be prepared next because residential treatment is the core of DJJ sexual behavior treatment program and is in "desperate need of standardization." Appendix D, p. 10. Dr. Cellini agrees and feels confident that he will finish all the curricula before the end of this fiscal year. Dr. Cellini statements to the special master September 21, 2007.

[118] See Appendix D, p. 3, 9 and 11.

[119] *See, Second Report of the Special Master*, p. 12-16. The sexual behavior treatment, mental health and medical experts are scheduled to confer on this issue in November 2007, to ensure that they harmonize their views about DJJ health care and treatment records.

[120] As of March 2006, it decided to use an instrument known as the J-SOAP II instrument and was awaiting the completion of a systematic training-needs assessment before training funds could be released and the staff trained to use J-SOAP II. In August 2007, DJJ finally sent staff for the necessary J-SOAP II training and, presumably, J-SOAP II will be implemented in the near future.

[121] *See*, Appendix D generally and especially pp. 10-11; c*f.* Appendix D to the *Second Report of the Special Master*.

DJJ take appropriate action to provide Dr. Martin with organizational authority over psychologists in the sexual behavior treatment program.

VI. EDUCATION

The special master filed an extensive report on education with her last report. The education experts have just begun their third round of monitoring and will be filing a comprehensive report next spring.

As discussed above in Section IV, the education and mental health experts are scheduling a meeting with DJJ education and mental health staff to consider (1) how DJJ can provide required education (240 minutes/day) and treatment services by joint programming during the traditional school day at the school site and (2) DJJ's options for consistent behavior management techniques to be applied throughout DJJ facilities and programs, including its schools.

VII. ACCESS FOR YOUTH WITH DISABILITIES

From October 2006 through June 2007, the *Farrell* expert in physical and programmatic access for youth with disabilities, Logan Hopper, conducted compliance audits at all DJJ facilities. His "Wards with Disabilities Program Remedial Plan Auditor's Report, " completed two years after DJJ filed the Wards with Disabilities Remedial Plan ("disabilities remedial plan") and a year after his first audit is attached as Appendix E. The first four pages of Hopper's report constitute a comprehensive and concise summary of his findings, conclusions and recommendations. The rest of his report details central office and facility-by-facility findings.

Mr. Hopper's second annual report is very similar to his first annual report: it reflects continuing progress in certain areas and a continuing inertia in certain others.[122] The central office and facility coordinators for the wards with disabilities program are, on a whole, extremely dedicated and effective and they have the support of many responsible central and facility administrators. As a result, all facilities are showing progress in the development of the wards with disabilities program. This reflected in the expert's central office and facility-by-facility audit findings this year compared to last year; DJJ's central office and each and every DJJ facility increased its proportion of "substantial compliance" audit items and decreased its proportion of "non-compliance" audit items.[123]

On the other hand, DJJ has not made significant progress towards integrating the disabilities program fully into its operations.[124] This is at least partly due to the same systems deficiencies that have impeded progress in other areas. Specifically, the disabilities program policy is one of the written policies that DJJ has not been able to finalize and promulgate as official policy. Further, one of the WIN modifications that has been delayed will facilitate recording and tracking information related to youths with disabilities. Thus, while the disabilities program staff and facility management staff understand the proposed policy and are committed to its implementation, that understanding and commitment has not permeated to most of the line and other program staff.[125] Equally important and probably related, DJJ still has not conducted the system-wide disability sensitivity, awareness and

[122] *Cf.*, this section of the special master's report with the disabilities section of the *Second Report of the Special Master*.
[123] *Cf.*, Appendix E (Hopper second annual report) with *Second Report of the Special Master*, Appendix E (Hopper first annual report). DJJ continues to remove architectural barriers generally on schedule, as set by the disabilities remedial plan. *See*, Appendix E (Hopper report), pp. 3 and 45-46.
[124] *See*, Appendix E (Hopper report), p. 2.
[125] *Ibid.*

harassment training for all staff that was due to be completed by June 2006.[126] In addition, DJJ has not made any progress since the expert's first annual report towards forming the special interdisciplinary, interdepartmental groups that are supposed to integrate consideration of disabilities issues in the context of other programs and services.[127] As a result, the disability program staff that are trying to implement the wards with disabilities remedial plan are unable to gain the cooperation they need from all the other staff that control facility operations and youth movements, programs and activities.[128]

Until DJJ remedies these systemic problems, its progress in implementing the wards with disabilities program will remain limited.

VIII. CONCLUSION

The special master respectfully submits this report.

Dated: October 23, 2007

_____

Donna Brorby
Special Master

[126] The disabilities expert considered the failure to conduct this training by June 2006 the most significant noncompliance issue more than a year ago. *See, Second Report of the Special Master*, p. 17. It is likely that the comprehensive training has been held up to be coordinated with training on the new policy and implementation of the related WIN disability feature, since policy and documentation will be the framework for staff actions with respect to youth with disabilities. Nonetheless, some staff training has occurred since the June 2006 report.

[127] *See*, *Wards With Disabilities Program Remedial Plan*, p. 15, 26, 34 and 58 and standards and criteria pp. 7,8, 11-12.

[128] *See*, Appendix E (Hopper report), p. 2.

DJJ PROGRESS ON THE STANDARDS AND CRITERIA OF THE SAFETY AND WELFARE REMEDIAL PLAN

Barry Krisberg, Ph.D.

Sept 7, 2007

DJJ PROGRESS ON THE STANDARDS AND CRITERIA OF THE SAFETY AND WELFARE REMEDIAL PLAN

Goal of this Report and Data Sources

The goal of this report is to offer my observations on the DJJ's progress in implementing the S&W Remedial Plan Standards and Criteria that were filed with the Court on October 31, 2006. This report covers the period from that date through June 30, 2007. My conclusions are based on two extensive meetings held at DJJ Headquarters on March 12, 2007, and April 9, 2007, and included many staff involved in the reform efforts as well as attorneys representing CDCR and the Attorney General's Office. After these verbal briefings I requested follow-up documentation or updates on key points that have been provided to me by Doug Ugarkovich, Michael Hanratty, Michele Angus, and Van Kamberian. Since these visits, I have requested and received extensive documentation and further data from DJJ staff, the AG's office, and the Office of the Special Master.

I conducted two general monitoring site visits lasting a total of three days to the Heman G. Stark (HGS) Youth Correctional Facility to learn about the progress being made there. The HGS facility is scheduled to be a major locus of reform efforts in the next 12 months. I visited HGS on March 16, 2007, and August 15-16, 2007, and was accompanied by Van Kamberian on both trips and Michael Hanratty for the first tour. In addition, Mr. Kamberian and I went to HGS on July 9-10, 2007, at the request of Bernard Warner to examine the issue of assaults on staff that have occurred there in 2007.

I also conducted on-site monitoring tours at the N.A. Chaderjian Youth Correctional Facility (Chad) on July 24-25, 2007, and the Preston Youth Correctional Facility (Preston) on August 6-7, 2007, accompanied by Mr. Kamberian. The DJJ staff at each of these facilities were very helpful and forthcoming in their comments. Superintendents at all three facilities provided me with all of the follow-up documentation that I requested from them after these site visits.

Where applicable, I have examined reports produced by the Office of the Inspector General (OIG) that were pertinent to the issues contained in the Safety and Welfare Remedial Plan.

Initial Monitoring Strategy

My approach to monitoring the Safety and Welfare (S&W) Remedial Plan has been to rely upon the detailed Standards and Criteria that were filed with the Court on October 31, 2007. These Standards and Criteria have been summarized in an Excel spreadsheet that lists the actions to be taken, the promised dates when these actions would occur, and the relevant sections of the S&W Plan that apply. My objective at both the Headquarters briefings and the DJJ facility site visits was to cover all actions that were to be completed by June, 30, 2007. I wanted to see what had been accomplished and collect information to permit me to judge if these steps were completed consistent with the intent of the S&W Remedial Plan in the Farrell case. If tasks had not been completed, I sought to find out what obstacles prevented their completion. I also attempted to determine if new dates had been established by DJJ to finish the promised reform activities.

In this report I have not attempted to report on every milestone in the S&W Remedial Plan that was to be completed by June 30, 2007. While I will cover these topics in later reports, I chose to focus on areas that I believe deserve immediate attention by DJJ, the plaintiff's attorneys, and the Court.

Building the Infrastructure for Reform

DJJ was to add central office resources, clarify lines of authority, and create a system for auditing and corrective action. DJJ was to improve its Management Information System capability and add resources as appropriate at each facility.

The S&W Remedial Plan emphasized the need for DJJ to establish or recreate a management structure that could plan, implement, and monitor the reform process. Not surprisingly, many of the early tasks were about putting the reform team in place and

solidifying the Headquarters' capacity to resolve issues in the Farrell case. The final version of the S&W Remedial Plan was filed by DJJ on July 10, 2006; the Standards and Criteria were filed on October 31, 2006. DJJ proposed that most of these "infrastructure building" tasks would be accomplished by the end of January, 2007, or before. DJJ has struggled with filling many of these headquarters positions, and some jobs have been filled only recently. Delays in creating the needed management resources and structure have delayed many aspects of the S&W Remedial Plan and have had cascading negative impacts on other downstream goals of the Plan.

This inability to build a complete and consistent management team to plan and implement the reforms has had adverse effects in many areas of rolling out aspects of the S&W Remedial Plan. The original timelines were mostly missed (see for example the DJJ memo from January, 2007, on Missed Deadlines). I would urge the parties to provide the Court with an amended schedule of the implementation of the S&W Standards and Criteria that would accurately reflect the current thinking on when various key reform goals will be accomplished.

In the last quarter of 2006, DJJ was scheduled to appoint a Director of Programs who would oversee a broad range of education, medical health, mental health, and rehabilitation services. This top position is central to the Farrell reforms. In addition, DJJ was to fill the position of Project Director for the implementation of the Farrell consent decree and agreements. Other staff were to be designated and assigned to fill three teams that would be responsible for (1) developing and implementing the needed reforms; (2) managing the transition of the required changes at designated facilities; and (3) setting up a compliance mechanism for the reforms. In addition, DJJ was to designate Community Court Liaison staff to work with judges and probation departments to implement clear admissions criteria for DJJ that were to be promulgated by its top management. A statewide coordinator for Performance-based Standards (PbS) implementation was to be designated. There was to be a headquarters staff member assigned to ongoing reviews of the Special Management Programs (SMP), and at least two staff from Headquarters were to be named as Security Service Specialists with duties specified in the interim plans to reduce institutional violence and to reduce the use of force. In addition, the S&W Remedial Plan called for the appointment of a Project Coordinator for the development of

capital master plans for the various facilities that were congruent with the goals and objectives of the S&W Remedial Plan. Finally, all of these new headquarters hires and reassignments were to be reflected in a new headquarters organizational chart by September 1, 2006.

As of this writing, only some of the anticipated personnel steps have been completed. DJJ still does not have a Director of Programs. In 2006 the DJJ filled the position of the Farrell Project Director who is to directly manage the various components of the consent decree, stipulated agreements, and the remedial plans. Unfortunately, the incumbent of this position resigned after a very brief tenure in this job. Only recently has the DJJ been able to refill this position. In terms of the ongoing work in the Farrell case, Doug Ugarkovich has stepped in and done a very good job of coordinating with the Special Master and the Experts in arranging meetings, processing information requests, and attempting to pay consultant bills in a timelier manner. Mr. Ugarkovich also has been working closely with the CDCR Accounting and Contracts units. But, the absence of a clearly defined senior manager to oversee the implementation of the various court-filed remedial plans has been a problem. While it is clear that Mr. Warner has overall responsibility for the operations of DJJ, it has often been unclear to the Subject Matter Expert in the S&W area as to who the lead DJJ manager is and which staff are regularly assigned to implementing the remedial steps in this particular domain. Because the S&W Remedial Plan covers a number of DJJ functions, it can be anticipated that several staff will be working in this area. This situation calls for close coordination among staff and the ability of DJJ management to establish work and resource priorities in this complex area of reform.

According to DJJ staff, the delays in filling these critical positions have occurred due to the cumbersome hiring and personnel practices in CDCR and the State Personnel Office and the very slow nomination processes in the Governor's Office. At least one candidate apparently turned down the position of Director of Programs. The Farrell Project Director position was filled very briefly, but the incumbent quickly resigned. This lack of key top managers seems to have led to an ad hoc division of tasks that has been taken over by Deputy Secretary Bernard Warner. The Deputy Secretary has been filling many reform roles in the near term, but the wide span of his ongoing organizational

responsibilities makes this task very challenging. The precipitous departure of Ed Wilder, who was the Acting Director of Juvenile Facilities, has led to additional anxiety and uncertainty by the facility superintendents about the future direction of reform efforts. While the position of Acting Director of Juvenile Facilities was filled within a month, the replacement of a well known and long term DJJ senior manager with a person coming in from outside of the Division sent an ambiguous message to institutional staff about the direction of reform.

Other tasks that should be managed by the unfilled leadership positions have been delegated to the Director of Juvenile Facilities, and other Headquarters staff, increasing the workload and pressure on remaining personnel who have other ongoing job responsibilities. Some DJJ staff in Headquarters are responsible for both monitoring and directing current day-to-day operations at all facilities, and they have been assigned to design and help implement various aspects of the reform agenda. This is reminiscent of the imagery of someone trying to drive a car and fix it at the same time—a very difficult job, if not an impossible one. The S&W Expert heard several concerns expressed by Headquarters staff about excessive workloads. There were concerns expressed that the focus on implementing the reforms was sometimes sidetracked by more routine operational concerns at the facilities. The initial S&W Remedial Plan envisioned dedicated staff that would plan and assist in the implementation of the Farrell reforms. It appears that DJJ has decided to reduce the number of dedicated reform staff, and the positive and negative consequences of this decision will be observed over the next several months. For now, it is clear that many milestones in the S&W Remedial Plan have been missed and rescheduled into the future. It will be important for DJJ to reestablish an updated and realistic schedule for the S&W reforms, and to communicate these revisions throughout the Division.

Headquarters staff that are assigned to the reform efforts complain that they are stretched very thin and are working long hours in multiple roles. This workload stress may have contributed to some important resignations of top DJJ staff. In particular, the loss of the Director of Policy Elizabeth Siggens was a major setback. Ms. Siggens was central to conceptualizing the S&W Remedial Plan, and she has led the DJJ reform

planning process over the past two years. As noted above, the first Farrell Project Director resigned after a very short stay.

Most important, the lack of a clearly defined and permanent reform leadership structure has led to perceptions by other members of the reform team and by some facility superintendents of ever-shifting policy and program directions and lack of clarity in terms of lines of authority. This Headquarters management problem has been compounded by the fact that most top managers at the DJJ facilities are "acting," with uncertainty as to when regular appointments will be made.

DJJ was able to hire a highly respected Director of Youth Facilities, Sandra Youngen, from Washington State. However, the newness of this person to the California system necessarily created a period involving a steep learning curve. DJJ did assign Sue Easterwood, an experienced manager in information systems, to head up the statewide coordination of PbS, and Mark Blaser, who has capably maintained system-wide information of restricted housing programs, was assigned to continue in the role. DJJ has assigned Court Liaison staff to begin improving communication and liaisons with the counties.

Permanent DJJ Headquarters staff have not yet been assigned to coordinate the facility master plans that are needed to support the Remedial Plan. The staff person assigned to coordinate the development of new reform policies has been assigned to this job in the last 60 days. The S&W Plan called for dedicated staff for policy development and maintenance. Failure to meet this goal has slowed the development and promulgation of required new operating policies at the facilities. The S&W Remedial Plan filed by DJJ envisioned the creation of three Headquarters teams: (1) a program development and implementation team, (2) a temporary transition team to assist in the changes at the institutional level, and (3) a compliance team. The DJJ has recently filled 16 or 18 budgeted positions for the program development and implementation team. State personnel polices slowed this process down considerably. It appears that DJJ has decided not to create a special temporary transition team and to merge compliance monitoring of the Farrell reforms with general DJJ divisions. While these simplifications of the DJJ organizational structure may make sense in the long run, it is still unclear whether these changes will help or hinder the Farrell reforms.

I have also heard complaints that the DJJ Reform team has not been working closely enough with top management staff who are managing key aspects of operations such as Mental Health Services. The concern is that decisions are made without proper input from those who will be required to make these decisions happen. Further, the superintendents and other managers at HGS, Preston, and Chad all complained that they were not fully aware of the direction of the Reform team and that there seemed to be constant changes. Facility management personnel felt that they wanted to support the reform process but were not sufficiently included in the Headquarters planning process. Staff at HGS, Chad, and Preston wanted more opportunities to share their experiences and expertise with the Reform team.

Improve DJJ's Management Information Capacity

A major area of planned activity in the S&W Remedial Plan involved improving and upgrading various data gathering and reporting programs on issues such the incidence of institutional violence, the use of force, the DDMS system, and the use of restricted housing. DJJ has already executed a contract to implement Performance-based Standards (PbS) that was developed by the federal Office of Juvenile Justice and Delinquency Prevention and the Council of Juvenile Corrections Administrators. PbS is a highly structured data collection system that allows for comparisons to other facilities that voluntarily contribute to the national PbS program. PbS also has a well-defined system of helping implement facility-level quality assurance processes.

DJJ has designated Sue Easterwood as the Headquarters coordinator for implementing PbS, and staff at every facility have been designated as the PbS coordinators. Training on PbS has occurred at all included facilities, and DJJ has shared with me the results of early data collection. The first "test drive" of PbS worked quite well and, while it is "a work in progress," it is likely that the PbS system will be properly implemented. The superintendents at HGS, Chad, and Preston all commented that they found the early PbS data useful to them and looked forward to having this on a regular basis in the future.

A key part of this transformation is to use the standardized definitions from the PbS codebook rather than the more informal definitions used by DJJ in the past. DJJ staff report that the pilot testing of PbS is going well, but that it will likely take a year until the new data gathering and quality assurance are fully operational. PbS national staff assume that it will take most new sites up to 24 months to be certified as providing complete and accurate data into the PbS system. In the interim, DJJ will need to rely on other data systems such as COMPSTAT (required of all facilities in CDCR), the WIN system, the Lieutenant's reports, the Treatment Needs Assessment (TNA), the Offender Based and Information and Tracking System (OBITS), monthly summaries of UOF data, and other "stand alone" data systems to provide information to managers on how well reform objectives are being met. I have been given the latest versions of each of these data reports and convened a meeting with several DJJ staff to discuss the status of these various data systems.

The completion of the WIN Exchange has not yet occurred. It is long overdue in terms of the S&W Remedial Plan schedule. This data system contains the most detailed information on every individual youth in the DJJ system, providing a rich source of data on a range of operational questions. The WIN Exchange is intended to link these data across all DJJ facilities, along with common definitions and common data formats. It was to be online as of January 1, 2007. It is difficult to get a definitive answer as to when the WIN Exchange will be operational. There is an email from Bob Eaton promising that the system was to be online by June 30, 2007. According to DJJ staff, the WIN Exchange System is now being "Beta tested" at O.H. Close, but I have not been given a definite date when the system will be fully operational throughout the DJJ.

DJJ staff explain that problems in retaining programming staff who accept positions and shortly leave DJJ. A further exploration and corrective actions are needed to allow DJJ to recruit and retain the needed computer professionals to complete the WIN Exchange system. The WIN system is central to the implementation of many DJJ revised policies in the areas of restricted housing, DDMS, the classification system, religious services, and the grievance system. WIN Exchange is the only automated system that Headquarters and some of the institutions can utilize to efficiently monitor compliance with many promised S&W Remedial Plan goals. There will still be a need to upgrade

WIN by getting someone to write code to produce system-wide management reports using WIN data.

There is also an urgent need for Headquarters to establish a routine system for auditing these data. I found many cases in which WIN data did not accurately reflect practices in particular cases or in particular living units. Those staff who work with WIN every day are well aware of some of the current problems with the system, but it is all that they have to work with at present. While the current system will still need many improvements once it is operational at every facility, these upgrades require that the WIN Exchange be completed as soon as possible. This must become a priority of top DJJ management.

One rumor that is circulating around DJJ is that CDCR intends to drop the WIN system as the larger department creates an integrated inmate information system. In my view this would be a major setback for DJJ and its efforts to meet the goals of the S&W Remedial Plan.

As mentioned above, there are several other stand alone data systems such as COMPSTAT, which was designed by CDCR to help manage all of its facilities. COMPSTAT is currently a very useful tool to help assess some aspects of the various Farrell remedial plans. The superintendents that I met with all found it very helpful and found value in the meetings in which they had to present these data to other CDCR management. Someone at CDCR should invest in a modest effort to computerize the monthly COMPSTAT data, allowing for trend analyses, cross-facility comparisons, and other interpretive graphic presentations of the data.

The OBITS and the TNA data are older DJJ data systems that have been utilized by the Research Division for a range of planning studies, program evaluations, or descriptions of trends in the DJJ population. These data are essential for any competent planning for new and evolving treatment strategies. Effective programs must be both "evidence-based" and grounded in real data about youth who will be receiving these services. These data were proven to be very helpful in developing the custody classification system.

DJJ staff were working on automating and unifying the data that is being entered by staff at the end of their shifts. Once known as the "daily operations reports," these

exist in various forms at each living unit, mostly in the form of handwritten log books. The standardized and automated "daily ops" are now referred to as the Lieutenant's Reports. This system still has great potential to offer daily profiles of critical incidents that occur in every living unit. Absent a very sophisticated revamping of the WIN system, the Lieutenant's Reports can provide very important data to management. At this writing, I have been unable to determine when the new Lieutenant's Reports will be fully operational. DJJ states that the testing of the Lieutenant's Reports are "in process" and that Headquarters staff will meet in the next two weeks to review the test results.

What is apparent from the above description of current or "in progress" data systems in DJJ, is that there is no clear written plan on how these disconnected systems can complement each other. I could find no staff at DJJ who could articulate to me how these various information sources would be integrated. Nor is there a formal plan for who needed to get what sorts of information, and within what time frames. Also, DJJ has not invested in teaching its managers how to use data to better manage current operations, or to plan future improvements. So what remains is an agency which is mostly driven by anecdotes and subjective impressions, with limited capacity to implement data-driven planning and management. While there are some DJJ staff who frequently use different parts of the various stand alone data systems, there does not appear to be a systematic strategy to improve how timely and objective information is utilized in DJJ. There is not necessarily a need for "one comprehensive management report," but rather a thoughtful plan that includes a specification of who needs regular information and how the various stand alone data systems complement each other. The DJJ is rich with data, but poor in its ability to interpret and use that information to monitor the progress of the S&W Remedial Plan.

Reduce Fear and Violence

Implement a new custody classification system for living unit assignments. Separate high- and low-risk youth in general population living units, especially in dormitories. Revise use of force policies and create violence reduction committees at the facilities. Qualify 18 staff as crisis management trainers and train staff at two facilities in crisis management. Develop and use databases to track violence and the use of force, Implement a pilot to monitor the use of chemical agents. Develop strategies and

procedures to reduce gang and racial conflicts in DJJ facilities. Limit the use of restricted housing units and improve the conditions of confinement in these units.

Classification

One of the major reform tasks to be acted upon on a priority basis was the implementation of the interim custody classification system. The implementation of the new system was to be accomplished by January, 2007. Amy Seidlitz has informed me that the interim custody classification instrument has been applied to all new admissions to DJJ and has been used for all youth requiring a reclassification process. DJJ has also sent along data suggesting that they successfully separated high-risk and low-risk youth at each institution in DJJ by January, 2007. The interim classification system was applied only to youth in general population living units. Youth in mental health units or other specialized treatment programs were exempt from the classification system. It was agreed that the primary goal was to separate youth that scored high or low on the screening instrument. Youth scoring moderate risk could be housed in either type of living unit. The major goal of the initial use of the classification instrument was to separate youth who were residing in dormitory settings. The idea was to move high-risk youths into single rooms if possible, and to separate youth by risk levels in the remaining dorms.

I repeatedly requested formal documentation of the new classification process including a copy of the final instruments that were used at intake and at reclassification hearings. I requested documentation of any interim policies that were promulgated to guide the implementation of the new custody classification, or the content of any training given to staff. I also asked for a brief written description of how many transfers were needed to separate the high- and low-risk youth, or the methods utilized to affect these transfers. These requests were contained in series of 14 questions that were submitted to DJJ on June 6, 2007.

Answers for many of these questions were finally received via email on August 6, 2007, thanks to the help of Doug Ugarkovich, Dorene Nylund, and Van Kamberian. This information is important, because I was asked by the Special Master and the PLO to render a judgment as to whether the implementation of the new custody classification was done as envisioned in the S&W Remedial Plan. I was also asked to report whether the new custody classification system was being done consistent with nationally

recognized standards. At this point, my judgment is that DJJ has not complied with the spirit and intent of the S&W Standards and Criteria. The current state of the custody classification process in DJJ does not meet nationally-accepted professional standards. I reach this conclusion, in part, because the policies and procedures, underlying the new system are still being formalized, and there has been inadequate attention to the special staffing or programming of operating living units that contain a large percentage of high-risk youths. DJJ headquarters staff report that they are working on ways to respond to these concerns.

During site visits to HGS, Chad, and Preston, I spoke with relevant staff to understand the process of employing the new custody classification at each of these facilities. I asked about any issues that the facility may have experienced as a result of the implementation of the new system. In later site visits, I will examine the use of the classification tool at other DJJ facilities.

The actual instrument used in the classification process was developed by the DJJ Research Division with consultation from nationally-known experts Christopher Baird and myself. The development process and the instrument itself met the highest professional standards.

I do have concerns about the implementation of the custody classification instrument at the facility level. Guidance that was given to each facility was based primarily on verbal briefings, there was relatively little formal policy or written instructions to guide the use of the process. As a result of this lack of formality, each of the facilities applied a slightly different approach to implementing the new system. For example, at Chad the youth were assigned risk scores but there were no movements, since Chad now houses many youth who reside in exempt units including intake, sex offender and mental health units. The general population units at Chad consist entirely of single rooms, not dormitories. By contrast, HGS interpreted the new system as requiring that high-risk youth be separated from low-risk youth, even in living units that had only single cells. Preston created high- and low-risk living units that were mostly dormitories.

Another classification objective involved updating the classification scores of youth based on subsequent behavior. The initial scores assigned by the central office were based on factors that were primarily known at the youth's admission. The DJJ staff

expected that this reclassification process would be provided to them by a retained outside expert. At site visits to Preston and HGS, I learned that each institution had developed its own approach to reclassification. For instance, at Preston the PA III developed a point system that added or subtracted to the initial classification scores based on behavioral issues involving DDMS allegations. Preston staff made modest adjustments to the initial classification scores. At HGS revisions on classification scores were not based on a formal point system, and were determined by staff observations on how well youth were interacting with others in the various units. HGS also has instituted a policy of segregating almost all "Northern Hispanics" in the SMP unit, even though current behavioral indictors would not call for an SMP placement. It should be noted that DJJ staff believe that many of these youths had engaged in "violent or disruptive" behavior in the past. HGS staff felt that it was unsafe to house alleged Northern and Southern gang members together in General Population units. HSG also operates a unit in which youth may request placement without regard to their classification levels. This unit is variously described by some staff as a PC unit, as a place for youth who want to stop their involvement in gangs and violence, or youth who fear for their safety for a number of reasons. As noted earlier, Chad is not using the classification system for most of its living unit assignments, although all youth at Chad do receive custody classification scores. Chad does use the classification scores for all their youth who parole or transfer out of the facility.

DJJ reports that full implementation of a reclassification process will not be fully implemented until the delayed WIN Exchange System is operational. Further, DJJ staff state that the current classification process was always presented as an interim step, and is subject to further review and refinement. Since performance standards for the classification system have not been routinized as yet, it is difficult to determine which data will be utilized by DJJ to make the needed adjustments.

While there was a clear intent to coordinate living unit movements at a statewide level, the differences that I observed at individual facilities may have been due to the lack of clear written procedures guiding the use of the new custody classification system and the limited formal training offered to facility staff on how to implement the new classification system.

While it should be noted that a very small number of youth (approximately 66) were actually moved to new living units during the January, 2007, startup period, it is likely that there is wide variation in the application of new classification processes in each of the DJJ facilities. Further, there was insufficient guidance given to facility staff on how, if at all, they should alter procedures or practices in staffing or other daily operations for the living units that contained high concentrations of high-risk youth. While the management staff at HGS, Chad, and Preston indicated that the new classification system was not creating big issues, there were staff that expressed concerns about the safety of the new system. In effect, each facility seemed to be implementing some kind of "work around" the new classification process that made sense to them.

One concern that I have is that staff sometimes are using the terminology of "high-risk, low-risk" to refer to youth in their presence. Staff need to be trained that these custody classification designations are not certain predictions of future behavior, but rather group designations. This could lead to a self fulfilling prophesy that propels certain youth into high-risk behavior or lulls staff into a false sense of safety. I have always suggested that the custody classification process must be tied to the development of strategies of supervision for living unit staff, and the training of staff.

Another component of the custody classification system that I believe should be further refined in the near future is the application of a variation of custody classification for youth in special programs and for parole violators. The October 31, 2007, agreement left these groups out of the Interim Classification system, but ultimately DJJ will need to design some sort of objective and research-based screening system for these youths. This is particularly important to manage movements of these special program youth as they move into general population units or to other DJJ facilities.

Other classification tasks scheduled for completion were not completed as of the writing of this report. For example, DJJ was supposed to establish performance standards in consultation with the S&W Subject Matter Expert to measure the impact of the new custody classification system, especially in the high-risk dormitories, DJJ also was to implement "alternative risk management strategies for male youth in dormitories who are high risk of institutional violence." These tasks were not done, or at least, no information

was presented to me to reach a conclusion on whether DJJ was in compliance with the S&W Standards and Criteria submitted to the Court on October 31, 2006.

DJJ made a commitment to issue an RFP for a new risk and needs assessment system to supplement the custody classification system by October 1, 2006. DJJ did release an RFP that has combined the development of a new risk and needs assessment system with consultation on evidence-based treatment models, as well as staff training. DJJ selected Orbis Partners to conduct this work. It was hoped that the contract would be finalized before the end of the 2006-2007 fiscal year. This contract was awarded in June of 2007.

According to DJJ, the primary holdup on the release of the risk and needs assessment RFP was the insistence of state automation people who demanded a feasibility study about the integration of any new risk and needs assessment system with other data systems. Moreover, the well documented problems at DJJ to get new contracts approved through the CDCR and State purchasing process led DJJ to combine the RFP on classification with other tasks related to building a model treatment approach. This decision probably limited the number of organizations who responded to the RFP, since the capacity to perform such a wide variety of functions might only be available for certain groups. Also, the time frame for responding to the RFP was relatively short. While the selected vendor, Orbis Partners, seems qualified to do all of the work that is called for in the RFP, this repertoire of consulting skills is pretty rare in the juvenile justice field. I am awaiting a copy of the final contract and work plan that will be negotiated by DJJ and Orbis Partners to get a better handle on the new schedule and resources to be devoted to the development of a new risk and needs assessment system.

DJJ had agreed to continue using the interim custody classification system until it could be integrated with the new risk and needs assessment system, or replaced by a new one. According to Amy Seidlitz, the interim custody classification system will be the main living unit assessment tool for the immediate future. It is very confusing to me how the new risk and needs assessment classification system will relate to work done at the DJJ clinics. Also, the risks that are designed to be managed by a custody classification system are different than those addressed by a risk and needs assessment system that is designed to drive case management and reentry planning. It is unclear to me whether DJJ

has thought through how these very different classification systems will be integrated. The danger here is that DJJ will end up with a series of overlapping, somewhat duplicative classification systems that may not be useful to line staff who are directly supervising the young people.

Development and Dissemination of New Policies Consistent with the S&W Remedial Plan

One crucial area in which very limited results have been achieved is in the updating and revising of DJJ policies to be consistent with the Standards and Criteria in the S&W Remedial Plan. In January of 2007, DJJ was to develop a table of contents for a new policy manual and to establish a master schedule for updating all relevant DJJ policies. This was not done. At the facility level, the superintendents and their staff are using Temporary Department Orders (TDOs) and policies that may date back 3-5 years. For example, the staff at Preston showed me the current policy on restricted housing that was from 2002. There is general awareness that many DJJ policies will change as part of the Farrell reform process. Indeed, we talked with staff at HGS, Preston, and Chad who worked on committees that were revising key policies. Managers at the facilities that I visited expressed the view that everything was on hold, awaiting decisions coming out of Headquarters. There is recognition at the facility that these new policies must be coupled with a plan for staff training and integration of the new policies with WIN Exchange. All of this suggests that fundamental changes in DJJ policies on issues such as use of force, restrictive housing, grievance policies, DDMS, access to religious services, among other topics, will be delayed into the future. More fundamentally, it is important to establish the importance of finishing and implementing new operational policies among the wide range of reform tasks being worked on by the understaffed DJJ Headquarters personnel. Prioritizing new policies will get even more complex as DJJ begins the implementation of new treatment programs and the realignment responsibilities for DJJ admissions with the counties. DJJ needs to avoid the situation of compounding delays that are already affecting the institutions. The pace of promulgating and training in new policies has contributed to the sense of facility staff (as measured by staff at HGS, Chad and Preston) that the direction of the DJJ is unclear to them, or that “things keep changing from week

to week." An additional aspect of this uncertainty will be the expected declines in the DJJ population due to SB 81 and the anticipated closures of several current DJJ facilities.

In my view, there will be few sustained changes in the confinement conditions for the DJJ youth until new reform policies are in place. Many of the promised reforms in the S&W Remedial depend on significant changes in DJJ policies. Managers and staff at DJJ facilities must still depend on formal policies that are several years old. Moreover, in a government bureaucracy, new policies and formalized procedures provide concrete examples for staff at all levels of the organization of the new treatment and reform philosophy that DJJ wants to institute.

In the recent past, DJJ leadership moved fairly quickly to change practices through the use of TDOs. For example, the reforms of Temporary Detention at some facilities resulted from TDOs. There is a sense among both Headquarters and institutions staff that the TDOs process has become bogged down and is no longer an effective way to alter policies and practices in an expedited manner. Also, it is unclear what, if any, role the CDCR top management now plays in the vetting of new policies. Reconciling policies for the much smaller DJJ operations within the massive prison operations of CDCR is a complicated job and may be contributing to delays.

In March, 2007, DJJ appointed a dedicated Headquarters staff person, Susan Sonoyama, to lead this policy development effort. It is not clear how many staff are assigned to Ms. Sonoyama to complete this assignment. There were also a number of policies to be completed in connection with several interim S&W areas such as access to attorneys, administrative lockdowns, and use of temporary detention, family visitation, and custody classification. These policy revisions are still under review by top management. Temporary Departmental Orders in the area of restricted programs were to be produced and disseminated by April 20, 2007. According to DJJ Headquarters staff, there are as many as 300-800 new policies or policy revisions that are required by the various Farrell remedial plans. It does not appear that there are currently sufficient staff assigned to complete this work in a timely fashion. The Farrell monitoring team should receive a complete listing of the policies that DJJ believes should to be revised to be consistent with the Remedial Plan. There needs to be a plan and timeline developed as to when these policies will be completed. In addition, DJJ must define a clear process of

review and approval of new policies so that progress in this area can be tracked. On several policy topics, I was told that the policy was virtually completed and was "awaiting approval by the executive team" or "it's on Bernie's desk." A more precise system of tracking policy development is needed.

I have only recently received working drafts of some of these policies and received a request from Sandra Youngen to provide her with some informal feedback on these policies. The overall DJJ position on sharing draft materials with the S&W Experts remains unclear. I have repeatedly asked to see drafts so that I could offer suggestions to DJJ. If policies can be seen only after they are formally published, this creates the situation in which DJJ will have to reopen the policy process if the S&W Expert or other Subject Area Experts express concern with the policies. This creates additional delays in implementing needed policy revisions. I urge DJJ to share reasonably complete draft polices and plans with the Farrell Experts so that we can offer advice for improvements in a timely fashion.

The Use of Restricted Housing or Programs in DJJ

Earlier reports that I wrote spoke about the heavy reliance of DJJ staff on restricted housing, lockdowns, criminal prosecutions, and the DDMS system to manage the very high levels of violence in its institutions. In the past these tools were over-utilized by DJJ staff and may have made the violence situation worse.

DJJ has made some definite progress in reducing the use of restricted housing units. There are regular management reports produced by Mark Blaser that track the use of temporary detention and SMPs at all DJJ facilities. In general there has been a decline in the numbers of youth placed in restricted housing units, a reduction in the use of temporary detention living units. Placement in a restricted housing unit is no longer viewed as an automatic response to a fight or to defiance of staff orders. There have been attempts to limit the use of restrictive housing for youth who are primarily in "danger from others." Staff are learning to utilize rooms on the living units to help defuse non-emergency situations and return youth to their regular living arrangements more quickly. DJJ has begun exposing staff to training on how to deescalate confrontations with youth through talking rather than resorting to chemical and physical restraints, and the use of

restricted housing. The time in temporary detention and the SMPs have been reduced, and DJJ has set up a good process in which Headquarters staff are working with facility managers to regularly review all youth in restricted housing and to attempt to prevent youth from getting lost in the process. Some of the successes may also be due to lower living unit sizes and much higher staff to youth ratios that allow for more dialog and interaction to resolve conflicts. It also appears that DJJ is housing youth facing new criminal charges for institutional behavior in local jails, or some are returned to regular living units if the staff determine that these youth do not pose a further violence threat. In the past, the youth facing criminal prosecution were routinely held in the SMP units, driving up the average length of stay in those units.

This progress, however, has not been fully uniform. For example, at Chad there were just 14 youth in TD and another 25 in the SMP program on the day of my visit. Of course, the overall Chad population is way down—about one-third of its size before admissions to Chad were closed off. The Chad restricted unit was primarily being used as a TD unit to manage problems that had emerged at the Dewitt Nelson facility. At Preston and HGS there were many more youths in restricted housing units than at Chad. In effect, all available beds in the restricted units were being utilized. HGS was housing a number of youth who were labeled as “Northern Hispanic” gang members in its restricted housing units. Although the HGS staff did not feel that all of these youth posed a serious danger to others or staff, they felt that the Northerners would be attacked by Southern Hispanic gang members. Several of the Northern youth complained to me and to staff that they wanted an opportunity to be in general housing units and to receive more programming time.

While admissions and length of stay in restricted housing units have declined, DJJ has made far less progress in reforming the operations of the restricted housing units. I made a physical inspection of restricted units at HGS, Preston, and Chad and generally found that the conditions in these units were deplorable. The cells were dimly lighted, there was graffiti throughout the units, sanitation conditions were below standards of decency in the rooms and in the hallways, and plumbing in the cells worked intermittently or poorly. Some facility staff report being aware of these plumbing issues, but I informed each of the superintendents at HGS, Chad, and Preston of the problems

that I observed. The general living conditions in the restricted units were, in my opinion, oppressive and punitive—certainly not conducive to a treatment and rehabilitation approach. I have been informed by DJJ that Sandra Youngen has issued a directive to remove graffiti from the rooms in the restricted housing units.

There was some painting of a few rooms taking place at HGS but few visible improvements were being made at Preston and Chad. It was clear from comments of managers at these three facilities that substantial improvements of current restricted housing units were not a top priority, either for them or for Headquarters staff. There appears to be an effort at these institutions to make repairs and to paint rooms that will be designated in the future as Mental Health or BTP units, but the S&W Remedial Plan called for these improvements to be completed in the restricted housing units by March, 2007. This is problematic at several levels and may reflect that the fundamental thinking about the content of the restricted housing programs has not changed very much. Further, many of these same units may be designated to house the new Behavioral Treatment Programs. It is hard to envision how an innovative psychological intervention program can take place in these depressing, unsanitary, and inhospitable living units.

For the most part, the regimen in the TDs and the SMPs had not changed as yet. Youth still spend at least 20 hours in their rooms each day, with three hours of program time and one hour of school. There are still some youth in restricted housing that get less time out of their rooms, based on staff judgments that they cannot interact with any other youth without creating violent situations. Outside recreation for most youths in restricted housing is still limited to barren cage-like structures with virtually no recreational equipment. It is difficult to see how this programming time meets the legal standard for large muscle exercise. Out-of-room time is still well below that envisioned by the S&W Remedial Plan. I believe that the education hours are below the goals of the Education Remedial Plan. Staff operating the restricted housing units are trying to be creative in getting youth out of their rooms for more hours a day, but they are often constrained by the utter lack of program or education space in these units.

Many staff at HGS, Chad, and Preston are awaiting information about the new Behavioral Treatment Programs. They have been told that these programs will be alternatives to the existing SMPs, but have yet to receive even rudimentary training on

the new program. Staff assigned to the restricted housing units continue to guide their interactions with youth on the basis of presumed threats of gang or racial violence. They work to move youth back to regular housing units by attempting a sort of "shuttle diplomacy" among the youth, or their groups, to achieve promises of temporary halts in hostility. While I was not able to determine how frequently the youth in the restricted housing units were seen by the clinical staff, I rarely if ever witnessed the clinical staff working on the restricted housing units to assist the YCC's in better managing the restricted housing units. This might be result of not assigning the clinical staff to the limited office space on the restricted housing units. In sum, the daily reality of the restricted housing units has changed little over the past year.

Monitoring the Use of Force

DJJ has established committees at each facility to review each instance of the use of force. These institutional force review committees (IFRC) meet on a monthly basis, and there are minutes of all these deliberations. In addition, there is a division-level force review committee (DFRC) that also reviews a sample of force instances. These groups go through a fairly thorough reading of incident reports and behavioral reports to reach a judgment about whether force was used appropriately and proportionately. There was a protocol developed by Headquarters that guides this review. Based on these reviews, there are recommendations about further actions including staff training, further inquiries, and other personnel actions.

My reading of the IFRC and DFRC meeting notes suggests that these reviews are usually completed in a thoughtful and serious manner. The main difficulty that the committees face is that the underlying reports written by line staff are incomplete or contradictory. Further, these reviews tend to focus on the amount and extent of force that was used as opposed to an analysis on what actions could have been taken to prevent the use of chemical or mechanical restraints. DJJ reports that there are also Joint Labor Management Staff Assault Committees that specifically look at preventive steps and corrective actions aimed at staff to avoid or minimize the use of force. I am unfamiliar with these committees and will request minutes on the content of these deliberations. It does seem that this particular focus on staff assaults should not remove the need of the

IFRC's to consider the appropriateness of alternatives to the use of force on a regular basis.

In the past, UOF reviews also covered statistical data on the time, location, and other aspects of the types of force being used. These statistical data are no longer routine parts of these more qualitative examinations of individual incidents. In the future, DJJ expects that the PbS data will be the main source of statistics on the use of force.

Besides these UOF reviews, DJJ has sent 18 staff to be trained in alternative strategies to manage facilities with reduced use of force. These staff are intended to be models and trainers for other DJJ staff. Also, at the request of the PLO the DJJ has instituted a pilot test program to examine methods of reducing the use of chemical agents. The launching of this pilot was somewhat delayed due to negotiations between the PLO and DJJ on how the pilot test program was to be implemented. It has been reinstituted with the agreed upon changes. I have not seen the results of the revised pilot test program so far.

Other Significant Reform Milestones

Develop a request for letters of interest for contract services for DJJ girls programs. Define a training agenda to support the S&W Remedial Plan. Identify the rehabilitation and treatment model and lay the foundation for the new reform approach.

In the area of reforming programs for girls in the DJJ, there has been a bit more progress accomplished. A "letter of interest" (LOI) was sent around the country to determine which agencies might be interested in contracting with DJJ to operate programs for young women committed the Division. DJJ did send me a copy of the materials that were sent out to prospective contractors for girls' services, but DJJ has not shared with me the results of this LOI and how that might change plans for the future of girls' programming in DJJ. The DJJ has received legislative authorization and funding to enter into contracts for programs for young women. There has been consultation with nationally known experts on gender-responsive programming—Dr. Barbara Bloom and Dr. Stephanie Covington, who are also advising CDCR on the design of women's

programs in the adult corrections system. A letter of interest to bring on board contractors so that the young women at the Ventura facility could be transferred to these programs was released. I was told that the response to the LOI was very limited and that several potential contractors felt that the contract amount was not sufficient to adequately provide for medical and mental health services in these contracted programs. It is my understanding that DJJ has revised the LOI in response to these issues. The plan is to reissue the RFP very soon. To date, I have not received a copy of the revised solicitation, so I cannot comment on the new content. It is not clear to me at this point what the timeline is for further actions on the reforms of DJJ programs for young women. Now would be the time for DJJ to offer a plan of next steps in this area.

Difficulties of working through the CDCR contracting process have also led to delays in retaining the services of several external experts to provide consultation in areas such as motivational interviewing and normative culture. This, in turn, has delayed the scheduling of interim training schedules in these areas. DJJ has recently expanded the existing contract of the Change Company to offer consultation and training in Interactive Journaling. There is also a contract being developed with faculty at UC San Diego to obtain assistance in implementing Motivational Interviewing. Another contract has been issued on the topic of Aggression Replacement Therapy.

The DJJ also shared with me an analysis of DJJ training needs pertinent to the Farrell remedial plans, which was prepared by California State University at Chico. This report by faculty at Chico State was somehow tied to legislative requirements to release existing training funds. I reviewed that report and found it inadequate to serve as a real training plan for DJJ. My comments are limited to the fairly short final report that was submitted. I did not review the request given to Chico State by DJJ. It is also worth noting that the project advisors consisted entirely of DJJ staff and did not include the Farrell Subject Matter Experts. I believe that our involvement might have substantially improved the final product, for example, in determining how the Chico State team derived its estimates on how long each module should take to complete. Like DJJ training currently, the Chico State plan does not specify the competency measures to be used to determine if the training objectives were met. At least, in terms of the S&W Remedial Plan, I do not think that this plan is sufficient to design, budget for, and implement a

significant training effort. I have shared the Chico State plan with the Office of the Special Master, and I believe that it is their intent to gather reactions to the existing plan for improved DJJ training with Experts in other areas of the Farrell case.

The Chico State report contains a fair amount of generic language about training. The plan presented is mostly about training in the Academy and leaves out training of managers and clinical staff. DJJ since has tasked Orbis Partners to develop a training plan on classification, treatment, and rehabilitation issues as part of their new contract, and the Chico State plan will cover other aspect of the Farrell reforms. The Chico State plan does seem adequate to cover the needed new training needs under the existing Farrell remedial plans. Further, the Chico State plan contains substantial overlaps with the proposed training to be designed by Orbis Partners.

Impressions on the Progress of Reform at HGS, Chad, and Preston

My visits to HGS, Chad, and Preston were primarily intended to assess the progress on the S&W Remedial Plan that was to be accomplished by at each facility in the past 12 months.

One of my visits occurred shortly after the release of a highly critical report on HGS that was disseminated by the Office of Inspector General (OIG). This report generated considerable media coverage and led to harsh criticism of DJJ top management by some members of the legislature. Staff at HGS were unhappy with the report and believed that some of its recommendations were incorrect. It was felt that the OIG report was corrosive to staff morale at the facility. At this point, I will not comment directly on the OIG report except insofar as its findings shed light on the current progress of the S&W Remedial Plan.

There is little question that violence is still a major problem at HGS. During each of my visits, I was told about group disturbances, assaults on staff, and hundreds of youth who engage in individual fights. For example, the HGS COMSTAT report for the first three months of 2007 showed 632 individual youth involved in physical altercations or "mutual combat," and there were 202 youth involved in similar incidents in April and May of this year. During my recent visit to HGS on August 15 and 16, there were serious

staff assaults that occurred each day. I was also told about a group disturbance that broke out during visiting hours, resulting in the spraying of chemical agents on relatives who were seeing their youth. Back in February and March of 2007, there was a rash of very serious assaults on staff. I was asked by DJJ top management to review the incidents of youth assaults on staff and to provide recommendations to curtail this violence.

A site visit report by Sara Norman of the PLO confirmed the existence of these problems at HGS. I have also received phone calls from media representatives who have visited HGS and noted the high levels of violence and tension among youth and staff.

Superintendent Ramon Martinez is well aware of the violence issue at HGS and is actively trying to reduce the problem. His response to recent incidents seems more measured than past Stark administrations. For example, he has tried to limit the duration and extent of lockdowns and temporary detention to the minimum, attempting to restore normal programming as soon as possible. Mr. Martinez recognizes that some of the violence is a result of racial and ethnic conflicts. He is trying to institute activities among the youth to reduce these tensions, building more inter-group cultural understanding. His staff are trying to model this cooperative spirit for the youth. Martinez had also recognized that idleness is a contributory factor to the violence. He is working hard to increase school offerings, recruitment of more teachers, and reducing class cancellations, which are still a significant problem at HGS. There also is a concerted effort to immediately identify as many as 200 work assignments that could be filled by youth at HGS and to encourage the residents to sign up for these work opportunities. Martinez has begun training his staff in a version of cognitive behavioral therapy to help his YCCs reduce the violence at the institution.

All of these steps have been initiated by Mr. Martinez on an ad hoc basis in advance of more formal and structured direction coming from DJJ Headquarters, but the HGS superintendent told me that he is regularly communicating with the Director of Institutions and her staff about his plans and actions. Headquarters staff want to be helpful to Mr. Martinez without trying to micromanage the daily activities at HGS. Managers at HGS are eager for training and consultation on how best to defuse the extremely racialized violence that is impacting the facility. There is a perceived need for

more clinicians to assist in the management of the most violent youths at HGS, even though these youth are not assigned to formal mental health units.

Mr. Martinez has put in place an ad hoc organizational chart for the facility that placed individuals in various positions at the facility consistent with the S&W Remedial Plan. It is hoped that these assignments will be formalized as soon as the Headquarters reform teams are filled. Further, Mr. Martinez is hopeful that the planned increases in budget, staffing, teaching staff, expanded training, and reduced living unit populations will help stem the violence at HGS. But, it is important to note that the current conditions at HGS are not conducive to the massive transformation in the culture and operation of that facility that is envisioned in the S&W Remedial Plan.

A few more observations relative to the OIG report are in order. The frustration by Headquarters and HGS staff about inaccurate findings in that report underscore the lack of reliable data that DJJ managers now possess to anticipate problems or to respond objectively to adverse reviews by others. Second, the OIG report highlights the urgent need to respond to significant issues in the capital plant at HGS that are likely to frustrate the planned reforms. The OIG report raises questions about how well staff at HGS understand the planned phase-out of the more traditional operational norms at restricted housing units at one of the most historically troubled DJJ facilities. Finally, the OIG report identifies concerns of sexual misconduct by youth and the presence of contraband at the facility. However, the OIG recommendations appear to endorse a return to past DJJ harsh security practices that are not necessarily in keeping with the philosophy guiding the sweeping reforms being undertaken by DJJ. While safety and security issues are crucial to a successful treatment model for DJJ, the Headquarters staff need to clearly articulate how they plan on responding to custody concerns as the reforms evolve. At a minimum, DJJ staff should offer a fuller briefing of the OIG staff as to the direction and status of reform efforts.

There is also great uncertainty among the staff at HGS as to the future of the facility. There is a possibility that the institution will be closed as part of the realignment of DJJ population. There is the rumor that Headquarters will not invest in fixing or enhancing the physical plant at HGS because it is slated to be closed. On the other hand, HGS is scheduled to become the first model treatment facility under the existing S&W

Remedial Plan. There seems to have been limited preparation for managers or line staff about what it might mean for them to become the prototype intensive treatment facility.

Staff at HGS are anxious to hear about the direction that DJJ reforms will take at their facility. They are not standing pat and are brainstorming ways to reduce the violence at HGS, but there is very much the sense that the future of HGS is uncertain.

Preston is another facility at which uncertainty about the future is palpable. Preston staff feel that they were the hardest hit in terms of the closing of admissions to Chad. Historically, Preston used transfers of its most disruptive youth to Chad as a sort of safety valve. Although the population at Preston has declined somewhat from previous years, there is still a serious problem in terms of youth assaulting each other and group disturbances. Data from COMPSTAT show an average of approximately 120-130 fights per month. While staff at Preston report that they have been able to contain about 60% of these fights without resorting to the use force, this level of youth-on-youth violence is still too high. When calculated based on the resident population, Preston actually possesses a higher violence rate per capita than HGS.

A particular problem, according to Preston staff, have been fights and attacks at the school. Staff report that most of these fights take place outside the classroom as part of either school movements or class changes. Whereas Preston managers believe that the new classification system is helping reduce problems at the living units, they feel that there is a need to strategize about how this classification approach can be used to reduce school-located violence. The superintendent and custody staff at Preston are seeking ways to have more communication with the education staff (who have a separate chain of command) on how to jointly solve some of the violence problems at Preston.

The current S&W and MH Remedial Plans call for the transfer of Preston youth in their mental health units to Chad. It is unclear whether the Preston staff that are assigned to these units will be following the youth to Chad. However, in November, staff at Preston were instructed to halt the plans for transfer of their youth to Chad. The superintendent told me that everything is “on hold” even though they have worked through detailed transition plans for the mental health units. Preston now operates the Reception Center and Clinic for Northern California, but it is unclear if the clinic function will remain at Preston. At this point is frustrating for Preston staff to envision

what their new mission will be under the changing reform plan. This has implications for staffing, facility repairs, and program planning. There appears to be less than a free flow of information between Preston and Headquarters staff. Preston staff are committed to working collaboratively with Headquarters staff, but the mechanisms of effective communication are being developed on both sides.

As with HGS, the Superintendent at Preston, Tim Mahoney, is continuing to find ways to improve their operations. Most impressive has been the launching of the Conflict Resolution Teams (CRT), under the supervision of Elaine Stenoski. The CRTs, in effect, provide additional staff that have been trained in defusing violence and conflict situations, who can be dispatched to living units that are experiencing the most problems. The CRTs can provide some respite for regular living unit staff, and offer one-on-one counseling and guidance for those youth that have special difficulties in avoiding violent situations. Preston has introduced Project Impact, which is designed to reduce gang-related violence in the institution. The very early results from Project Impact are promising.

Even though new reform policies have not been officially released, Preston staff have been adjusting their operations in the areas of Grievances, DDMS, and access to religious services to be able to quickly comply with the new mandates. There is clear support for the general thrust of the reform direction at Preston. They need and want to know their new role in the DJJ plan. A related issue is a shortage of psychologists at Preston. There have been issues recruiting and retaining clinicians, given the increase competition for these personnel from CDCR. Preston could use several additional psychologists to help manage their current population.

Staff at Preston also expressed concerns about vacancies that the facility experienced in plant operations and a range of facility repairs that have been requested over the past three years. Preston has been able to somewhat reduce the size of the living units in the SMP unit, but is still awaiting new recreation areas for these restricted housing units that have been requested since 2004. Preston managers note that the closing of intake at Chad has meant that Preston staff have been working hard to reduce the level of institutional violence without the option of moving youth to another facility. Preston

staff take pride in the youth from that facility that have been transferred to DJJ camps and seem to be performing well in those programs,

On my site visit in August, 2007, Chad presented a very different picture than the two facilities discussed above. The youth population at Chad was at 227, but staffing ratios were maintained at the levels when the population was higher. The institution that has been notorious for its violence and harsh security regime was much calmer and more relaxed. There were just 14 youth in the TD unit (mostly short-term placements from Dewitt Nelson and approximately 25 youth in other restricted housing programs). The number and severity of violent incidents were down. The staff reported that there were fewer gang fights, group disturbances and assaults on youth or staff. It was reported to me that both staff and youth felt much safer, and it was obvious to the observer that there was far more interaction between the staff and the youth than in previous days. The overall tone of Chad was much more focused on rehabilitation versus violence issues.

In my view, many of these positive changes were a product of the lower institutional population and the much higher staff-to-youth ratios. Living unit sizes at Chad were currently lower than what was envisioned in the S&W Remedial Plan. Some of the calm at Chad was purchased at the expense of increased tension at HGS, because some of the disruptive youth at Chad had been transferred down to HGS. Further, the leadership at Chad was working hard to change the organizational culture at the facility.

Some of the remaining concerns at Chad involved balancing various programs that were being made available to the youth. In the view of the superintendent, education, counseling, vocational programs, and other options were competing for the same limited daytime hours. The education staff wanted to maintain the regular school hours as defined by their union contract. This forced clinical programs, volunteer efforts, case work time, and other programs to be packed into the late afternoons, evenings, or weekends. Superintendent Umeda suggested that Chad experiment with a limited night school program, to reduce the “competition” for scarce daytime programming hours.

Another concern at Chad was a shortage of clinical staff. Superintendent Umeda felt that he was understaffed by at least five psychologists and one psychiatrist. While he believed that there were plans in the future to fill these positions, Chad may still be short-handed in the clinical positions needed to serve its population. The current shortage of

clinical staff at Chad is concerning, because current DJJ plans call for the transfer of a number of mental health programs and sex offender treatment programs to Chad. There is a question of whether the clinical team at Chad will be at full strength to handle this new mission.

As with Preston and HGS, Chad staff had many questions and uncertainty about how the reforms would impact their facility. There are some concerns that the declining population at Chad may place that facility on the list of DJJ institutions that will be closed or transferred to CDCR adult programs. The present halt in plans to move youth from Preston to Chad creates further uncertainty. As with the other facilities, the top staff at Chad are eager to embrace a new reform mission, but they feel that they lack sufficient information to help them plan for the needed changes. Similarly, staff at Chad would like greater dialog and exchange with DJJ Headquarters and the Reform Team to help shape several operational details of the transition process.

Concluding Observations

The DJJ has faced significant staffing and state bureaucratic obstacles in establishing the infrastructure of Headquarters management that was believed to be essential to enact the S&W Plan. Many deadlines have been missed, and DJJ will face an uphill battle to get back on schedule with the dates specified in the S&W Standards and Criteria. Also, it is somewhat unclear to me and to the leadership at several DJJ institutions as to the precise directions that reform will take over the next several months.

While it is essential that DJJ pick up momentum in the reform process over the next few months, it is equally important that the scope and direction of reform efforts be further clarified. For example, at a meeting with the Special Master and all of the Farrell Experts on Feb. 16, 2007, the DJJ management presented a complex plan to move youth among various living units, open units that were presently closed, and to begin the conversion of programming at Chad and HGS. The assembled Farrell Experts raised many questions about how these changes would be accomplished, and what staff preparation would be conducted. The DJJ indicated that there were “action plans” being developed and reviewed for each facility. The S&W and MH Experts offered to review

these draft action plans and to provide DJJ with timely feedback. To date, no action plans have been shared with this S&W Expert. I do not know if the other Farrell Experts have had the opportunity to review these transitional action plans.

I remain concerned that DJJ is behind schedule on several milestones of the reform effort. While some delays in the first 9-12 months of the S&W Remedial Plan may have been anticipated, it is unknown if the next reform deadlines will be met. Delays have a way of snowballing and impeding future progress towards needed reform. It may well be that the parties, the pertinent Subject Matter Experts, and the Court should review this situation and propose solutions to get the S&W Remedial Plan back on schedule.

The contractor who will guide DJJ in the development and implementation of the new intensive treatment model and behavior treatment programs has only recently been hired. We do not know the nature of the programs that will be recommended, or how long implementation of those programs will actually take. One can assume that change at DJJ will not be immediate and that the agency faces substantial challenges of changing the organizational culture, both at Headquarters and at the institutions to accommodate these reforms. It is also important to assess whether the new rehabilitation programs are adequately funded in future budgets.

This is a time of great uncertainty for DJJ. The Governor and Legislature seemed poised to adopt a “realignment” of state and county responsibilities that will profoundly affect the population to be served by the DJJ. For example, if DJJ will be serving a smaller population of youthful offenders that are principally charged with 707B offenses, this has implications for the sorts of services to be offered, living unit sizes, staffing ratios, and the kinds of evidence-based rehabilitation services that will be needed. The current Governor’s budget anticipates the closing of at least two DJJ facilities in the next two years. We will need to understand the implications of these closures on existing operations and for changes in the specifics of the S&W Standards and Criteria. It seems likely that DJJ and the plaintiff’s attorneys will very soon need to redefine key portions of the current Farrell agreements in light of changed circumstances at DJJ.

Recap of Recommendations of S&W Expert

1. DJJ needs to immediately recruit and hire a highly qualified Director of Programs.

2. The organizational roles of various Headquarters staff in the development and implementation of the S&W Remedial Plans need to be clarified, especially relative to overlapping issues with the Mental Health, Medical, and Education staff.

3. DJJ must complete the WIN Exchange System and develop a management strategy to integrate its several stand alone data systems. DJJ should make greater use of its research staff to analyze data to assist other DJJ managers in their planning and monitoring activities.

4. The custody classification process needs to be further refined, performance measures developed, and further refinements in policy and procedure be implemented.

5. DJJ must place a high priority on implementing an efficient process and timetable for developing and finalizing new policies that are central to the S&W Remedial Plan. Policies once promulgated must be supported by high quality staff training and effective monitoring of compliance with new policies.

6. DJJ must continue to substantially improve the conditions of confinement and the treatment of youth in its restricted housing units.

7. DJJ management should place renewed emphasis on reducing the unacceptable levels of violence at some DJJ facilities, especially HGS and Preston, including expanding the deployment of the Conflict Resolution Teams and consultation with national experts on reducing gang and racial violence in juvenile facilities.

8. DJJ needs to move quickly to prepare facility staff for the likely directions that will be part of the model rehabilitation and treatment programs, including the Behavioral Treatment Programs.

9. In this time of great uncertainty about the future of DJJ, it is imperative that Headquarters staff are in close contact with DJJ institutions and that there is two-way communications between staff and youth.

10. Due to the likely impact of SB 81 and facility closures, the parties in the Farrell case should begin evaluating certain aspects of the existing Remedial Plans and Standards and Criteria and whether they will require significant modifications.

Selected Safety and Welfare and Mental Health Remedial Plan Audit Items: Report of Findings

October 2007

Monitor Cathleen Beltz

Between May and August 2007, the monitor conducted site visits to all eight DJJ facilities.[1] Items monitored on site include (1) all Safety and Welfare Remedial Plan and Mental Health Remedial Plan action items designated to be monitored by the Office of the Special Master ("OSM") and with deadlines through May 2007 at the Stockton facilities and through June 2007 at Preston and the southern facilities; (2) additional mental health plan action items, at the request of the mental health experts for their review and with deadlines through May 2007 (Stockton facilities) and June 2007 (Preston and the southern facilities); and (3) updates to certain central office action items discussed in the fourth special master's report.

As always, DJJ facility administrators and staff were very accommodating during site visits. Facility staff provided invaluable assistance in scheduling staff and youth interviews, preparing for and assisting in document review, interpreting facility vernacular, and accompanying the monitor to housing units. The OSM is grateful for their assistance, and for the assistance of Doug Ugarkovich, DJJ *Farrell* Litigation Coordinator, who has been diligent in arranging for responses to the OSM's requests for information and coordinating site visits.

I. Safety and Welfare Remedial Plan

Dr. Barry Krisberg, *Farrell* Safety and Welfare Expert, Dr. Eric Trupin and Dr.Terry

[1] The monitor visited O.H. Close on May 22, 2007, N.A. Chaderjian on May 23, 2007, DeWitt Nelson on May 30, 2007, Southern Reception Center on July 30, 2007, Ventura on July 31, 2007, Stark on August 1, 2007, Preston on August 9, 2007, and El Paso de Robles on August 17, 2007.

Lee, *Farrell* Mental Health Experts, and the OSM share the responsibilities for monitoring and reporting on DJJ's compliance with the safety and welfare plan. This section of the report concerns only those items from the Safety and Welfare Remedial Plan Standards and Criteria designated for on site monitoring by the OSM as well as updates on certain information contained in the June 2007 report of findings attached as Appendix A to the Fourth Report of the Special Master.

A. Management Information Systems (S&W 2.3.1, 2.3.3a, 2.3.3b and 2.3.3c)[2]

To date, DJJ has not completed the WIN exchange.[3] DJJ is not in compliance with safety and welfare audit item 2.3.1.

As previously reported, DJJ successfully contracted with PbS and assigned a state-wide PbS coordinator.[4] The monitor reviewed PbS coordinator, AGPA (assistant government program analyst) and SSA (staff services analyst) duty statements and interviewed the PbS site coordinators and/or facility AGPAs or SSAs at all DJJ facilities. All of the facility PbS coordinators and analysts interviewed demonstrate an understanding of PbS and all report that they have sufficient time to perform all duties in PbS duty statements.[5] DJJ is in substantial compliance with safety and welfare audit items 2.3.3a, 2.3.3b, and 2.3.3c.

B. Violence Reduction Committees (S&W 3.3b)

The safety and welfare plan requires that DJJ facilities create violence reduction committees to review and evaluate incidents of violence quarterly and to develop plans to reduce violence and use of force.[6] The implementation deadline for this requirement was

[2] "S&W 2.3.1, 2.3.3a, 2.3.3b and 2.3.3c" refers to specific sections/items of the Safety and Welfare Remedial Plan Standards and Criteria. All "S&W" citations refer to the Safety and Welfare Standards and Criteria.
[3] Staff interviews, 2007 site visits.
[4] *See,* Fourth Report of the Special Master, Appendix A (Beltz Report) p. 6.
[5] Staff interviews, 2007 site visits.
[6] *See,* Safety and Welfare Remedial Plan, pp. 24-25 and 31.

January 1, 2007.[7] A pilot violence reduction committee was established at El Paso de Robles in October 2006 and by April 2007 six additional facilities had created committees that met at least once.[8] On May 2, 2007, Sandra Youngen, Director, Division of Juvenile Facilities, issued a memorandum to facility superintendents outlining the violence reduction committees' monthly and quarterly requirements and goals and directing them to establish committees at all DJJ facilities by May 18, 2007.[9] DJJ central office provided meeting minutes from El Paso de Robles, Heman G. Stark, N.A. Chaderjian, Preston and O.H. Close as well as two emails that reference committees at DeWitt Nelson and the Southern Reception Center.[10] The monitor spoke with violence reduction committee members at all DJJ facilities and was provided additional meeting minutes during some site visits.

El Paso de Robles created the first violence reduction committee pursuant to the safety and welfare plan in October 2006. Minutes provided during the August 2007 site visit at El Paso de Robles indicate its committee has met seven times.[11] Earlier, in February 2006, Heman G. Stark created a "Special Committee on Violence and Racial Hate Reduction," which met five times in 2006.[12] In March 2007, this committee became the Heman G. Stark "Violence Reduction Committee" and by August 1, 2000, it had met three times.[13] N.A. Chaderjian's violence reduction committee was established in March 2007, DeWitt Nelson's in April 2007 and O.H. Close's in May 2007. Minutes provided during the May 2007 site visits indicate that N.A. Chaderjian's committee had met monthly in March, April and May,

[7] *Id.* at 31.
[8] Violence Reduction Committee meeting minutes and emails, Liam Cowan and Dan Valdez, May 2007.
[9] *See* Attachment 1 (violence reduction committee memorandum, May 2007).
[10] Violence Reduction Committee meeting minutes and emails, Liam Cowan and Dan Valdez, May 2007.
[11] Meeting minutes for El Paso de Robles were provided for October 24 and November 16, 2006 and for January 18, March 15, April 19, June 21 and August 16, 2007.
[12] Meeting minutes for Heman G. Stark's Violence and Racial Hate Reduction Committee were provided for February 28, March 16, April 13, May 23, and October 25, 2006.
[13] Violence reduction committee meeting minutes were provided for March 9, May 24 and June 22, 2007.

DeWitt Nelson's committee had met twice in April and twice in May and O.H. Close's committee had met once.[14] Ventura's committee met first in March 2007 and again in May 2007 and has conducted two "Quarterly Reviews" of DDMS and use of force cases for the first and second quarters of 2007.[15] Southern Reception Center's committee was created in April 2007 and met once in April 2007 and once in July 2007.[16] Finally, Preston's violence reduction committee was established in March 2007 and as of August 9, 2007, had met four times.

Facility superintendents and violence reduction committee members interviewed understand the goal generally of reducing violence in their facilities and believe that committees have been helpful in beginning to reduce violence and use of force.[17] Interviews and meeting minutes indicate that each committee is devising its own system in efforts to meet the quarterly expectations outlined in the May memorandum and every member interviewed described successes they have had in identifying trends or reducing violence in their facilities.[18] At the time of the monitor's site visits, seven of eight DJJ facilities had sent meeting minutes to DJJ central office.[19]

Committee members interviewed report that additional guidance would be helpful in creating quarterly reports and violence reduction plans and that they do not understand exactly how the central office intends to measure the committees' progress.[20] Finally, committee

[14] N.A Chaderjian administrators provided committee meeting minutes for March 15, April 25 and May 16, 2007, DeWitt Nelson administrators provided minutes for April 11, April 26, May 1, and May 15, 2007, and O.H. Close administrators provided minutes for May 14, 2007.
[15] The OSM was provided meeting minutes from Ventura dated March 29 and May 16, 2007 and "Quarterly Reviews" for the first and second quarters of 2007.
[16] During the monitor's July site visit, staff at the Southern Reception Center reported that the committee has met at least once since the initial meeting April 26, 2007; however minutes were not provided for either meeting.
[17] Staff interviews, 2007 site visits.
[18] *Ibid.*
[19] Staff interviews, 2007 site visits.
[20] *Ibid*.

rosters reflect multidisciplinary membership and some members interviewed report that meetings provide a much needed forum for staff across disciplines to strategize together.[21] A few members interviewed report (and some meeting minutes reflect) waning attendance at meetings, which these members fear may indicate that committees are not yet well established[22]

C. Tracking Violence And Use Of Force (S&W 3.5 and 3.6a)

The OSM previously reported that by the end of June 2007, DJJ expected to modify its daily security operational reports to begin tracking injuries to youth, injuries to staff, injuries to youth by other youth, assaults on youth and assaults on staff.[23] This will allow DJJ to record daily data for PbS safety outcome measures 2-4, 11 and 12. On June 11, 2006, DJJ provided a draft "Daily Operations Report" that standardizes tracking of these outcome measures across facilities. In July, DJJ reported that the tracking system was in beta testing and anticipated implementation in August 2007 to coordinate with its activation of the WIN exchange.[24]

D. Conversion Of DJJ Facilities To The Rehabilitative Treatment Model (S&W 6.1b, 6.6, 6.4a, 6.4b, 6.4c and 6.4d)

The safety and welfare plan requires DJJ to begin its conversion to a rehabilitative treatment model by reducing youth populations and increasing housing unit staffing.[25] Heman G. Stark was the first facility scheduled for population and staffing changes by January 1, 2007, followed by Preston July 1, 2007.[26] Initial changes require that housing units converting to core programs not exceed 36-38 youth per unit and that they meet the

[21] *Ibid.*
[22] *Ibid.*
[23] *See,* Fourth Report of the Special Master, Appendix A (Beltz Report) p. 6.
[24] DJJ Quarterly Report, July 2007, Safety and Welfare Remedial Plan Matrix p. 6.
[25] *See,* Safety and Welfare Remedial Plan pp. 45, 46 and 49 *and* S&W 6.1b.
[26] *Ibid.*

staffing standards outlined on pages 45 and 46 of the safety and welfare plan. Population has declined and many of what will become core program units are within the safety and welfare plan population guidelines.

DJJ provided the OSM with "administrative summaries" for Heman G. Stark that show facility population data.[27] From May 7, 2006 to June 5, 2007 Heman G. Stark's population declined from 830 youth to 757 youth. The facility has four general population units in two wings (each identified as a "company"), "E&F company" and "W&X company." From May 7, 2006 to June 5, 2007, E&F company declined from 106 youth assigned to 75 youth assigned and W&X company's population went from 96 assigned to 77 assigned.

DJJ youth are currently housed according to risk classification and administrative summaries do not detail the number of youth on each "side" of a company. During the August 1, 2007 site visit, Heman G. Stark administrators provided an exact count of youth present on each unit.[28] E&F company had 73 youth present, 24 on E side and 49 on F side. W&X company had 71 youth present, 37 on W side and 34 on X side. Facility administration reports that general population units are currently staffed commensurate with remedial plan requirements.[29] Four additional units, "O & R Company" and "U & V Company," will also transition to core programs once DJJ implements the treatment model at Heman G. Stark. Populations on those units on August 1, 2007 were, 34 on O side, 34 on R side, 42 on U side and 28 on V side.

[27] Heman G. Stark administrative summaries, May 8, 2006 and June 6, 2007.

[28] Administrative summaries provide two population counts, one of youth assigned to a given unit and one of youth actually present on a unit. Youth assigned, but not present are being temporarily housed on another unit such as facility medical or temporary detention units or are off facility grounds. Administrative summaries are updated daily to reflect "assigned" and "actual" counts.

[29] Units are staffed with mental health clinicians, youth correctional counselors, senior youth correctional counselors and youth correctional officers commensurate with plan requirements. Facility administration reports that case manager positions, which are intended to be filled with casework specialists, are currently being filled by youth correctional counselors.

During the August 9, 2007 site visit, Preston provided administrative summaries for June 15, 2006 and August 5, 2007. From June 2006 to August 2007, Preston's population declined from 435 youth to 382 youth. Preston currently has six units ("lodges") that will transition to core programs. On August 5, 2007, all but two lodges met the population guidelines outlined in the safety and welfare plan.[30] In addition, Preston administrators report that all but two core program lodges are staffed consistent with the remedial plan requirements. The monitor did not review staffing documentation for Preston's general population units; however, unit staff interviewed report that there are more staff and fewer youth on the units.[31] DJJ is in partial compliance with safety and welfare audit item 6.1b.

The safety and welfare plan requires DJJ to eliminate all of its "special management programs" and establish "behavior treatment programs" for youth exhibiting violently disruptive behavior.[32] By January 1, 2007 DJJ was required to develop a Program Service Day Schedule for Heman G. Stark's behavior treatment program unit to, "maximize out-of-room time and to ensure structured activity based on evidence based principles for 40 to 70 percent of waking hours. . ." and to begin operating the program in accordance with the approved schedule.[33] The implementation deadline for the program service day schedule at Preston was July 1, 2007.[34] Development and implementation of the program service day schedules has been delayed.[35] DJJ has not provided an anticipated implementation date for this item. DJJ is not in compliance with safety and welfare audit item 6.6.

[30] Preston core program lodges (and populations on August 5, 2007) include, Buckeye (33 youth), Evergreen (35 youth), Fir (40 youth), Greenbriar (35 youth), Hawthorne (37 youth) and Manzanita (46 youth).
[31] Staff interviews, August site visit.
[32] *See*, Safety and Welfare Remedial Plan, p. 49
[33] *See*, Safety and Welfare Remedial Plan, p.57 and S&W 6.6 audit criteria.
[34] S&W 6.6.
[35] Statements of DJJ staff, DJJ central office meeting, May 2007 *and* DJJ Quarterly Report, July 2007, Safety and Welfare Remedial Plan Matrix p 9.

The safety and welfare plan requires that DJJ fill or assign staff to several key positions and create conflict resolution teams at DJJ facilities.[36] The implementation deadline for these requirements was January 1, 2007 for Heman G. Stark and July 1, 2007 for Preston.[37] DJJ reports that it has not yet filled the facility Administrator of Programs or Program Manager positions at any DJJ facility.[38] DJJ is not in compliance with safety and welfare audit items 6.4a and 6.4b.

DJJ provided an AGPA "Positive Incentive/Volunteer Coordinator" duty statement and documentation showing it filled the Heman G. Stark coordinator position in October 2006.[39] DJJ filled the position at Preston ahead of schedule in September 2006. Other facilities have filled volunteer/positive incentives coordinator positions as well. DeWitt Nelson hired a coordinator on September 18, 2006 and N.A. Chaderjian hired its coordinator on May 23, 2007.[40] The monitor spoke with volunteer/positive incentives coordinators at Heman G. Stark, Preston and DeWitt Nelson. All three coordinators demonstrate an understanding of facility ward incentive programs and report that they are motivated to plan activities that reward youth for positive behavior.[41] Coordinators report generally that they have sufficient time to perform all tasks in their duty statements, but need more time for recruiting and coordinating volunteers.[42] Coordinators at Heman G. Stark and Preston are assigned only volunteer positive incentives coordinator duties. As of May 2007, DeWitt Nelson's coordinator was assigned only incentive program duties. She was, however,

[36] *See,* Safety and Welfare Remedial Plan, p. 57.
[37] S&W 6.4a-d.
[38] Statements of DJJ staff, DJJ central office meeting, May 2007 and staff interviews, August site visits.
[39] DJJ "Request for Hire" and "Notice of Personnel Action" and staff interviews and document review, August site visit, *and see,* Attachment 2 (duty statements for SSA and AGPA Youthful Offender Incentive/Volunteer Coordinator Facility). DeWitt Nelson's position was filled in September 2006 and N.A. Chaderjian's in May 2007.
[40] Staff interviews, May 2007 site visits.
[41] Staff interviews, 2007 site visits.
[42] *Ibid.*

responsible for coordinating programs for all three Stockton facilities until N.A Chaderjian and O.H. Close filled their positions. N. A. Chaderjian administrators report that they filled the coordinator position on May 23, 2007.[43]

At the time of the 2007 site visits, the remaining facilities had not yet been authorized to fill volunteer/positive incentives coordinator positions; however, O.H. Close, Ventura and Southern Reception Center administrators have assigned the volunteer/positive incentives coordinator duties to one or more program managers and/or youth correctional counselors.[44] These staff generally report that they spend a portion of their time planning activities for youth, although their work does not conform to the volunteer/positive incentives duty statements.[45]

El Paso de Robles has filled the coordinator position with a retired annuitant to plan and coordinate the El Paso de Robles Ward Incentive Program and to supervise three additional retired annuitants who coordinate recreational activities for youth.[46] Youth in DJJ are assigned to one of three incentive levels, "A" (the highest level), "B" and "C." Youth move among incentive levels based on institutional behavior and other factors. Youth and staff interviewed at El Paso de Robles report a substantial increase in incentive and recreational activities for youth at A and B incentive levels.[47] The acting coordinator at El Paso de Robles provided copies of detailed monthly memoranda and incentive, recreational and "special activity" schedules as well as youth rosters that detail activities offered on a weekly rotation for all eligible youth.[48] At O.H. Close, the facility manager and DDMS

[43] Follow-up phone conversation, May 2007.
[44] *Ibid.*
[45] *Ibid.*
[46] Staff interviews, August 2007 site visit.
[47] *Ibid.*
[48] Site visit, August 2007.

coordinator who is assigned the bulk of the positive incentives coordinator duties provided a schedule of incentive activities that shows several activities are scheduled each month.[49]

Generally, coordinators and staff interviewed report that the incentive program activities are reserved for youth at A and B incentive levels.[50] A few coordinators, however, report that they plan activities for C level youth to motivate them to advance in the program.[51] Preston's coordinator spends time on living units talking with C level youth to address behavior problems and provides them with small rewards (such as pizza) for improved behavior.[52] DJJ is in partial compliance with safety and welfare audit item 6.4c.

On April 27, 2007, Sandra Youngen issued a memorandum authorizing five facilities to recruit and interview applicants for facility conflict resolution teams, but directed them not to commit the positions to applicants pending further notice.[53] The Conflict Resolution Team Program Statement is attached.[54] In May 2007, DJJ central office reported that implementation deadlines for the conflict resolution teams were delayed pending labor negotiations.[55] In June, facility superintendents were authorized to appoint current facility staff to conflict resolution teams.[56] Heman G. Stark identified five of its conflict resolution team members on July 2, 2007 and in August 2007, administrators told the monitor that they expected to complete team assignments in the near future.[57] The team currently consists of two youth correctional counselors and three parole agents.[58] Duty statements for "Conflict

[49] Document review, May 2007 site visit.
[50] Staff Interviews, 2007 site visits.
[51] *Ibid.*
[52] Staff interviews, August 2007 site visit.
[53] *See*, Attachment 3 (conflict resolution team memorandum, April 2007).
[54] *See*, Attachment 4 (conflict resolution team program statement).
[55] Statements of DJJ staff, DJJ central office meeting, May 2007.
[56] Staff interviews, August 2007 site visits. Five facilities were authorized for conflict resolution teams: Heman G. Stark, El Paso de Robles, DeWitt Nelson, Preston, and O.H. Close.
[57] Staff interviews, August 2007 site visits.
[58] Staff interviews, August 2007 site visits.

Resolution Team Leader" and "Conflict Resolution Team Member" are attached.[59] In August, two team members attended the first of two three-week crisis intervention and conflict resolution training sessions.[60]

Preston's conflict resolution team was essentially in place on July 1, 2007.[61] It is currently staffed with four youth correctional counselors and four parole agents. Preston administrators expect to assign one additional parole agent to the team.[62] Three team members attended the crisis intervention and conflict resolution training sessions in August 2007.[63] Preston administrators expect that they, in turn, will provide needed conflict resolution training to remaining team members.[64] Preston's program administrator responsible for supervising the conflict resolution team has developed a statement identifying the team's role and an outline for responding to group disturbances that is based on the needs of youth at that facility.[65] Implementation deadlines for conflict resolution teams at the remaining facilities are January and July 2008.[66] DeWitt Nelson, O.H. Close and El Paso de Robles are expected to have teams in place ahead of schedule.

E. System Reform For Females (S&W 7.1 and 7.4)

The safety and welfare plan requires that DJJ issue a request for letters of interest from local government entities and qualified private parties to provide "secure residential and rehabilitative" contract services to DJJ's female population.[67] The implementation deadline

[59] *See* Attachment 5 (duty statements for conflict resolution team leaders and members).
[60] Staff interviews, August 2007site visit.
[61] *Ibid.*
[62] *Ibid.*
[63] *Ibid.*
[64] *Ibid.*
[65] Document review, August 2007 site visit.
[66] S&W 6.4d.
[67] *See,* Safety and Welfare Remedial Plan p. 58.

for this requirement was July 1, 2006.[68] Also by July 1, 2006, DJJ was required to request legislative authority and funding to contract for those services.[69]

In April 2006, DJJ sent a formal "Request for Information" regarding contract services for girls and young women to approximately 150 stakeholders and potential bidders.[70] DJJ received 24 responses to its request for information, 10 from private and non profit entities and 14 from county probation departments.[71] DJJ also received legislative authorization and funding for contract services. Specifically, the Governor's budget for fiscal years 2005-06 and 2006-07 proposed $5.2 million and $47.5 million respectively for implementation of the safety and welfare plan over five years. DJJ is in substantial compliance with safety and welfare audit item 7.4.

Since the request for information and receipt of responses, DJJ has consulted with national experts on gender-responsive programming and issued a "Request for Proposals" to contractors. The *Farrell* safety and welfare expert reports that responses from potential contractors indicate that DJJ underestimated the cost of contract services for women.[72] As a result, DJJ will issue a revised request.[73]

F. Designation Of Community/Court Liaison Staff (S&W 8.1.2)

The OSM previously reported that by November 2006, DJJ had filled three of four community/court liaison positions.[74] Liaisons are responsible for improving "communication, relationships, and collaboration with community, courts, probation and law

[68] S&W 7.1
[69] *Ibid.*
[70] DJJ provided the OSM a copy of a cover letter to "Juvenile Justice Stakeholders/Potential Bidders" from Bernard Warner, dated April 17, 2006, and a formal "Request for Information" regarding contract services for girls and young women as well as an "RFI Master Mailing List" with 154 recipients.
[71] DJJ provided copies of responses to its request for information.
[72] *See,* Fourth Report of the Special Master, Appendix A (Krisberg report, August 2007) pp. 22-23.
[73] *Ibid.*
[74] *See,* Fourth Report of the Special Master, Appendix A (Beltz Report) p. 7.

enforcement."[75] DJJ has since provided documentation that it filled the fourth liaison position in June 2007, which it anticipates will allow for additional outreach to counties. DJJ is in substantial compliance with safety and welfare audit item 8.1.2.

G. Changes To DJJ's Disciplinary Decision Making System And Procedure For Review Of Eligibility To Restore Time (S&W 8.4.2a, 8.4.2b and 8.4.6b)

The safety and welfare plan requires that DJJ reduce the maximum time allowed for disciplinary fact finding hearings from 24 to 14 days after youth are notified and, for cases sustained at fact finding, reduce the maximum time allowed for disposition hearings from 14 to seven days.[76] The implementation deadline for these requirements was March 31, 2007.[77] DJJ has not completed a policy on its Disciplinary Decision Making System ("DDMS") and provided neither a draft policy nor projected completion or implementation dates for a new policy. Staff at all DJJ facilities are, however, aware of the 14 and seven day requirements of the safety and welfare plan and some facilities are implementing guidelines proactively.

At O.H. Close, N.A. Chaderjian and DeWitt Nelson, the monitor reviewed DDMS documentation for the month of April 2007. At O.H. Close, all 19 DDMS fact finding hearings in April 2007 were held within the required 14 days and most were completed within 7 days.[78] Of the 14 cases sustained at fact finding, all disposition hearings were completed within 7 days.[79] At N.A. Chaderjian, all nine DDMS fact finding hearings in April 2007 were completed within 14 days.[80] All nine were sustained at fact finding and disposition hearings were held within three days.[81]

[75] *See*, Safety and Welfare Remedial Plan, p. 61.
[76] *Id.* at 70
[77] S&W 8.4.2a and 8.4.2b.
[78] Document review, May 2007 site visit.
[79] *Ibid.*
[80] Document review, May 2007 site visit.
[81] *Ibid.*

At the Southern Reception Center, the monitor reviewed DDMS documentation for May 2007. The Southern Reception Center issued 58 level three disciplinary write-ups in May 2007. Of those, five went to fact finding.[82] All five fact finding hearings were completed within 14 days of youths' notification of the write-ups and three of the five were completed within seven days of notification.[83] Two DDMS actions were sustained at fact finding and both disposition hearings were completed within seven days.[84]

At Preston, the monitor was provided DDMS documentation available in Preston's WIN system for July 2007. Of the 173 level three DDMS write-ups issued in July 2007, 34 went to fact finding.[85] Fact finding hearings for 22 of the 34 cases were completed within 14 days.[86] Twenty-nine cases were sustained at fact finding and of those, 10 were completed through disposition within seven days.[87] The remaining cases at Preston as well as cases reviewed at all other DJJ facilities were generally adjudicated within current 24 and 14 day policy guidelines.[88] Typically, where deadlines exceeded current requirements, extensions were requested and relevant notes were made and/or documentation was attached.[89] Some facility administrators express concern that the new guidelines will be difficult or impossible to meet unless additional staff are allocated to assist with the processing of DDMS cases.[90] DJJ is in partial compliance with safety and welfare audit items 8.4.2a and 8.4.2b.

The safety and welfare plan requires that DJJ ensure that youths' eligibility for time restoration to sentences lengthened by DDMS serious misconduct/violations is reviewed at all

[82] Document review and staff interviews, July 2007 site visit. The rest were either dismissed or youth admitted to the behavior and fact findings hearings were unnecessary.
[83] Document review and staff interviews, July 2007 site visit.
[84] *Ibid.*
[85] Document review and staff interviews, August 2007 site visit.
[86] *Ibid.*
[87] *Ibid.*
[88] Document review and staff interviews, 2007 site visits.
[89] *Ibid.*
[90] Staff interviews, 2007 site visits.

case conferences and that reviews are noted in WIN.[91] The implementation deadline for this requirement was March 31, 2007.[92] The monitor spoke with both DJJ central office staff and parole agents at all DJJ facilities.. Parole Agents review youth sentences for time restoration eligibility and make recommendations accordingly. Currently, if a youth is eligible for time restoration (if a youth has "earned back" time according to automatic WIN calculations), a notification pops-up on the WIN screen directing staff to confirm eligibility.[93] Most parole agents interviewed report following this procedure in preparation for case conferences.[94] DJJ is revising its policy to incorporate requirements for systematic review and documentation of time restoration eligibility.[95]

Review of time restoration eligibility is one of many important procedures that will be streamlined with the WIN exchange. Currently, WIN only calculates time restoration eligibility for each youth by facility after one year.[96] Youth who transfer between facilities may be eligible for time restoration, or have write-ups making them ineligible, based on behavior at previous facility assignments that is not systematically reviewed at current facility case conferences.[97] The only way to accurately evaluate the eligibility for time restoration for youth who have transferred between facilities is to manually review youth "field files" that contain DDMS information from previous facility assignments.[98] Parole agents interviewed report that they review field files upon youths' requests (pursuant to current policy) or when

[91] *See,* Safety and Welfare Remedial Plan, p. 71, *and* S&W 8.4.6b audit criteria
[92] *Ibid.*
[93] Staff interviews, 2007 site visits.
[94] *Ibid*.
[95] Statements of DJJ staff, DJJ central office meeting, May 2007, *and* staff interviews, 2007 site visits.
[96] *Ibid., and* follow-up telephone conversations, June 2007.
[97] Staff interviews, 2007 site visits and follow-up telephone conversations, June 2007. However, youth also receive annual case conferences during which time restoration is always calculated manually.
[98] Staff interviews, 2007 site visits.

they believe youth may be eligible for time restoration.[99] With the WIN exchange, eligibility for time restoration will be automatically calculated to account for facility transfers and the information will be readily accessible to housing unit staff.[100] DJJ is in partial compliance with safety and welfare audit item 8.4.6b.

H. Time Adds And Program Credits (S&W 8.6.3a, 8.6.3b, 8.6.4b and 8.6.4c)

The safety and welfare plan requires that DJJ revise existing time restoration policies to (1) allow for time restoration to eligible sentences after six months of good behavior rather than the current 12 months and (2) round up rather than down the number of months restored to sentences where youth parole board dates are extended an odd number of months.[101] The implementation deadline for these requirements was March 31, 2007.[102] Time add policy revisions have been delayed and DJJ has not provided projected revision/implementation dates for these policy provisions. DJJ is not in compliance with safety and welfare audit items 8.6.3a or 8.6.3b.

The safety and welfare plan also requires that DJJ revise current policy to (1) ensure youth receive full program credit if their absence from school or failure to participate in work or treatment occurs through no fault of their own and (2) develop standards for awarding incentive points for youth participation in restorative justice projects.[103] On April 10, 2007, Jay Aguas, Deputy Director of Juvenile Facilities, sent a memorandum to facility superintendents reminding them to provide youth with full program credit when non-

[99] *Ibid.*
[100] *Ibid.*
[101] *See,* Safety and Welfare Remedial Plan, pp. 73-74.
[102] *Ibid.*
[103] *Ibid.*

participation is not the youths' fault.[104] Most youth interviewed are generally aware that they are entitled to full program credit if they are unable to participate in facility activities through no fault of their own.[105] Some youth interviewed report receiving this information from their youth correctional counselors or parole agents.[106] Some youth were unable to remember how they received the information and some were unaware of the requirement.[107] At units observed, the information was not yet posted on unit information boards.

The monitor spoke with parole agents and/or youth correctional counselors at all DJJ facilities who, along with representatives from education and other facility departments, make up youth treatment teams. Treatment teams are responsible for assigning program credits and making recommendations for time "cuts"/credits to DJJ Youth Authority Administrative Committees (YAAC) and parole boards.[108] The number of program credits a youth accumulates is considered to reflect a youth's progress toward rehabilitation and is a determining factor in his or her eligibility for parole. Treatment team members interviewed report providing full program credit whenever youth are unable to participate in treatment, work or educational programming through no fault of their own.[109] Most report that this is not a new practice, but rather a procedure that was already in place prior to the April 2007 memorandum.[110] DJJ is in partial compliance with safety and welfare audit item 8.6.4b.

Sandra Youngen issued a memorandum, effective June 1, 2007, to facility superintendents and facility incentives coordinators detailing points standards for eight restorative justice activities and individual achievements for which youth may earn incentive

[104] *See,* Attachment 6 (program credit memorandum, April 2007).
[105] Youth interviews, 2007 site visits.
[106] *Ibid.*
[107] *Ibid.*
[108] Staff interviews, 2007 site visits.
[109] *Ibid.*
[110] *Ibid.*

points.[111] Youth interviewed after June 1, 2007 appear to understand that they are to receive "credit" for participating in restorative justice activities or for completing certain individual achievement activities or educational goals, but none had seen the memorandum and were not aware specifically of the eight achievements listed or the points values for each.[112] At units observed after June 1, the information was not yet posted on unit information boards.

Facility administrators have generally assigned the planning of restorative justice activities and the rewarding of points for those activities to facility volunteer/positive incentives coordinators or other staff allocated incentive coordinator duties.[113] Individual achievement points for educational successes, such as earning a high grade point average, a high school diploma or a GED are automatically entered in each youth's record via the automated ward incentive program. The seven remaining restorative justice or individual achievement goals must be observed and noted by facility staff, submitted to the superintendent for review and tracked manually.[114]

Coordinators at facilities visited after June 1, 2007 had begun the planning needed to incorporate the requirements into their ward incentive programs. Most coordinators and acting coordinators report they need additional time or staff support in order to plan and assign points for restorative justice or other individual achievement activities.[115] By the August 9, 2007 site visit, Preston had begun to make substantial progress toward providing incentive points for restorative justice and other activities pursuant to the restorative justice memorandum.[116] Preston's positive incentives coordinator has conducted block training on

[111] *See,* Attachment 7 (restorative justice and individual achievements memorandum, May 2007).
[112] Youth Interviews, 2007 site visits.
[113] Staff interviews, 2007 site visits.
[114] *Ibid.*
[115] *Ibid.*
[116] Document review and staff interviews, August 2007 site visit.

the ward incentive program for unit staff and spends time on each unit orienting youth to the ward incentive program generally and to the individual achievement and restorative justice opportunities specifically.[117] For English language learners, the coordinator enlists help from Spanish speaking staff to ensure youth understand the program requirements.[118] Preston's coordinator plans restorative justice activities at least quarterly, holds regular student council meetings and has implemented a peer counseling/mentoring program that allows youth to earn incentive points.[119] The coordinator reports that participation in these activities is giving youth a sense of accomplishment and is already resulting in improved behavior.[120] DJJ is in partial compliance with safety and welfare audit item 8.6.4c.

I. Grievance System (S&W 8.5.1, 8.5.2, 8.5.3, 8.5.4 and 8.5.5a)

The safety and welfare plan requires that DJJ revise the existing Ward Grievance and Staff Misconduct Complaint policies to ensure, among other provisions that: (1) grievance forms are accessible on all living units without the assistance of a grievance clerk or facility staff; (2) lock boxes are installed on all units for submission of forms to prevent loss; (3) grievance clerks will be trained to ensure adequate supplies of grievance and staff misconduct forms are available and will assist youth in the grievance process; (4) youth are notified upon receipt of a grievance or allegation of staff misconduct form; and (5) facility grievance coordinators prepare monthly reports summarizing prior months and identifying long term trends and possible areas for corrective action. The implementation deadline for these items was March 31, 2007.[121]

DJJ did not provide the OSM with a copy of its draft grievance policy, but in May

[117] *Ibid.*
[118] Staff interviews, August 2007 site visit.
[119] Document review and staff interviews, August 2007 site visit.
[120] Staff interviews, August 2007 site visit.
[121] *See,* Safety and Welfare Remedial Plan p.71.

2007, it reported that the policy was being prepared for executive review in mid June 2007.[122] Pending necessary negotiations and other procedures, DJJ was unable to estimate when the policy would be finalized or implemented. DJJ has not provided updated information or an anticipated completion date for the new grievance policy. The grievance coordinators at all DJJ facilities are, however, aware of anticipated policy revisions.[123] Coordinators at DeWitt Nelson have prepared "preliminary" information packets and have conducted orientations to new policies for grievance clerks and facility managers.[124]

DJJ provided a memorandum from Sandra Youngen, dated December 20, 2006, to facility superintendents requiring facilities to install lock boxes on all units by March 1, 2007 and instructing them to order locks and provide keys to facility grievance coordinators.[125] It also states new policies would be implemented in March 2007.[126] In May 2007, the monitor observed that lock boxes had been installed on living units in all three Stockton facilities and by the end of the rounds of site visits in August 2007, lock boxes were in place at all facilities. All boxes observed are clearly stenciled "Grievances" and all youth interviewed are aware of them.[127] DJJ is in substantial compliance with safety and welfare audit item 8.5.2.

By the August 2007 site visits, one facility had begun implementing portions of the new grievance policy. At El Paso de Robles, grievance forms are available to youth without assistance and youth insert grievance forms onto lock boxes rather than handing them to unit staff for processing.[128] At remaining DJJ facilities, youth were still required to request grievance forms from (and submit completed grievances to) grievance clerks or living unit

[122] Statements of DJJ staff, DJJ central office meeting, May 2007.
[123] Staff interviews, 2007 site visits.
[124] Staff interviews and document review, May 2007 site visit.
[125] *See,* Attachment 8 (grievance policy memorandum, December 2006).
[126] *Ibid.*
[127] Site visits and youth interviews, May 2007.
[128] Youth interviews, August 2007 site visit.

staff.[129] As of the August 2007 site visit, DJJ was not in compliance with safety and welfare audit item 8.5.1.

None of the facilities have implemented new procedures for monthly reporting and notification of receipt of grievances and staff misconduct allegations.[130] Facility administrators indicate that they are not implementing new grievance policy provisions pending their completion and further instruction from DJJ central office.[131] At some facilities, staff expressed relief that grievances would be processed by facility grievance coordinators instead of unit staff.[132] On one intake unit, there seemed to be some confusion about whether or how much of the grievance policy was implemented.[133] Staff reported that they instructed the youth to use the lock boxes to submit grievances and believed that youth were following their instructions.[134] They expressed that their workload had been reduced now that they no longer "have to deal with grievances."[135] Grievance forms, however, were not available to youth without assistance from grievance clerks and youth interviewed report that they never received instruction from staff or youth grievance coordinators.[136] Most youth interviewed on that intake unit were unaware of who unit grievance clerk or facility grievance coordinators were or how to obtain grievance forms.[137] This confusion will presumably be eliminated once the grievance policy is finalized and unit staff, grievance coordinators and unit clerks receive training in the new policy. DJJ is not in compliance with safety and welfare audit items 8.5.3, 8.5.4 and 8.5.5a.

---

[129] Staff and youth interviews, 2007 site visits.
[130] Staff interviews, 2007 site visits.
[131] *Ibid.*
[132] *Ibid.*
[133] Staff and youth interviews, 2007 site visits.
[134] Staff interviews, 2007 site visits.
[135] *Ibid.*
[136] Youth interviews, 2007 site visits.
[137] *Ibid.*

II. Mental Health Remedial Plan

Dr. Eric Trupin, Dr.Terry Lee and the OSM share monitoring and reporting responsibilities on DJJ's steps toward compliance with the Mental Health Remedial Plan. This section of the report concerns items from the Mental Health Remedial Plan Standards and Criteria designated to be monitored by the OSM that require on site monitoring as well as updates to certain information reported in the June report of findings attached as Appendix A to the Fourth Report of the Special Master.

A. Screening And Assessment (MH 4.4 and 4.5)[138]

The mental health plan requires that DJJ administer the Massachusetts Youth Screening Instrument-Version 2 ("MAYSI-2") and the Suicide Risk Screening Questionnaire ("SRSQ") to all youth within 24 hours of their arrival at a DJJ facility.[139] The implementation deadline for this requirement was September 1, 2006. Currently, DJJ does administer the MAYSI (version 1) as part of a three part "treatment needs assessment" completed for all youth within 21 days of intake, consistent with current policy.[140] Current DJJ policy requires that youth are administered the SRSQ within 24 hours of intake. The monitor reviewed documentation showing SRSQ administration at all DJJ facilities. All DJJ facilities currently administer the SRSQ within 24 hours of intake.[141]

B. Reduce Size Of Mental Health Treatment Units (MH 5.14a and b)

As part of the conversion to a rehabilitative treatment model discussed in section D above, the mental health plan requires that DJJ reduce the population assigned to its Intensive Treatment Programs (ITP) and Specialized Counseling Programs (SCP) to no more than 30

[138] "MH 4.4 and 4.5" refers to those sections/items of the Mental Health Remedial Plan Standards and Criteria. All "S&W" citations refer to the Safety and Welfare Standards and Criteria.
[139] *See*, Mental Health Remedial Plan, pp. 16-17 and 19.
[140] Statements of DJJ staff, DJJ central office meeting, May 2007 *and* staff interviews, 2007 site visits.
[141] Document review, 2007 site visits.

youth and reduce the population assigned to its Intensive Behavior Treatment Programs (IBTP) to no more than 20 youth (exclusive of youth mentors).[142] The implementation deadline for this requirement was June 30, 2007.[143] Currently, all but two of the eight DJJ facilities have an ITP and/or SCP and an SBTP (Special Behavior Treatment Program): N.A. Chaderjian has an ITP and SCP; Southern Reception Center has an ITP; Ventura has an ITP and SCP; Heman G. Stark has an ITP and SCP; Preston has an ITP, SCP and SBTP and Paso has an SCP.

At the time of the site visits, the treatment model and facility transitions/movements had not yet been implemented. Each of DJJ's residential mental health programs, however, was populated according to safety and welfare plan guidelines. Some unit populations were reduced ahead of schedule: on May 22, 2007, N.A. Chaderjian's ITP had 16 youth assigned and its SCP had 31 youth assigned and 29 present on unit; on July 29, Southern Reception Center's ITP had 24 youth assigned; on July 1, Ventura's ITP and SCP had 15 and 18 youth assigned respectively; Heman G. Stark's ITP had 28 youth assigned and its SCP had 29 youth assigned and 30 present on unit; on August 5, Preston's ITP and SCP had 27 and 18 youth assigned respectively and Preston's SBTP had 20 youth assigned and 18 present on unit; finally, on August 16, El Paso de Robles' SCP had 26 youth assigned to the unit. In July, DJJ reported that it would conduct daily monitoring of residential mental health program populations.[144] DJJ is in substantial compliance with mental health audit items 5.14a and 5.14b.

C. Collaboration With California Department Of Mental Health (MH 5.20)

The safety and welfare plan requires that DJJ begin meeting periodically with the

[142] *See*, Mental Health Remedial Plan, pp. 28 and 44.
[143] MH 5.14a and 5.14b.
[144] DJJ Quarterly Report, July 2007 Mental Health Plan Matrix, p. 6.

Department of Mental Health ("DMH") to "strengthen communication, expedite transfers to DMH of youth who are appropriately referred for inpatient mental health services, and facilitate transition of youth no longer in need of such care back to DJJ facilities."[145] The implementation deadline for this requirement was November 30, 2006. The OSM previously reported that DJJ provided documentation that its staff met with DMH staff in October 2006 and January 2007 and created a "DJJ Coordinated Clinical Assessment Team ('CCAT') Process" to resolve issues with DMH referrals.[146] In July, DJJ reported that it held a third meeting in May 2007.[147] DJJ is in partial compliance with mental health audit item 5.20.

D. Par Parity With Comparable Adult Division Staff (MH 7.1)

By September 1, 2006, DJJ was required to ensure pay parity for DJJ mental health care providers with comparable staff employed by CDCR adult operations.[148] The OSM previously reported that DJJ provided a pay letter from the Department of Personnel Administration, issued April 16, 2007, "(i)n accordance with the *Farrell v. Allen* consent decree". . . "(d)irecting DJJ to implement the health care services remedial plan. . ." The letter identifies pay differential and salary range amendments that include key mental health positions.[149] DJJ is in substantial compliance with mental health audit item 7.1.

E. Implementation Of The Mental Health Plan (MH 12.1, 12.2 and 12.3)

By February 29, 2007, DJJ was required to appoint a "senior administrator with experience in implementing mental health programs to oversee and direct implementation of [the mental health] remedial plan and its coordination with other remedial plans."[150] In July

[145] *See,* Mental Health Remedial Plan, p. 45.
[146] Emails, agenda and meeting minutes, Katie Riley.
[147] DJJ Quarterly Report, July 2007 Mental Health Plan Matrix, p. 2.
[148] *See,* Mental Health Remedial Plan pp. 56 and 60.
[149] *Ibid.*
[150] *See,* Mental Health Remedial Plan, pp.75-76.

2007, DJJ reported that this position has not been filled because it is "on hold."[151] DJJ is not in compliance with mental health audit item 12.1.

By October 31, 2006, DJJ was required to hire or appoint four senior clinicians and/or senior administrators, "with expertise in mental health services" to the Program Development and Implementation Team (or "Reform Team").[152] The OSM previously reported that as of May 31, 2007, there were two senior clinicians on the team.[153] In July 2007, DJJ reported that a third position had been filled.[154] DJJ is in partial compliance with mental health audit item 12.2.

By January 31, 2007, DJJ was required to create a "dedicated mental health training team consisting of three or more licensed clinicians plus an instructional designer and office technician."[155] As of May 31, 2007, the office technician position was filled with a staff support analyst.[156] No other team members have been identified.[157] In July 2007, DJJ reported that these positions have not been filled because they are "on hold."[158] DJJ is not in compliance with mental health audit item 12.3.

F. Family Involvement—Mental Health Expert Monitoring Of Safety And Welfare Action Items (S&W and MH 8.3.2a, 8.3.2b and 8.3.3)

The safety and welfare plan requires that DJJ facilitate phone contact between a youth and his or her family within 24 hours of arrival at DJJ reception centers, "to assist youth in early adjustment to his/her confinement."[159] The implementation deadline for this

[151] DJJ Quarterly Report, July 2007, Mental Health Plan Matrix p. 2.
[152] *See*, Mental Health Remedial Plan, pp.75-76.
[153] *See*, Fourth Report of the Special Master , Appendix A (Beltz Report) p. 7.
[154] DJJ Quarterly Report, July 2007, Mental Health Plan Matrix p. 2.
[155] *See*, Mental Health Remedial Plan, pp.75-76.
[156] Statements of DJJ staff, DJJ central office meeting, May 2007.
[157] *Ibid*.
[158] DJJ Quarterly Report, July 2007, Mental Health Plan Matrix, p. 4.
[159] *See*, Safety and Welfare Remedial Plan, pp. 62 and 70.

requirement was November 1, 2006.[160] DJJ provided a September 11, 2006 memorandum from Ed Wilder, former Director of Juvenile Facilities, sent to Ventura, Preston and Southern Reception Center (DJJ's reception centers) instructing them to ensure all youth have phone contact within 24 hours of arrival and to document the calls in phone logs.[161] The memorandum did not specify whether youth were permitted direct dial calls (free of charge to youths' families) or collect calls using DJJ collect call phones.[162]

On June 11, 2007, Sandra Youngen issued a memorandum to all facility superintendents directing them to ensure youth receive a direct dial phone call to their families or guardians within 24 hours of arrival at any DJJ facility.[163] The June directive includes youth entering DJJ as parole detainees and also requires that facilities permit youth to make second direct dial calls within 24 hours of their permanent assignment to a DJJ facility or upon parole revocation.[164] Generally, all youth and staff interviewed report that youth are permitted to call their families upon arrival.[165] In order to ensure youth make initial phone contact, the supervising casework specialist at Southern Reception Center issued a memorandum and the Preston administrators have prepared a draft facility policy tailored to their facilities' needs.[166]

Most youth and staff interviewed report that youth have always been permitted to make direct dial calls upon arrival at DJJ reception centers.[167] Some staff interviewed report that prior to the June directive, policy was unclear and some youth were only allowed access

[160] *Id.* at 70.
[161] *See,* Attachment 9 (initial call memorandum, September 2006).
[162] *Ibid.*
[163] *See,* Attachment 10 (family phone contact memorandum, June 2007).
[164] *Ibid.*
[165] Staff and youth interviews, 2007 site visits.
[166] Memorandum, "Follow-up of 24 Hour Phone Contact Procedure at SYCRCC" dated July 17, 2007 *and* "Initial Notification of Parent or Guardian" (draft), Preston, provided during July and August site visits.
[167] Staff and youth interviews, 2007 site visits.

to collect call phones. However, staff interviewed report that the June directive made clear DJJ's policy on initial calls and all youth and staff report that youth now receive initial calls to their families consistent with DJJ policy.[168] Nearly every youth interviewed reported that they were permitted to make an initial direct dial call to his or her family within the first day.[169]

DJJ staff report, and review of manual tracking systems indicates, that tracking of initial calls is inconsistent and lacks uniformity across facilities. Staff interviewed report that tracking phone calls, including each attempt by youth to reach unavailable family members, is burdensome and a simplified tracking system would reduce workload.[170] Southern Reception Center staff provided a print out of a current WIN system palette for a "phone log" for each youth that identifies dates each call is placed, the number called, the recipient's relationship to the youth, whether the call was completed and the staff facilitating the call.[171] The palette is, however, currently inoperative and staff interviewed did not know if they will be using WIN to track phone calls in the future.[172]

The safety and welfare plan requires that DJJ ensure youth have phone contact with families or guardians on "a regular basis."[173] The implementation deadline for this requirement was December 1, 2006.[174] DJJ central office as well as facility staff and youth interviewed report that youth have regular access to collect call phones based on ward incentive levels and points earned.[175] Staff and youth interviewed report that many youth

[168] *Ibid.*
[169] Youth interviews, 2007 site visits.
[170] Staff interviews, 2007 site visits.
[171] WIN 2006 "Ward Phone Log," provided during July 2007 site visit.
[172] Staff interviews, 2007 site visits.
[173] *See*, Safety and Welfare Remedial Plan pp. 62 and 70.
[174] MH 8.3.2b.
[175] Staff and youth interviews, May 2007 site visits.

cannot contact their families on DJJ collect call phones.[176] Among other reasons, many families have "collect call blocks" on their phones and are unable to receive calls from DJJ collect call phones.[177] Some youth interviewed report being allowed to make direct dial calls on housing unit phones.[178] Others report that they are never permitted to make direct dial calls to their families.[179] Most unit staff interviewed report allowing youth to make some direct dial calls.[180] Youth and staff report that the frequency and duration of these calls may vary depending upon the facility, the unit or the staff member. Some staff interviewed report never providing direct dial calls. Others report that they must receive authorization from youths' parole agents when providing direct dial calls to families. Still others report using their own discretion in allowing youth to contact families. At Southern Reception Center, youth are allowed to make direct dial calls to families during visits to facility chaplains. Chaplains report that they allow all you to make calls on a rotating basis. All staff interviewed report monitoring calls carefully and ensuring that the youth are actually calling their families or guardians when making direct dial calls.

The safety and welfare plan requires that DJJ arrange for "family visiting days" at least four times a year.[181] The implementation deadline for this requirement was March 1, 2007.[182] Facility staff report that DJJ central office has not issued a directive regarding this requirement.[183] However, most facility administrators interpret the family visiting days to include family visits in addition to those provided during DJJ's regular weekend and holiday

[176] *Ibid.*
[177] *Ibid.*
[178] Youth interviews, 2007 site visits.
[179] *Ibid.*
[180] Staff interviews, 2007 site visits.
[181] *See*, Safety and Welfare Remedial Plan pp. 62 and 70.
[182] S&W 8.3.3.
[183] Staff Interviews, 2007 site visits.

visiting schedule.[184] Most facility administrators report that facilities are beginning to hold regular "family nights" that range from extending weekend visiting hours to planning weeknight events with families that include dinner and movies.[185] O.H. Close held a "family night" in November 2006. N.A. Chaderjian held two family nights in March and May 2006 and DeWitt Nelson held family visiting days in February and May 2007.[186] Southern Reception Center had a family night in June 2007, Ventura scheduled family events in April and June 2007 and Heman G. Stark arranges family nights monthly.[187] Preston held two family nights in May.[188]

Most staff report planning family nights based on the ward incentive program allowing youth on "A" or "B" incentive levels to participate. Heman G. Stark administrators report scheduling family nights for all youth on a rotating basis.[189] Chad administrators report that all youth from participating units were invited to attend a pizza party regardless of incentive level and even if youth had no family members present.[190] Ventura administrators report inviting all family members to a facility concert and a youth high school graduation ceremony regardless of youth incentive levels.[191]

Mental Health Review Of Youth On Mental Health Caseload Facing Disciplinary Time Add (MH 8.6.1a and 8.6.1b)

The mental health plan requires that a non-treating mental health professional review all write ups for infractions subject to disciplinary hearings that are committed by youth on

[184] *Ibid.*
[185] *Ibid.*
[186] Staff interviews and document review, site visits, May 2007.
[187] Staff interviews, July and August 2007 site visits.
[188] Staff interviews, August 2007 site visit.
[189] *Ibid.*
[190] Staff interviews, July 2007 site visit
[191] Staff interviews, 2007 site visits.

the mental health caseload.[192] Reviewing mental health professionals will ensure that infractions committed are not the result of youths' mental health diagnoses or treatment plan's and ensure that disciplinary dispositions are appropriate given youths' diagnoses and treatment.[193] The plan requires that disciplinary hearing committees include a mental health professional with no clinical relationship to youth whose dispositions are being determined.[194] The implementation deadline for these requirements was September 1, 2006.[195]

The monitor spoke with administrators and mental health clinicians at five of eight DJJ facilities regarding this requirement.[196] Staff interviewed report that they have not yet received directives specific to the requirements but some facility administrators were aware of them.[197] El Paso de Robles administrators report that mental health clinicians are involved in every DDMS adjudication involving youth on the mental health caseload.[198] They provided documents regarding that facility's three "most recent" disciplinary dispositions for mentally ill youth. Each set of DDMS documents was initialed by a mental health clinician.[199] Administrators were not sure whether the reviewing mental health professional had a clinical relationship with youth involved in the disciplinary proceeding.[200] Some facility administrators interviewed report that for residential mental health programs, clinicians review all write-ups, but that clinicians do not yet systematically review write-ups for all youth on the mental health caseload.[201]

G. Implementation Plan For Offices And Mental Health Treatment Rooms (MH 11.1)

[192] *See,* Mental Health Remedial Plan, p. 24.
[193] *Ibid.*
[194] *Id.* at 66.
[195] MH and S&W 8.6.1a.and 8.6.1b.
[196] This requirement was not addressed during site visits to the Stockton complex in May 2007.
[197] Staff interviews, August 2007 site visit.
[198] *Ibid.*
[199] Document review, August 2007 site visit.
[200] Staff Interviews, August 2007 site visit.
[201] Staff interviews, 2007 site visits.

The mental health plan requires that DJJ create a plan for renovating existing structures and using modular buildings to create additional office and mental health treatment space.[202] Specifically, the plan requires that mental health clinicians be given sufficient office space that is appropriate for treatment, provides a therapeutic milieu and areas for confidential conversation.[203] Additionally, the space must be sufficient so that no regular mental health programs must be cancelled due to lack of space.[204] The implementation deadline for this requirement was January 31, 2007.[205]

DJJ provided email communication dated April 25 and 26, 2007 reflecting the monitor's request for the implementation plan and a responsible staff member's brief response.[206] The monitor was not able to interview the responsible staff person. DJJ has commenced some projects to add mental health office and treatment space, and some facility administrators interviewed report that they were told they would receive additional space.[207] Two facilities showed the monitor copies of plans for additional space.[208] Some projects have been temporarily halted due to regulatory issues.[209] Most staff and clinicians interviewed report that clinicians do not have sufficient treatment space.[210] The Farrell Sexual Behavior Treatment Expert, Dr. Barbara Schwartz, observed that one sexual behavior treatment group met regularly held in a busy corridor.[211] DJJ has not yet provided a coherent plan for the necessary renovations or anticipated completion dates for this requirement.

---

[202] See, Mental Health Remedial Plan pp. 72-73.
[203] *Ibid.* and MH 11.1 audit criteria.
[204] MH 11.1 audit criteria.
[205] MH 11.1
[206] Email, Keith Beland, April 26, 2007.
[207] Staff interviews, 2007 site visits.
[208] *Ibid. and* document review, 2007 site visits.
[209] Staff interviews, 2007 site visits.
[210] *Ibid.*
[211] SBTP site visit, May 2007.

Dated: October 24, 2007

_____

Cathleen Beltz
Monitor

Farrell v. Hickman
First Report of Consent Decree by the Medical Experts

Based on Site Visits Conducted

August 23, 2006 to February 15, 2007

Submitted September 13, 2007

FARRELL MEDICAL EXPERTS

Joe Goldenson, MD
Madie LaMarre, MN, APRN, BC

Contents

Introduction

In February 2006, the Health Care Services Remedial Plan (Remedial Plan) was accepted by the parties and filed with the Court. During the course of the year, DJJ's Health Care Services staff worked on implementing the Remedial Plan, focusing initially on hiring headquarters staff and developing health care policies and procedures.

Mike Puisis, DO, departed as one of the Farrell medical experts and with agreement of the parties, was replaced by Joe Goldenson, MD, in August 2006. The medical experts drafted a Health Care Audit Instrument based on standards and criteria in the Remedial Plan and in consultation with the parties and Special Master. From August 2006 to January 2007, the medical experts conducted site visits to Health Care Services at headquarters, and to each DJJ youth facility to field test the audit instrument and to generally assess the status of health care delivery in the facilities. Following these site visits, we developed two documents that were circulated to the parties for comment and discussion:

- a draft audit instrument
- detailed instructions for using the audit instrument to conduct audits

This first report includes a summary of our headquarters and facility site visits. We have included initial assessments of compliance for the Headquarters audit tool. However, because the primary purpose of the first round of site visits was to field-test the audit instrument, our facility findings are somewhat general and do not include assessments of compliance. In this report, we have also included recommendations to address identified problems or to improve efficiencies. A draft version of the report was sent to the parties prior to submission. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated August 8, 2007.

We would like to thank DJJ staff for their cooperation and assistance during our site visits.

Methods of Assessment

During our headquarters and facility site visits, our assessment methods including the following:

- Tours of the facility medical units, Correctional Treatment Centers (CTC), housing units and administrative-segregation units
- Interviews with medical, nursing, ancillary, correctional staff, and youth
- Review of tracking logs and medical records
- Observation of selected health services such as medical reception, nursing triage, and medication administration
- Review of documents including policies and procedures, and treatment manuals
- Review of staffing patterns and professional licensure

Glossary of Acronyms

AGPA	Associate Government Program Analyst
BCP	Budget Change Proposal
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Health Services Administrator
CMO	Chief Medical Officer
CTC	Correctional Treatment Center
DGS	Department of General Services
DON	Director of Nursing
DPA	Department of Personnel Administration
FMLA	Family and Medical Leave Act
HCS	Health Care Services
HCSRP	Health Care Services Remedial Plan
ITP	Intensive Treatment Program
LOC	Loss of Consciousness
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBP	Monthly Budget Plan
MTA	Medical Technical Assistant
NP	Nurse Practitioner
OHU	Outpatient Housing Unit
OT	Office Technician
PCP	Primary Care Provider
PHN	Public Health Nurse
RFB	Request for Bid
RN	Registered Nurse
SCP	Specialized Counseling Program
SRN	Supervising Registered Nurse
SSA	Staff Services Analyst
TDO	Temporary Departmental Orders
UHR	Unified Health Record
YCC	Youth Correctional Counselor

Health Care Organization, Budget, Leadership, and Staffing

The medical experts visited DJJ Health Care Services (HCS) on August 23-24, 2006 to conduct an initial assessment of HCS progress with respect to implementation of the Health Care Services Remedial Plan (HCSRP). We subsequently conducted a follow-up visit on February 14-15, 2007. At that visit, we evaluated the status of health care using the draft Health Care Audit Instrument audit tool entitled "Health Care Organization, Budget, Leadership, and Staffing."

We thank HCS staff for their assistance and cooperation during these visits. Our findings and assessment of compliance with the questions in the audit tool are described below.

Question 1: The Health Care Services Table of Organization is consistent with the HCSRP (pages 9-10).

DJJ has not finalized a table of organization for Health Care Services. DJJ staff has informed the medical experts that in the final version, the Statewide Medical Director/Director of Health Services will report to the Director of Programs. This is not consistent with the Remedial Plan, which requires that the Statewide Medical Director report to the Chief Deputy Secretary.

DJJ staff stated that the reorganization of the California Youth Authority (CYA) into the Department of Corrections and Rehabilitation, Division of Juvenile Justice (CDCR, DJJ) was directed under Senate Bill SB737. Within that piece of legislation, the structure of DJJ was designed as follows: the Chief Deputy Secretary has overall responsibility for the operations of DJJ. Under the direction of the Chief Deputy Secretary there are three Divisions with a Director appointed over each; the Division of Juvenile Facilities, the Division of Juvenile Programs, and the Division of Juvenile Parole Operations. Although not specifically designated by the legislation, DJJ has determined that Health Care Services is one of the entities that reports through the Division of Juvenile Programs. In addition, DJJ holds that the Remedial Plan does not require that the Medical Director reports directly to the Chief Deputy Secretary, and permits and indirect reporting relationship. The medical experts do not agree with this interpretation of the Remedial Plan and believe that the Plan provides for a direct reporting relationship.

The position of Director of Juvenile Programs is currently vacant, so the Medical Director reports directly to the Chief Deputy Secretary at this time. However, when this position is filled, the Medical Director/Health Services Director will report to the Director of Juvenile Programs and not directly to the Chief Deputy Secretary. Thus, while the department is currently compliant with the remedial plan, when the proposed organization is fully implemented, it will no longer be in compliance.

Although SB737 establishes a broad organizational structure, it is unclear that this legislation specifically prevents the Statewide Medical Director from reporting to the Chief Deputy Secretary. The medical experts' concern is that historically, correctional systems underestimate the complexity of health care service delivery, and often treat health care as simply another program. This often results in inadequate support for health care and in avoidable morbidity and mortality. Thus, the Remedial Plan organizational model was proposed to elevate health services in the organizational structure to ensure that health care issues are given adequate voice and weight in the organization. The medical experts agree that the proposed organizational model is

not the only one that can promote success of the health care program. However, we remain concerned that the position of health services in the proposed organizational structure is potentially problematic, particularly if the Director of Programs has no experience in health care administration.

DJJ has informed the experts that a finalized table of organization will be presented at a court hearing in October 2007. After the DJJ table of organization has been finalized and operationalized, the experts will review and monitor the progress of implementation of the health program and determine if the new structure is acceptable.

Assessment: Non-Compliance

<u>Question 2:</u> The DJJ organizational structure has established a centralized model for health care delivery, supervision, and oversight. Health Care Services has authority over facility personnel decisions including decisions to hire and discipline staff.

As noted above, DJJ has not issued a final table of organization.

Interviews with facility staff during the expert's site visits raised a concern related to the current organizational structure at the institutions. According to the Remedial Plan, headquarters clinical staff, (e.g., Medical Director, Chief Psychiatrist, Chief Dentist, and Director of Nurses etc.) provides clinical supervision of their respective counterparts in the field. The facility Chief Medical Officer (CMO) is to provide administrative supervision of all health care services staff. However, staff at the facilities stated that CMOs administratively supervise health administrators, nurses and physicians; but do not administratively supervise dentists and mental health staff. Staff reported that historically the CMOs were not supportive of the needs of the dentists and mental health staff and, rather than address the issue directly with the CMOs, the reporting relationships were changed. During our tours, CMOs reported that they were generally unaware of the activities of the dentists and mental health staff. This practice does not promote administrative accountability or collaboration. The superintendent is administratively responsible for all areas of the facility, and the CMO should be administratively responsible for health care services at each facility.

Assessment: Not evaluated due to lack of a finalized table of organization.

<u>Question 3.</u> Key HCS leadership positions (HCSRP pages 9-12) are budgeted, filled, or being effectively recruited. Pay parity exists with CDCR.

The following key HCS positions are budgeted and filled:

- The Statewide Medical Director position is budgeted and is technically vacant; however, the position is filled through a contract with UCLA.
- Director of Nurses
- Chief Psychiatrist
- Chief Dentist (there are three Chief dentist positions)
- Pharmacy Services Manager

The following key HCS positions are either not budgeted or filled:

- The Health Care Administrator (HCA) position is not a budgeted position. The HCA occupies a Correctional Health Care Administrator II position from Heman G. Stark. Staff reported that the process of establishing a budgeted position is underway.
- At the time of our review, the Standards and Compliance Coordinator position was established and available to be filled. We have been informed that the position was subsequently filled and the coordinator began working in June.
- The Clinical Record Administrator position was filled, but then vacated in August 2006. Staff reported that this it is very difficult to recruit for this position, since statewide salary levels are not competitive with the private sector. In the interim, HCS has developed an RFB to obtain the services of a contractor to provide administrative record oversight until a permanent staff can be recruited.

We were provided a copy of the Department of Personnel Administration (DPA) pay letter 06-46B that was issued on December 15, 2006. This pay letter brings all of the salaries for applicable DJJ health care workers in parity with health care staff working in CDCR Adult Services.

Assessment: Partial Compliance

<u>Question 4.</u> The Statewide Medical Director position is filled or being effectively recruited and provides competent oversight and leadership of DJJ Health Services in compliance with Remedial Plan requirements (page 10). The Medical Director has medical autonomy for the health care program.

Robert Morris, MD, Professor of Pediatrics at UCLA, is the Statewide Medical Director. He is on a contract position, and normally works Tuesday to Thursdays. Dr. Morris reported that he is available when he is not in the office and often works more than 40 hours per week. When Dr. Morris is at headquarters, he often attends meetings that last much of the day, even when the meetings do not directly relate to health care operations.

With respect to implementing the Remedial Plan, Dr. Morris has:

- Overseen the development and distribution of 29 of 32 initial policies and procedures
- Distributed chronic disease guidelines to the CMOs
- Filled physician vacancies with board-certified or eligible primary care physicians
- Organized and conducted quarterly statewide health care meetings attended by medical, nursing, mental health, and dental staff. The medical experts have attended several of the meetings and found them to be very informative and constructive, encouraging communication and teamwork.
- Medical autonomy over the health care program

In addition, the Remedial Plan calls for the development and implementation of a health care standards and compliance program and a quality management program that includes peer review. According to the plan, both of these programs were due in June. The experts have recently been informed that these programs are currently being developed.

Assessment: Partial Compliance

Question 5. The Statewide Director of Nurses position is filled or being effectively recruited and provides competent leadership and oversight of nursing services in compliance with the Remedial Plan (page 11). The DON has clinical authority for nursing services.

The Statewide Director of Nurses position was vacated on 1/24/07, but filled again in May 2007 by Ms. Cathy Ruebusch, RN. Ms. Louise Allen, RN, previous Director of Nurses, was instrumental in the completion of the initial policies and procedures. However, other aspects of the nursing program, such as training program for nursing physical assessment and protocols, remains to be developed and implemented.

Assessment: Partial Compliance

Question 6. The Health Care Administrator (HCA) position is filled or being effectively recruited and provides competent administrative leadership. The HCA has developed a comprehensive health care budget that includes monthly tracking and reporting for each line item (e.g. pharmacy, hospitalizations, equipment and supplies, etc) per facility. The HCA provides administrative support to clinical staff to ensure that operational systems are functioning smoothly.

The HCA position has been filled since January 2005. Beginning in the 2005-2006 fiscal year, a comprehensive health care budget was established for each facility as well as for headquarters. Also beginning with the 2005-2006 fiscal year, Health Care Services at each facility was required to submit a comprehensive Monthly Budget Plan (MBP) identifying all projected expenditures for each line item. The HCA at headquarters reviews each of these MBPs, and obtains clarification on questionable projections, whether under- or over-projected. The experts will monitor the completeness of the budget tracking process in future visits.

Assessment: Partial Compliance

Question 7. The health care budget is adequate to meet all the requirements of the Health Care Service Remedial Plan. The integrity of the health care budget is maintained (funds are not diverted to other programs except when approved by the Chief Deputy Secretary).

A health care budget has been established. The budget plan provides a detailed chart of accounts for various expenditures. At the time of our review, the health care budget included non-health related expenditures such as Youth Correctional Counselors (YCCs) assigned to specialized treatment programs (e.g., Intensive Treatment Program). This makes it difficult to accurately assess health care expenditures. It is our understanding that as of July 1, 2007, Health Care Services has a completely separate budget that does not include non-health related expenditures. The medical experts will re-evaluate this issue during future visits.

Assessment: Deferred

Question 8. There are job descriptions for each budgeted position in the DJJ Office of Health Services.

We requested and were provided a job description and duty statement for each central office position.

Assessment: Substantial Compliance

Question 9. HCS has developed and implemented a structured, written orientation program for headquarters and field staff. All new headquarters staff is oriented within 30 days of hire. Personnel orientation is documented and maintained in personnel files.

HCS staff has developed a structured, written orientation program for headquarters staff. This is a new program that has not yet been implemented at the time of our visits because no new employees have been hired since its development. The plan is for supervisors to provide specific training to new employees based on their specific assignment. The orientation is to be documented via a checklist that is maintained in the supervisory file.

HCS staff is currently working to develop a standardized health care orientation program for facility staff. For field staff, there is currently a generic 40-hour orientation program at each facility that is mandated for all new employees. The employee then receives specific training based on their assignment. These records are maintained at each facility in the training department (facility orientation) and in the supervisory file (job specific training).

Assessment: Partial Compliance

Question 10. HCS has developed and implemented initial policies and procedures, and health record forms in collaboration with the Medical Experts. These policies are reviewed and updated annually, and as necessary.

The Office of Health Services, in collaboration with the medical experts, has developed an initial set of 29 of 32 policies and procedures and accompanying forms. The Peer Review, Credentialing, and Organizational Structure policies have not been finalized. The remaining policies and procedures are still in draft, pending approval of labor review; however, they have been disseminated to the field as Temporary Departmental Orders (TDOs). Facility staff is in the process of writing local operating procedures to implement the statewide policy.

Assessment: Partial Compliance

Question 11. DJJ Office of Health Services has developed chronic care policies and procedures and clinical guidelines that are consistent with nationally accepted standards of care (e.g., Centers for Disease Control and Prevention, American Diabetes Association, etc.). DJJ has provided appropriate policy and guideline training for the clinicians.

HCS has developed a chronic care policy and procedure, and NCCHC chronic disease guidelines have been distributed to the CMOs with instructions to review the guidelines with the physicians. According to DJJ, small group interactive training on these policies and guidelines has been completed. The medical experts were not aware of these trainings and did not evaluate them. The experts will further evaluate the training during upcoming visits.

Assessment: Deferred

Question 12. HCS has developed and implemented a structured auditing process in compliance with the HCSRP.

The Office of Health Services has not yet developed and implemented a structured auditing process. The absence of a Standards and Compliance Coordinator contributes to the lack of process development.

Assessment: Noncompliance

Question 13. The Clinical Records Administrator monitors health record management at each facility a minimum of once annually to ensure compliance with health record policies and procedures.

The Clinical Records Administrator position is unfilled at this time and monitoring is not occurring.

Assessment: Noncompliance

Statewide Pharmacy Services

As our most recent headquarters visit in February 2007, the Statewide Pharmacy Services Manager position had not been filled and none of the requirements (Questions 1 through 10) for the statewide pharmacy audit tool had been met. Since that time, the position has been filled, but experts have made no further assessment regarding implementation of Remedial Plan requirements.

Assessment: Noncompliance

Other Statewide Health Care Issues

Medical Contracts

A serious issue that was identified during our headquarters and facility site visits was the lack of ability of DJJ to award contracts for the health care services in a timely manner. This is due to the organizational changes that resulted in the transfer of DJJ support staff to CDCR in an effort to become more efficient. However, the result has been a lack of dedicated resources and responsiveness on the part of CDCR Contract Services to DJJ needs, despite multiple efforts on the part of DJJ to resolve the issue. The services for which contracts are necessary are critical to health care delivery in DJJ and include nurse registries, clinical laboratory services, hospital contracts, and psychiatric services. The problems are further described in a June 15, 2007 memorandum from the Special Master to the medical experts (See Appendix A).

In addition to problems with processing of contracts in a timely manner, both headquarters and field staff expressed frustration at their inability to obtain support from CDCR for other support services such as personnel, information technology, etc. Staff reported that they did not have these issues when DJJ had dedicated support services staff.

Staffing

Headquarters and facility staff positions were initially difficult to fill for some job classifications (e.g. nursing, pharmacy) due to lack of timely pay parity with the CDCR adult correctional system. This has, for the most part been corrected.

The experts interviewed staff at the facilities, who stated that a lack of responsiveness at the headquarters and facility personnel level was also responsible for delays in hiring or inability to fill positions because the candidates took another job in the interim period. DJJ asserts that these delays are not due to a lack of responsiveness, but are due to factors that are beyond the control of DJJ management, such as fingerprinting and physicals. In any event, these delays are not acceptable, and CDCR issues which are responsible for these delays need to be addressed.

Staff positions are being added to DJJ as the department considers changing facility missions. During this initial tour of the facilities, the experts did not fully assess the adequacy of staffing but will do so in future visits.

Facility Findings

Facility Leadership, Budget, Staffing, Orientation and Training

At each facility, we used the draft Facility Leadership, Budget, Staffing, Orientation, and Training audit instrument to evaluate the leadership and organizational infrastructure. Below is a brief description of our findings at each facility.

Ventura Youth Correctional Facility

The medical experts visited Ventura Correctional Facility on September 12-14, 2006. At the time of our visit, the population was 210 youth, 140 females, and 70 males at the camp. This is a 39% decrease in population from our last visit in May 2003, when the population was 535 (300 females and 235 males).

All facility leadership positions (CMO, Supervising Nurse, and Pharmacist) were filled. Dr. Mark Hynum is the CMO and is board certified in internal medicine. Although a HCS table of organization has not yet been published, in practice he reports to the Statewide Medical Director on clinical issues and administratively to the Superintendent.

The CMO reported that he did not yet have control over the medical budget because it had not been provided to him. With respect to spending decisions, he believed that he has budget authority; however, technically he had to get signature approval from the business manager.

With respect to clinical staffing, currently the facility has a CMO, 1.0 nurse practitioner, and 1.0 physician and surgeon (although Dr. Hynum has not filled the 1.0 and is using a .5 pediatrician). On-call time is shared by the pediatrician and the nurse practitioner. The CMO stated that 40% of his time is devoted to clinical activities.

In practice, the Supervising Nurse reports clinically to the DON. One issue was that in DJJ, SRN I positions have not been upgraded to SRN II positions, and SRN IIs upgraded to SNR IIIs as has occurred in CDCR. As a result, they were losing SRN IIs to the adult side. We understand that this has been corrected and now SRN's must apply for the upgraded position.

Dr. Hynum reported that it was difficult to hire and retain pharmacists due to salary issues. At the time of our visit, CDCR pharmacy salaries had not been upgraded and therefore, pay parity could not be used as a vehicle to increase DJJ pharmacist salaries. It is our understanding that this has been corrected since our initial round of visits. The CMO plans to upgrade a pharmacist to a pharmacist II position, and hire a pharmacy technician. The CMO believes at this time he has adequate clerical support, recognizing that this may change with the implementation of the new health care programs.

With respect to health care autonomy over the hiring, discipline, and reallocation of health care positions, administrative staff reported that they do not have autonomy in this area. Staff stated that the Superintendent has to sign Letters of Instruction before they can be given to an employee, thus giving the Superintendent control over disciplinary matters. DJJ has stated that this is not the case. The experts will further evaluate this issue on subsequent visits.

There are three clinicians (including one part-time) and one clinical examination room. During medication administration that occurs four times per day, no other youth are permitted to be in the medical unit. This creates significant down time and loss of productivity in the clinic. DJJ has recently informed the experts that this issue has been resolved. The experts will re-evaluate this issue on subsequent visits.

Sanitation in the unit was generally good. The facility currently has a janitor and will be hiring a second janitor in the near future. They also have a team of youth who wax and buff the floors under the supervision of a YCC.

A Senior Medical Transcriber tracks staff licensure, DEA, and CPR certification. Our review showed that all RNs are currently certified in CPR. They did not have copies of the dentist's and senior psychologist's license.

The facility does not have a structured, written orientation for health care staff. Currently training consists of a three-day training that includes blood-borne pathogen and first-aid training. The statewide or local health care policies have not yet been developed, finalized, and implemented.

Heman G. Stark Youth Correctional Facility

We visited Heman G. Stark Youth Correctional Facility on September 25-28, 2006. Heman G. Stark's population was 808 youth at the time of our visit. Although Stark is not a reception center, it receives parole revocators and transfers from other DJJ facilities.

At the time of our visit, the facility CMO position was vacant but has since been filled by John Close, MD. Dr. Close is board certified in Family Practice. The Supervising Nurse II position was filled, and the Correctional Health Administrator position was not filled. Dr. Hue Vo, the medical director for the CTC (and acting CMO at the time of our visit), has since departed and been replaced by Gayanni Reynolds, MD, a psychiatrist.

For the main facility, clinical staffing consists of a CMO, three physicians, and a nurse practitioner. The nurse practitioner sees patients but is also responsible for negotiating hospital contracts, and tracking and paying bills. There are three dentists and two registered dental assistants.

The facility's medical mission includes an 11-bed Correctional Treatment Center (CTC) that is licensed for mental health purposes only. During our visit the census was three youth. For the CTC, clinical staffing consists of a full-time medical director, a psychiatrist who works four hours per day, seven days per week, a licensed social worker (who also functions as the standards and compliance coordinator), and a senior psychologist. Nursing staff consists of nine registered nurses (one who functions as an infection control nurse) and five Psychiatric Technicians. The DON considers himself responsible only for the CTC and not the rest of the facility. There are three dietary employees for the CTC. Ms. Louise Allen, RN, Statewide DON reported to us that for the previous month, the CTC census was less than one patient per day.

Health care staff reported a lack of ability to hire personnel in a timely manner and a lack of autonomy with respect to disciplinary matters. The hiring process depends on timely response by

the facility personnel office, which reportedly was not occurring. Also, disciplinary measures such as Letters of Instruction (LOIs) require approval signature of the Superintendent. As noted above, DJJ stated that this was not the case. The experts will further evaluate this issue during subsequent visits.

With the exception of the pharmacy staff, the facility did not have current copies of medical and nursing licenses. According to a roster, all registered nurses, psychiatric technicians, and MTAs were certified in CPR. No information was provided regarding the CPR certification status of the physicians and nurse practitioner.

With respect to coordination of health care services with facility operations, medical staff reported that custody staff cancels specialty appointments without notifying or consulting them. There were also problems reported with custody escorting youth to the medical clinic for evaluation and treatment in a timely manner. A significant concern is that custody staff requires nurses to be on-standby in case chemical agents are used, which occurs frequently at the facility.

Southern Youth Correctional Reception Center and Clinic (SYCRCC)

We visited SYCRCC on November 12-14, 2006. At that time, its population was 270 youth. The facility's medical missions include medical reception and mental health.

All key health care leadership positions were filled. Dr. Do, CMO, is a general practitioner and is not board eligible or certified in a primary care field. He reported that he has not been given a health care budget and it is not under his management control.

The facility has three clinician FTEs (one CMO, one physician, and one nurse practitioner). They reported that they have adequate budgeted RN positions, but they are not all filled and working positions. There is one RN vacancy and the SRN is out on extended Family and Medical Leave Act (FMLA) status. They are not backfilling with registry because Dr. Do has not approved the use of agency staff. There is no centralized system for licensure tracking system at the facility. The nursing licensure file could not be located for our visit; however, copies of nursing staff licensure were printed from the internet and provided for our review. New policies have not yet been implemented and there is no written orientation program for staff.

Custody support is not consistently provided for health care operations, particularly for sick call. Staff makes multiple calls to custody, who report that youth are on their way, and then nothing happens. Often it requires calls to the Lieutenant to order the officers to bring them up.

There is inadequate support for sanitation services. A janitor position has been allocated; but staff reported that there were no candidates on the certification list to be interviewed and hired.

Preston Youth Correctional Facility

We visited Preston Youth Correctional Facility on November 28-30, 2006. The population of Preston was approximately 400 youth. The facility's medical missions include medical reception (added since 2003), an Outpatient Housing Unit (OHU), and mental health.

At the time of our visit health care leadership positions were all filled; however, the Supervising Nurse was on extended vacation. Dr. Evalyn Horowitz is the CMO and is board certified in internal medicine and infectious disease. Although a HCS table of organization had not been published at the time of our visit, in practice she reports to the Statewide Medical Director.

With respect to clinical staffing, the facility has the following budgeted positions: 1.0 CMO and 2.0 physician FTE positions. However, Dr. Horowitz reported insufficient psychiatry hours.

At the time of our visit, DJJ nurses did not have pay parity with CDCR nurses, and the current advertising on the internet stated a difference between what CDCR and DJJ nurses were to be paid that inhibited recruiting for DJJ. Thus, it had been extremely difficult to hire registered nurses. Given this difficulty in hiring nurses, the use of MTAs has been important in health care operations.

Dr. Horowitz indicated that at this time she does not have effective control of the health care budget because of delays at the business office level. Six months ago the nurses had to go to Wal-Mart to buy band-aids because they could not get the purchase order through the business office in a timely manner. Computers and desks had been ordered in September but had not yet arrived at the time of our visit, two months later. Dr. Horowitz had recently gone on vacation and in her absence, had delegated the purchase of drinking cups to other staff. The business manager approved the purchase, but the Superintendent did not approve it until Dr. Horowitz returned from vacation and signed the form. Staff reported that the business office delays orders by holding onto purchase orders for 30 days and then they review it; if it's not perfect, they send it back to medical to be corrected.

Staff reported that there are problems in getting custody escorts to bring youth to physician sick call.

Earlier in the year, there had been conflict between the superintendent and health care leadership with respect to the primary role of the MTAs and whether their duties were primarily medical or custody. The Remedial Plan is clear that the primary duties of the MTAs are medical. Only registered nurses and licensed vocational nurses can be MTAs. This requirement for health care licensure should place them under the direction of the health care leadership with respect to scheduling and assignment of duties. If there are insufficient numbers of custody staff at a given facility, this should be resolved through normal channels of obtaining additional custody staff.

Dr. Horowitz's biggest concerns were about the purchasing and contracting process.

She expressed her concerns regarding inadequate psychiatry hours. Specifically, she expressed concern that she will not have a psychiatrist at the end of December and has 180 youth who routinely need to be seen. Moreover, due to its reception mission, the facility is receiving 6 - 15 youth per week, some who need long-term services. The existing psychiatrist is not seeing all the youth. Dr. Horowitz has 17 different psychiatry registry contracts and she has to call each one to get candidates. She has pursued individual references and all the psychiatrists she has contacted have turned her down. Our discussion raised the question of whether the psychiatrist or psychologist was the director of the mental health program at the facility. The absence of a departmental table of organization contributes to the lack of clarity.

With respect to hiring, staff reported that the personnel process is a nightmare. The personnel officer is retiring and only present half-time.

Staff reported that currently they do not have adequate clerical support but expect to receive two additional Office Technician (OT) positions. They will then have a total of 4.5 positions, which should be adequate.

Staff reported that the facility does not have adequate sanitation resources to ensure a clean and sanitary environment. Currently they have a ward allocated to the health care unit for three hours a day under supervision of an MTA. (DJJ recently informed the experts that this problem has been resolved and the MTA now only performs nursing duties. The experts will validate this on subsequent visits). The sanitation in the housing unit medication rooms was extremely poor. This is ironic since there is a janitorial vocational program for youth at the facility. A janitor position is being hired in the health care budget.

Dr. Horowitz tracks licensure for the physicians. The acting Supervising Nurse tracks licensure for the nurses.

There is no written health care orientation program at the facility.

Northern California Youth Correctional Complex (NCYCC)

NCYCC consists of three facilities: NA Chaderjian (Chad), OH Close, and Dewitt Nelson. The populations of the three facilities totaled 810 in November 2006. The medical missions include an OHU that serves the complex, an Intensive Treatment Program (ITP), and a Specialized Counseling Program (SCP) at Chad. Chad also has two administrative segregation units of 50 beds each and OH Close has an 18-bed segregation unit. Dewitt Nelson has ad-seg rooms scattered throughout the facility.

Health care leadership positions are filled with the exception of the Pharmacy II supervisor. Dr. Gabriel Tanson is the CMO and is board certified in family practice. Dr. Tanson clinically reports to Dr. Morris, although this is not reflected in an organizational chart. Although the CMO is administratively responsible for health services at the facility, the dental staff does not administratively report to the CMO at any facility. As a result, the CMOs are not responsible and do not know of the activities of the dental staff. He stated that the same is true of mental health staff. Dr. Tanson indicated that this is problematic, since decisions are made regarding mental health staff and he is not informed until after the fact. An example of fragmentation is that when we requested staff licensure, licenses for two dentists and two psychologists were not available for review. Dr. Morris and Dr. Morales later informed us that the CMO does administratively supervise the mental health staff. The CMOs, however, did not appear to be aware of this, and in most of the facilities, such supervision was not occurring.

In addition to the CMO, there are 3 physician FTEs and 1.7 nurse practitioner FTEs. Lisa Pacheco, RN, is the Supervising Nurse II; there are two additional Supervising Nurse 1 positions for the complex.

The facility has four budgeted psychiatrist positions but none of these are filled. They are using registry to fill two days per week.

NCYCC is unique in that there is a unified administrative unit that oversees the budget for the three facilities. The CMO reported that there was a health care budget but he did not know how much money was assigned to medical. Staff also reported that purchases were being held up, pending review by the Superintendent.

Staff reported not having adequate office or clinic space and that some staff is assigned to office space that does not have adequate heating or air conditioning. We did not fully assess this during this visit, but will in subsequent visits.

The procurement and contracting processes are problematic. To better understand the budget and contracting process, we met with the institutional business manager. He indicated that the new CDCR contracting process has greatly slowed things down. Contracts submitted for approval six months ago have still not been approved by CDCR. In the past, approval took three weeks. Staff reported that they have tried to call someone in CDCR personnel or contracts. They've called numerous individuals trying to get answers to questions, without success.

Staff reported significant issues with procurement of medical supplies and services. They still have to put three bids on every purchase over $100. (While the experts recognize that this policy applies to all state agencies, it, nevertheless, makes it difficult for staff to obtain needed supplies and services.) The staff ordered sharps containers for disposal of used needles and syringes and waited months for them to arrive. Once items arrive at the facility, staff has difficulty getting possession of the items because they sit in the warehouse for weeks because procurement hasn't inventoried them or has not sent the truck driver to bring the items to the medical unit. If a piece of furniture is in the warehouse, they might wait months.

With respect to the hiring process, there are significant delays due to the administrative process that includes obtaining Live Scan (fingerprint) results. One nurse who wanted to transfer from Avenal in the adult system to DJJ had applied three months before our visit, and they only received the clearance the week before we arrived. She turned down the job the day prior to our arrival. An Office Assistant who was interviewed on 11/29/06 called on 12/13/06 to say she had taken another job in the intervening period.

Staff reported that they do not have adequate custody support to carry out health care operations. Of particular concern is that a correctional officer is only assigned to the OHU Monday through Friday from 6 am to 2 pm. Thus, there is no correctional staff in the OHU during the afternoons, nights, and weekends, even when there are patients in the OHU. Nurses cannot open the doors without custody staff, who then must be paged if a nurse wants to administer treatment. If there was an emergency, nurses would not be able to respond appropriately.

Staff also reported inadequate support for sanitation and housekeeping. This was reflected by poor cleanliness in the OHU. Staff reported that they have requested a sanitation schedule but have not been given one. Trash is collected in the medical hallway because the custody staff won't open the dumpster lock more than once a day. The medical unit in Chad had not been cleaned in a year. In terms of cooperation with custody, one clinical staff reported that "We are literally a millstone around their neck until there is a crisis."

With respect to orientation, a new employee could be at the facility seven months before receiving facility orientation. Non-peace officer employees used to go to the ancillary new employee orientation that lasted five days. This training is no longer conducted.

El Paso de Robles

We visited the El Paso de Robles Youth Correctional Facility (EPDRYCF) on January 23-25, 2007. At that time its population was 194 males, a 49% decrease from a population of 400 youth in June 2003.

The CMO is Dr. Clemente Rodriguez. Dr. Rodriguez is board eligible in general surgery. He clinically reports to Dr. Morris. Dr. Rodriguez stated that although he is the CMO and administratively responsible for health care delivery, he does not believe he administratively supervises mental health or dental staff. He does not conduct staff meetings and believes that everyone does their own thing. Drs. Morris and Morales were at the facility during our visit and stated that the CMOs are administratively responsible for mental health staff, but not dental staff.

The CMO is the only physician at the facility. Although that is adequate to serve the medical needs of the population, there are issues related to his being the only clinician on call. Given that several facilities have more than one clinician and this is not a medically complicated population, consideration should be given to having a statewide call-sharing system.

All staff has a current and valid professional license. The CHSA is going to assume responsibility for tracking all licensure.

The CMO does not have control over the health care budget and expenditures. Staff reported that they don't yet know how much money is assigned to the budget or how many positions they have. Non-health care expenditures are charged to the medical budget, such as YCC positions assigned to the ITP and accompanying overtime. For example, recently the health care budget was charged $49,000 in overtime due to YCCs. Staff also reported that overtime for correctional officers assigned to the OHU was charged to the medical budget. The CHSA, who is new and learning about the budget process, indicated that overtime charges have been assigned to the medical budget but she was not always aware of where the expense was coming from. She said she believes that any custody staff assigned to medical functions are charged back to medical. There were no problems with ordering medical supplies. The business office was helpful to them.

Staff reported contract issues. They used to have an optometrist on site but because of contract issues they are sending all youth out for optometry examinations. They even have the equipment on-site. The CHSA was not aware of what the specific contract issues were.

Also, the Business Manager negotiated contract terms with Tenant Hospital and it was forwarded through channels to the Department of General Services (DGS). DGS did not like the contract and sent it back to Tenant, who did not agree with the changes. Now the facility has no contract with Tenant Hospital.

Staff reported no significant problems with custody support, although they indicated that access to youth would be more efficient if the facility assigned designated correctional officers to escort and transport duties.

The facility does not have a structured, written orientation for health care staff. The statewide or local health care policies have not yet been developed, finalized, and implemented.

Medical Reception

We reviewed the medical reception process at Ventura Youth Correctional Facility, Southern Youth Correctional Reception Center and Clinic, and Preston Youth Correctional Facility. In general, we found that facilities are in the early phases of implementing the new policies. The medical reception process is not being performed with auditory and visual privacy at all facilities. Staff has not uniformly implemented the new medical reception forms. The quality of the medical history, physical examinations, and treatment plans is generally poor.

Neither Heman G. Stark YCF nor the Northern California Youth Correctional Complex have a medical reception mission; however, parole violators are admitted to both facilities without going through the medical reception process. Thus, these youth are not receiving the medical reception evaluation, as required by the Remedial Plan. This presents a risk that youth with acute, chronic, and infectious diseases will not be diagnosed and treated in a timely manner. Moreover, parole violators may be at risk of alcohol and drug withdrawal. The National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health, in its April 2006 issue of Alcohol Alert stated, "Young adults are particularly likely to binge drink and to suffer repeated bouts of withdrawal from alcohol." Health Care Services should develop and implement protocols for the appropriate management of alcohol and drug withdrawal.

At Ventura YCF, staff reported that the medical reception process is conducted in a private and confidential manner. We did not observe the process during this visit. There were no signs in English and Spanish in the medical area reminding staff of the need to maintain confidentiality. Staff currently provide a verbal orientation to youths, but do not provide written instructions for accessing health care. It was reported that several staff members are fluent in Spanish and staff with sign language skills are at the facility five days a week.

With respect to monitoring the medical reception process to ensure that all components are completed in a timely manner, the staff developed their own medical reception tracking system. However, no one is currently monitoring the log. They plan to implement the headquarters tracking system when the policies are implemented.

At Preston YCF, a registered nurse was in charge of the medical reception/intrasystem transfer process. From May to October 2006 the facility averaged 37 admissions and seven transfers per month, respectively. Preston normally receives new intakes three days a week (Tuesday, Wednesday, and Thursday), and occasionally on Monday and Friday. The nurse uses a tracking book to document both new intakes and transfers into the facility, not the new medical reception tracking log.

Staff reported that youth arrive for medical reception after they undergo security processing, usually 2-3 hours after arrival. The nurse performs an initial interview and indicated that the

counties sometimes send medical information but often do not. The nurse added that it was particularly difficult to get immunization information. The nurse administers immunizations as needed and a TB skin test unless the youth was previously positive. In these cases, the nurse documents the history and obtains a chest x-ray. The nurse also administers a health questionnaire, performs HIV pre-test counseling, and obtains lab tests. The physician performs the physical examination. If the youth has a positive mental health history or is on medications, the youth is referred to a psychiatrist or psychologist. The policy is now that the psychologist has ten days to see the youth. Dental staff usually sees the youth within three or four days. The nurse schedules the youth to read the PPD and perform HIV post-test counseling. The facility does not yet have a chronic disease management program but the nurses schedule youth with chronic diseases to see the physician.

At SCYRCC, the new tracking log is in place but the dental portion of the log is not filled out. The medical reception process is performed in a manner that does not assure auditory confidentiality since other youth may overhear interviews. Staff is transitioning in the new medical reception forms. Our record review showed that the Problem List is not visible when opening the record. The documentation of the medical history, physical examinations, and treatment plans was inadequate.

Intrasystem Transfer

The intrasystem transfer process is taking place at all the facilities. The old forms are still in use. Newly arriving youth with chronic diseases are not consistently referred to a physician upon arrival.

At SYCRCC, there are problems with custody staff not bringing youth to the medical unit for health screening upon arrival.

At NCYCC, staff reported that not many youth transfer into the facility; however, they do receive parole revocators. They are not undergoing the medical reception process as required by the Remedial Plan. Staff also report that newly arriving youth are not brought to the medical unit in a timely manner for health screening.

Nursing Sick Call

Although nurses triage health care requests at all the facilities, the nursing sick call program has not been fully implemented at any facility. HCS has not yet developed Nursing Protocols and staff training has not been conducted. Therefore, nurses lack guidance on performing adequate assessments. At several institutions, nurses simply conduct a paper triage of health services request forms and then arrange to have the clinician see the patient.

When nurses do conduct assessments, the quality of the assessments is generally poor with minimal history and physical examinations performed. Vital signs are not routinely being measured for sick call encounters. In some cases, the nurse did not address the complaint on the request form; instead, the nurse addressed a new problem presented on the day the youth was seen.

At Heman G. Stark YCF, nursing and physician sick call was being conducted in the day rooms of the housing units, even though medically equipped clinics rooms were nearby. Youth submitting health service requests were not consistently seen in a timely manner, reportedly due to custody issues. For example, a 20-year-old submitted a sick call request form dated 9/18/06 complaining of severe abdominal cramping and pain that he thought was related to food. The form was dated as being received on 9/21/06. A note by the physician indicated that the youth was not available to be seen per unit staff. Another physician note on 9/27/06 indicated that the youth was seen on 9/26/06; however, there was no note in the record to support this.

At SYCRCC, the old forms are in use. The nurses collect health care services request forms five days a week rather than seven days per week. Therefore, nurses were not triaging health requests on the weekends to identify patients with urgent complaints that should be seen the same day, including dental and mental health complaints. From our review, it was not clear that youth are being seen within one business day of submitting their requests. The satellite clinics are inadequately equipped and supplied with no access to a sink for handwashing. The nurses often simply triage the request, and refer the youth directly to the physician.

At NCYCC, the nurses conduct a paper triage and arrange for the clinician to see the patient.

At EPDRYCF, nursing sick call is conducted five days a week and scheduled to occur at 2-3 scheduled intervals throughout the day to accommodate youth's schedules. There is signage in the medical areas with respect to maintaining patient confidentiality. A review of seven records showed that nursing assessments are not adequate with respect to the history, physical examination, and nursing diagnosis.

Medical Care

At all the facilities, we found few numbers of youth with acute, chronic disease or communicable diseases. The medical acuity of DJJ's population is low due to the age of the population and the agency's policy to defer admission of youth with high acuity medical and mental health conditions.

In general, we found that clinicians often are not documenting appropriate histories for sick call or chronic care visits. Clinicians do not ensure that vital signs are measured for sick call encounters. In most cases, education is not documented as occurring during sick call and chronic care visits. Furthermore, in our limited review of the facilities, we found cases of patients with serious medical conditions whose medical care was not appropriately managed. These cases are described below.

Patient 1: This patient underwent an appendectomy at a local hospital for a perforated appendix on 7/24/06. He returned to the facility on 7/29/06 and was housed in the OHU. On 8/8/06, at 10 pm, a nurse noted that the patient was complaining of a severe headache, had vomited, and had a temperature of 103.2 degrees. The nurse did not contact the physician on call. The nurse re-checked the patient a couple of hours later and noted that he was feeling better and was afebrile. The next morning, at 5:30 a.m., a nurse noted that the patient had a temperature of 102.1 degrees and was complaining of severe (10 on a scale of 10) right sided abdominal pain. The nurse contacted the physician who gave a telephone order for Vicodin. The patient stated that he could

not take Vicodin and the physician changed the order to Tylenol. The physician evaluated the patient in the OHU at 8:10 a.m. and sent him to the emergency department (ED) for further evaluation. The patient was diagnosed with an intra-abdominal abscess for which he underwent surgery that morning.

Assessment: The patient did not receive timely or appropriate care.

- A fever of 103.2 degrees and vomiting are very worrisome symptoms in a patient who has recently had abdominal surgery. The nurse should have contacted the physician on call, who should have either come in to evaluate the patient or sent him to the hospital for further evaluation.
- On 8/9/06, when the nurse notified the physician at 5:30 a.m. that the patient had a high fever and was complaining of severe abdominal pain, he should have transferred the patient to the ED for further evaluation.

Patient 2: This patient is a 16-year-old youth with a history of asthma who arrived at the facility on 11/1/06. The nurse noted that he was using an Albuterol inhaler and that he had been hospitalized two times. She did not obtain any further history. The physician performed a physical examination, but did not obtain any further history related to the patient's asthma. In his assessment, the physician did not note that the patient had asthma, and he did not order any medication.

On 11/11/06, a nurse saw the patient because he was complaining of shortness of breath. The nurse contacted the physician who gave a verbal order for an Albuterol inhaler. The physician did not order follow-up. As of 11/30/06, the patient had not been enrolled in the chronic disease program.

In addition, the patient had a 7-mm tuberculin skin test (TST) on 11/6/06. The nurse referred the patient to the physician who ordered a chest x-ray and INH for treatment of tuberculosis infection. The chest x-ray was performed on 11/10/06 and was normal.

Assessment: The patient did not receive timely or appropriate care for his asthma.

- Neither the nurse nor the physician obtained an appropriate history for a patient with asthma and two prior hospitalizations.
- The patient did not receive his medication in a timely manner.
- The patient was not enrolled in the chronic disease program.

The patient's TST was not managed appropriately. The patient did not have any of the medical conditions for which a 7 mm TST would be indicative of tuberculosis infection. Furthermore, even if treatment was indicated, it should not be initiated prior to ensuring that the patient did not have active tuberculosis disease. This case was referred to the CMO for follow-up.

Patient 3: On the evening of 9/20/06, a nurse noted that the patient was complaining of pain in his right hand. She noted that he had decreased range of motion and swelling in the area of his right fifth metacarpal bone. The nurse contacted the physician who gave a verbal order for ice, ibuprofen, and for the patient to be seen the next day. On 9/21/06, a nurse noted that the patient's hand was very swollen and that he was unable to move his fingers without pain. The nurse noted

that the patient stated that his pain was 10 on scale of 1-10. Later that day, the physician noted that the patient's hand was tender, with decreased range of motion. He ordered an x-ray. On 10/4/06, there was an entry from another physician noting that the x-ray revealed a fracture. (The results of the x-ray were not in the medical record and it is not clear when the x-ray was performed).

The second physician referred the patient to the orthopedic surgeon for further care. The consultation request stated that the injury occurred on 9/28/06 (not 9/21). The orthopedic surgeon did not see the patient until 10/6/06. He stated, "This is an 8-day-old fracture [it was actually 15 days old]. We will accept the position of this fracture. He will lose knuckle contour but will not have functional deficit, as the fifth metacarpal is quite mobile. Closed manipulation would be impossible at 8 days post injury in a patient of this age. He would require an open reduction, which is not warranted. A 4-5 gauntlet cast was applied today."

Assessment: The patient did not receive timely care for his hand injury.

Patient 4: A nurse saw the patient at 6:15 p.m. on Saturday, 7/8/06, and noted that he stated that his stomach was hurting and that he had vomited his lunch. The nurse noted that the patient was pointing to his upper and lower abdomen and stated that the pain was 10 on a scale of 1 to 10. The nurse did not examine the patient's abdomen and did not obtain vital signs. Her assessment was "alteration in comfort due to abdominal pain." She noted that she reassured the patient, advised him to increase fluids, and ordered Pepto-Bismol. She also advised the patient to notify the staff if he was not better in two hours.

A nurse saw the patient again at 8:20 p.m. and noted that he stated that the medication had not provided relief. The nurse further noted that the patient had vomited blood, had continuous pain in the stomach, and sat on the floor outside the control center due to the pain. She sent the patient to the medical clinic for further assessment and treatment.

At 8:45 p.m., a nurse saw the patient in the medical clinic. She noted that the patient had had pain and vomiting since the morning, that the pain was 10 on a scale of 1 to 10, that he did not have any urinary symptoms, and that his vital signs were normal. She further noted, "walking upright without restriction of movement or guarding, abdomen distended, o/w [otherwise] normal exam (no rebound or tenderness, soft)." The patient was unable to urinate and the nurse hydrated him with 1 liter of fluid. She subsequently obtained a urine sample and performed a urinalysis, which revealed trace white blood cells, nitrates, protein, and large ketones (all of which are non-specific abnormalities). The nurse contacted a physician who gave a verbal order for antibiotics for treatment of a urinary tract infection. The nurse noted that the patient was observed for an hour and given more oral fluids, which he tolerated. The nurse then sent him back to his housing unit with instructions to report any continued problems, and scheduled him to see the physician the next day.

Early Sunday morning, at 2:10 a.m., the nurse called the housing area for an update. The custody staff informed her that the patient had come back, eaten, and gone to sleep, and that he had not reported any further nausea or vomiting. At 7:30 a.m., a nurse noted that the patient was not complaining of nausea or vomiting.

At 11:30 a.m., a nurse noted that when she saw the patient at pill call, he stated that he had vomited five times. The nurse further noted that the patient was able to walk from his room to the control room with a steady gait. She did not obtain any further history or examine the patient at that time.

The patient was subsequently seen in the clinic at 1:15 p.m. He was complaining of right lower quadrant pain and vomiting at that time, and had a low grade fever and increased pulse. The nurse noted that he was warm to touch, that his abdomen was tender with rebound, and that his bowel sounds were decreased. (These signs and symptoms are indicative of an acute abdominal problem.) The nurse's assessment was "alteration of comfort secondary to vomiting." She contacted the physician who advised her to observe the patient.

At 1:45 p.m., a nurse noted that while awaiting the physician's arrival, the patient was in a "comfortable position" and moaning. At 1:50 p.m., the nurse contacted the physician to advise him of the patient's pain and increased vomiting. The physician advised the nurse to send the patient to the hospital via ambulance. The patient was subsequently diagnosed with an acute perforated appendix, for which he underwent surgery.

Assessment: The patient did not receive timely or appropriate care for his acute abdominal pain and vomiting. Furthermore, it was not appropriate for the physician to order antibiotics for a urinary tract infection without having evaluated the patient.

Patient 5: The patient injured his hand on 11/7/06. His right thumb was noted to be tender and swollen. An x-ray was ordered, but not performed until 11/30. The x-ray did not reveal a fracture.

Assessment: The patient did not receive timely care.

Chronic Disease Management

The new chronic disease management program is in its early phases of implementation at some facilities and has not been implemented at others. The tracking system has not been implemented in any of the facilities. Staff is using the medication list to track youth with chronic diseases, but reported that the facilities do not have an automated way to remove the names of youth who have left the facility and have to do this manually. This is not happening routinely at any of the facilities. As a result, the lists are not useful for tracking youth who have chronic diseases and many patients with chronic illnesses are not being seen within the timeframes specified by the Remedial Plan.

With respect to those patients who are being seen in the program, our record review showed that clinicians often are not documenting appropriate histories, obtaining vital signs, or documenting education for patients with chronic diseases.

At Ventura, the chronic disease management program has not been fully implemented. Patients are being seen for acute problems, not routine care.

At Preston YCF, youth with chronic diseases are not routinely receiving appropriate intake evaluations and are not routinely being seen for their chronic diseases.

At NCYCC, youth are often not being seen every three months as required by the Remedial Plan. The name of one patient with diabetes did not appear on the chronic disease list and did not show up on the pharmacy profile. Dr. Goldenson noted that the patient had diabetes when he was reviewing the medical record for another issue.

Other problems at NCYCC related to chronic disease were noted, including:

- Two patients had recently been started on medications for hypertension despite the fact that there was no clear indication that they actually had this problem. They had each had only one elevated blood pressure reading, and prior ones had all been normal.

- A physician increased a patient's (Patient 4) medication for diabetes despite the fact that he appeared to be well controlled. He had had one increased blood sugar reading, but the others had been within the normal range and his HgbA1c (5.5), which is a test that reflects glucose control, over a three month period was normal.

We discussed these cases with Dr. Tanson, who stated that he would provide training in chronic disease management to the physicians.

Infection Control

At most facilities, infection control programs are in early phases of development. DJJ does not have an adequate program to offer hepatitis B vaccination to health care or custody staff, or to obtain consent and declination forms as required by OSHA guidelines.

Most of the facilities have rooms designated as respiratory isolation rooms, but not all rooms were functional. Dr. Morris indicated to the medical experts that he wants all TB suspects sent out to local hospitals, but his staff was not aware of this. They advised the experts that they planned to use the respiratory isolation room should they identify a TB suspect.

At Ventura, the infection control nurse has worked at the facility for five years and has been the Infection Control/Staff Development Nurse for two months. He will be responsible for the annual TB skin testing for the youth and staff, in April and May of each year, respectively. He also manages the Hepatitis B vaccination program for staff. However, at the time of our visit, there was no local operating procedure for implementation of the infection control program. The nurse has not received formal training in infection control, just on the job training. He stated that he reported all reportable diseases and TB skin test conversions to the local health department and to Brenda Green, RN, in headquarters.

At EPDRYCF, the infection control program is further along and staff has developed a Blood-Borne Pathogen Exposure Control Packet that is to be used when a staff member is exposed to blood or other potentially infectious body fluids.

Pharmacy Services

With the exception of Quality Management activities, the pharmacy activities are consistent with the Remedial Plan.

Medication Administration Process

We reviewed the medication process at each of the facilities.

The medication rooms we inspected were generally clean and well organized. Most, but not all facilities had night locker accountability systems. Nurses at several facilities are routinely crushing narcotics for patients, which is not in compliance with the Remedial Plan. At several facilities, nurses are administering hour of sleep (HS) medications as early as 7:30 pm, which is not in compliance with the Remedial Plan. The Remedial Plan requirement advises not administering HS medications before 2100 hours (one hour window on either side permitted).

Individual facility findings are described below.

At Ventura, the medication room was clean and well-organized. The nurse demonstrated how she administered medications and followed the proper procedure. All medications in the storage bins were in unit dose packaging. The cabinet did not, however, designate separate storage areas for external and internal medications, as required by the Remedial Plan.

At Heman G. Stark YCF, the medication room was relatively clean and well organized. There was a night locker that contained prescription medications. There was no accountability system for the medications. A random review of two medications showed that they would expire within the week. The facility is crushing all psychotropic medications against Remedial Plan requirements. In the main clinic treatment room, there were expired medications in the refrigerator. There was a tray with frozen water in it with suppositories boxes frozen in the water. It had not been cleaned in some time.

At SCYRCC, there have been improvements since our initial visit. The medication room is cleaner; however, it still contains old cabinetry and medication carts. Stock medication bottles have been removed and a pharmacist is filling all prescriptions. There is a night locker with a medication accountability system, which includes narcotics. A random sample check showed that narcotics were accounted for. Unfortunately, the nurse prepoured her medications and was crushing all psychotropics. These actions are not in compliance with the Remedial Plan and new policies. Youth did not present identification cards as required by the Remedial Plan. The nurse attempted to verify identity by asking the patient's name, but not the ID number. The nurse did not consistently check the MAR before administering medications.

At NCYCC, staff indicated that policy requires that youth have ID's to be identified for medication administration but that youth come to pill call without the ID cards. When staff sends them back to the housing unit to get them, they often do not return. There are many no shows for medications. Medical staff request that youth refuse medication in person to ensure access to care, but custody is not consistently supportive of this. Staff also reported that when pill call is being conducted, security will not bring youth to the clinic to receive other services.

At EPDRYC, there are no local policies and procedures for medication administration. Medications that are to be administered at the hours of sleep (HS) are being administered as early as 7:30 pm, which is not in compliance with the Remedial Plan.

Urgent/Emergent Services

We found that none of the facilities had local operating policies and procedures or conducted quarterly emergency drills. All the facilities had at least one automatic emergency defibrillator that was checked daily. Emergency response bags were not checked daily at each facility and in some cases contained nonfunctional equipment or outdated medications. Individual site visit findings are described below.

At Heman G. Stark YCF, there is no urgent emergent log in use. There is a mace log. Staff reported that custody calls them and requires them to be present in advance of using chemical agents, and that nurses are required to triage youth at the scene and wash them down with a hose, instead of custody showering the youth and escorting them to medical as required by policy. This is an inappropriate use of medical personnel.

At SYCRCC there are two Automatic External Defibrillators (AEDs) that are checked daily. Emergency equipment was in proper working order; however, the emergency response bag is not checked daily.

At EPDRYCF, the Urgent/Emergent Tracking Log is in use. Most, but not all health care providers have current CPR certification. The facility has an automatic emergency defibrillator and emergency medications. The emergency response bag is not checked along with other emergency equipment. A review of the bag showed that the flashlight was broken and the glucagon medication had expired.

Outpatient Housing Unit

In general we found that the OHU environments are dismal, often dirty, and generally nontherapeutic. Local policies and procedures are not yet in place. Patients are not always within sight or sound of a licensed health care provider. Patients are not being admitted, monitored, and discharged in compliance with the Remedial Plan. At NCYCC, there are serious issues related to staff access to patients due to lack of custody staff assigned to the OHU. Individual facility findings are described below.

At Ventura, there was no local operating procedure related to operation of the OHU. There was a tracking log that listed all youth placed in the OHU. The OHU is located along a long corridor that is parallel to another hallway where clinical exams rooms are located. There are 5 beds plus a post-partum bed that was clean and warmly decorated. The OHU has one respiratory isolation room that was not working. Engineers had checked it the week prior to our visit and ordered a new motor for it.

Neither an officer nor nurse was consistently present when youth were in the OHU. There is a call system that rings to a non-staffed nurse's station. Thus, youth are not always within sight or sound of a licensed health care provider. During our visit, on 9/13/06 at approximately 1400, a youth was admitted to the OHU. There was no officer or nurse at the nurse's station. A nurse was to document 15 minute checks but did not document the 1500 and 1515 hour checks.

At Heman G. Stark YCF, there is no OHU, only an 11-bed CTC that is used for mental health purposes. They transfer any youth requiring OHU care for medical reasons to SYCRCC.

At SYCRCC, the OHU environment is dismal and nontherapeutic. There was no patient call system. Patients were not within sight or sound of a licensed health care provider. Clinicians did not write complete admission and discharge orders. Physician orders were not consistently implemented.

At EPDRYCF, the OHU patient call light was not functioning properly but was repaired during our visit.

At NCYCC, there was no local policy and procedure related to operation of the OHU. There was a tracking log that listed all youth placed in the OHU for the past 180 days. The log contained the youth name, ID number, diagnosis, and discharge dates. There was no standardized nursing procedure manual in the OHU. The OHU was under the supervision of an RN 24 hours per day, and a physician was on call 24 hours per day, 7 days per week. Youth are within sight or sound of licensed health care staff at all times; however, there are serious access issues.

Only correctional staff has keys to the infirmary rooms, yet the only correctional officer coverage in the OHU is from 6 am to 2 pm, Monday through Friday. There are no correctional officers assigned to the OHU from 2 pm until 6 am the following morning, and none on the weekends. If a nurse needs to get into a room to provide nursing treatment for a youth, they must call perimeter security staff who may take ten minutes or longer to come to the OHU. Thus, if a youth was hanging in a cell, health care staff would have to call security to open the door. This is unacceptable. It was also reported that there were officers allocated to the medical unit when it was to be a CTC; however, those officers were removed from the OHU and now staff the front gate. The medical budget is still charged for these correctional officers.

The OHU area in general was unsanitary. The floors were dirty and the walls of some of the rooms were splattered with unknown matter. The nurse's station was cluttered. Staff reported that there was no hot water for youth and sometimes no heat. On a positive note, the refrigerators were clean and appropriately labeled and used. There was an orientation manual that was somewhat outdated. Narcotics were kept in the refrigerator under a single lock and were accounted for. There was an AED and other emergency equipment that was checked daily.

Utilization of the OHU is infrequent. According to the tracking log for the period of 5/5/06 to 11/27/06, 235 youth were placed in the OHU, averaging 34 patients per month or approximately one per day. The majority of admissions were orthopedic/injury related (25%), dermatological (22%), and mental health (12%).

Patient Record Review

We reviewed records that showed clinical and nursing issues with respect to OHU Care. They are briefly described below. A concern is that in some records, nurses recorded that the physician saw the patient; however, there was no corresponding physician note.

Patient 1. This 17-year-old youth submitted a sick call request form on 9/18/06 for a twisted ankle. On 9/9/06 at 1515, the nurse documented in the unified health record (UHR) that the youth fell down while hiking the day before. He was unable to stand without significant pain. His left foot was swollen. She called the nurse practitioner who instructed that the youth be sent to the local emergency department (ED). He returned at 1845 and was admitted to the OHU. The

nurse did not document the medical diagnosis made at the ED. The physician was at the facility upon his return, and although he did not write a progress note, he wrote orders to send the patient to orthopedics and for primary care follow-up on Monday. This did not take place.

Assessment: The patient did not receive the ordered follow-up with the primary care physician or orthopedics as requested by the physician

Patient 2. This 16-year-old arrived at the facility on 10/30/06. On 11/27/06, he requested to be seen complaining of an insect bite. The nurse saw the youth the same day, took vital signs, and referred the youth to a physician. The primary care physician noted a 2 cm diameter area of induration on the right lower leg. He prescribed warm compresses and Bactrim and put him in the OHU. Daily physician and nursing rounds were made. The youth remained in the OHU until 11/29/06 and was sent back to his housing unit. However, later that day he returned to the OHU with increasing pain and the lesion had increased to 4 cm sign with slight drainage. The wound was never cultured.

Assessment: Although the clinician monitored this youth with a skin infection on a daily basis, on the day he discharged him from the OHU, the youth was readmitted with an increasing area of induration and drainage, suggesting the infection was worse. This raises questions as to whether physical examinations were actually performed while the patient was in the OHU. Also, a wound culture and sensitivity was not performed for this patient. In this era of increasing antibiotic resistance, performing wound cultures is important to guide antibiotic choice.

Patient 3. On 12/9/06 at 2000, an MTA saw this 20-year-old patient for blood in his urine (hematuria). The MTA did not take vital signs. At 2050, a note by the OHU nurse indicated that she took vital signs and stated that the physician was coming in to see the patient. The physician evaluated the patient at 2130. The physician suspected and treated the patient for a urinary tract infection but did not obtain a urine culture to confirm this.

Assessment: The diagnosis was not confirmed.

Patient 4. This 19-year-old complained of chest pain and shortness of breath on 9/23/06. He was taken to the OHU where a nurse assessed his condition and called the physician. He told the nurse to place the youth in the OHU until the morning. The physician did not give orders to the nurse for monitoring the patient. The nurse took initial vital signs, which showed his BP was 158/104 mm/hg and pulse was 67 beats/minute. The nurse did not repeat vital signs from 0120 until 0750. The physician saw him the next morning and released him to his housing unit.

Assessment: The purpose of OHU placement is monitoring and treatment, however the physician gave no orders for monitoring and the nurse did not repeatedly measure the patient's vital signs. Note: there is no custody staff in the OHU in the afternoon or night shift.

Patient 5. On 9/22/06 a nurse saw the youth who complained of upper abdominal pain. The nurse notified the physician who ordered Maalox and Donnatal. He complained again at 1720 and the nurse called the physician who ordered the youth sent to the OHU. The OHU nurse performed an assessment and called a physician who ordered a stat CBC. The youth requested to go back to the dorm about 1900 hours. The nurse notified the MD and the patient was released.

The CBC was collected on 9/22, received on 9/22, and reported on 9/29. The physician initialed it on 10/3.

Assessment: Ordering a stat blood count, but not getting the results for ten days is not an adequate system for evaluating acute abdominal pain.

Patient 6. On 10/23/06, a nurse saw this 20-year-old parole violator upon arrival. His vital signs were: pulse = 44 beats/minute and irregular, BP =137/65 mm/hg, respirations =18/minute and Temp = 98.4°. A physician saw him the same day at 1237, but did not take a cardiac history. He documented that the youth had a history of alcohol use the preceding night, and a history of cocaine and methamphetamine use, but did not document the date of his most recent use. The physician noted that his heart rate was 45-50 beats/minute and irregular. His assessment was bradyarrhythmia and probable hangover from alcohol overdose. He sent him to the OHU for observation and an EKG. The orders did not include vital signs. The youth arrived at the OHU at 1300. The nurse repeated the vital signs that were essentially unchanged.

The nurse documented that the OHU physician saw the patient but he did not write a note. He wrote no further orders. At 1438, the nurse measured the patient's vital signs, which were markedly changed (Pulse = 115 beats/minute and BP 134/77 mm/hg). At 1452, an EKG showed the patient's heart rate was 78 beats/minute with sinus arrhythmia with frequent PVCs.

The physician saw the patient the next day at 0825 and did not evaluate the patient's vital signs. He ordered a chest x-ray, CBC, and cardiology consult, and discharged the patient to the dorm. A part-time physician (who happened to be a cardiologist but not practicing in that capacity at the facility) saw the patient on 10/26 and determined that he had benign PVCs arising from right ventricle and reassured the patient, recommended avoiding alcohol use, a light potassium diet, and no physical limitation. His chest x-ray, CBC, serum chemistry, electrolytes, liver panel, and drug screen were all normal.

Assessment: Alcohol withdrawal is a concern for youth who may enter directly off the street. The physician noted that the youth had been drinking the previous night, but did not obtain a history related to the amount or extent of his alcohol consumption. Furthermore, the facility did not have an appropriate protocol for monitoring youth at risk for alcohol withdrawal. The patient's vital signs were not closely monitored. The on-site physician happened to be a cardiologist but was not acting in a consultant capacity; however, his evaluation was performed in lieu of a requested cardiology consultation. This was not clear in the health record documentation.

Health Records

New health record forms have not been implemented. The Problem List was often not completed and filed where it could be readily seen when the medical record was opened. In addition, information, such as normal physical examinations, the preparation of parole meds, and eyeglasses was sometimes documented on the Problem List. Such information does not belong there and makes the list less functional.

Information in the medical records was often not filed chronologically. Some forms and other papers were filed in different sections of the medical records in the different facilities. For

example, some facilities file HIV results in the laboratory results section, and others file them in the public health section.

Preventive Services

The preventive services program has not been implemented in any of the facilities.

- Most youth with chronic illnesses are being offered flu vaccines.
- In most cases, youth with chronic disease are not being offered pneumococcal vaccine.
- Yearly visits for weight and blood pressure checks, as well as for education, are not occurring. Blood pressure and weight are only documented for those youth who have been seen by the nurses for another problem.
- In most cases, tetanus-diphtheria boosters are not offered to youth who have not received one in 10 years.
- Most youth have been offered hepatitis A and B vaccines.

Dental Services

In anticipation of a dental expert being hired, the medical experts did not review dental services.

Consultation and Specialty Services

We found that in general, clinicians do not see patients within 5 business days following their specialty appointments to review consultant findings and recommendations with the patient and develop an appropriate treatment plan. Consequently youth are not receiving medical care in a timely manner. At most facilities there are significant issues with establishing contracts. A brief description of facility findings are described below.

At Ventura YCF, patients are not being seen by the medical staff within five days of their specialty appointments. Thus, there is no discussion to assess the youths' understanding of the consultant's findings and recommendations or the youth's willingness to follow the consultant's recommendations. In addition, while the consultant's reports are usually being signed off by the physicians or nurse practitioner, there often is no accompanying progress note.

At HGSYCF, patients were not routinely seen upon their return from specialty clinics. This results in similar problems as described above.

At SYCRCC, the contract with USC/LAC requires that when a clinician wants to refer a youth to a consultant, the youth must be evaluated in the emergency room before the hospital will schedule the appointment. This results in added cost and unnecessary transportation. Staff also reported that USC/LAC Hospital does not schedule appointments in a timely manner.

SYCRCC does not have a tracking system for specialty consultations and physicians are not following up with youth to ensure that the appropriate care is being provided. As a result, consultations are not consistently occurring within the required time frames. These issues should be addressed in contract negotiations. When consultations do take place, clinicians are not consistently seeing patients within five days of their specialty clinic visits.

At Preston, there was no x-ray technician from July 2006 until November 30, 2006. According to Dr. Horowitz, x-rays were only performed sporadically during that period, and she had advised the medical staff to send patient's who needed urgent x-rays to SJGH. This resulted in delays in obtaining and reading x-ray reports with resulting delays in referrals to the orthopedist or other specialists.

At NCYCC, primary care physicians do not fill out a consultation request form for on-site consultants. Thus, these consultants (e.g., dermatology) document their findings in the progress notes, rather than documenting on a consultation form. In addition, the primary care physicians were not following up either with patients who were being seen by on-site or off-site consultants.

We recommend that primary care providers request all consultations through use of the consultation referral form, and that results are documented and filed in the section for consultation reports.

During record review, examples of the problems we found included the following:

Patient 1: This patient was seen in surgery clinic at USC/LAC Hospital on 3/30/06 for evaluation of gall stones. The surgeon referred the patient for surgery. The surgery did not occur and he was sent back to surgery clinic for further evaluation on 9/19/06. The surgeon noted that the patient was a "candidate for surgery." There was no follow-up when the patient returned to SYCRCC. As of 11/14/06, the surgery had not been scheduled.

Patient 2: The patient was seen 8/25/06 in surgery clinic at USC/LAC Hospital for evaluation of an inguinal hernia. The surgeon noted that the patient needed a surgical repair. There was no follow-up upon the patient's return to the facility. The patient was sent to the emergency room at USC/LAC Hospital on 10/6/06 for evaluation of abdominal pain. The physician noted, "surgery pending, no date yet." As of 11/14/06, the surgery had not been scheduled.

Patient 3: The patient was seen at surgery clinic at USC/LAC Hospital on 4/18/06 for evaluation of a hernia. The surgeon noted that an elective procedure to repair the hernia would be scheduled. The patient was seen again at the clinic on 5/16/06 and the surgeon noted that he would place the patient on the elective list. The patient was sent to the USC/LAC Hospital emergency room on 10/24 for evaluation of abdominal pain. The physician noted that the patient had been seen by general surgery for his hernia. As of 11/14/06, the surgery had not been scheduled.

Patient 4: The patient had a history of hyperthyroidism. He saw an endocrinologist on 4/3/06. The endocrinologist noted that the patient did not exhibit signs or symptoms of hyperthyroidism and stated that his disease could be in remission. The endocrinologist recommended discontinuing the patient's medication and monitoring him. He recommended repeating laboratory tests in two weeks and again in one month to confirm remission. The tests were performed on 4/19 and 4/28/06, and indicated that the patient was still hyperthyroid. On 5/1/06, the physician reviewed the laboratory tests. He did not evaluate the patient, but instead ordered repeat laboratory tests in three months.

On 5/18/06, the patient submitted a health care request stating that he needed his medication. The physician saw the patient, but did not obtain a history or perform a physical examination related

to his thyroid status, and did not reorder his medication. He referred the patient back to the endocrinologist. The endocrinologist saw the patient on 8/21/06 and restarted his medications.

The patient did not receive timely or appropriate care for his hyperthyroidism.

Patient 5: The patient had a history of recurrent shoulder dislocations. The orthopedic surgeon saw the patient on 8/23/06 and recommended follow-up on 9/8/06 to discuss surgical options. On 8/28/06, a physician submitted a request for this consultation. The appointment was not scheduled as of 9/27/06. As a result, the patient has not received timely care.

Credentialing, Peer Review and Quality Management

Credentialing, peer review, and quality management programs have not been implemented at any of the facilities.

Recommendations

Headquarters

1. Finalize the Department, Headquarters and Field tables of organization and include all key positions. Adopt a uniform model for clinical and administrative supervision and oversight from headquarters to the facility level. The CMO should have administrative supervision over all health care operations in the facility.

2. Continue to work with CDCR Contracts Section to develop an efficient process for establishing and executing health care contracts in a timely manner.

3. Develop and implement a nursing health assessment and protocol program.

4. Finalize all initial policies and identify other health care policies to be developed in the next 12 months.

5. Develop and implement a clinical auditing program.

6. Finalize and implement the peer review, credentialing and organizational structure policies.

7. Once institutional missions have been determined and programs implemented, conduct a staffing assessment to determine staffing needs.

8. Develop and implement a plan to evaluate the cost effectiveness of pharmacy services. Consider establishing Licensed Vocational Nurse positions in DJJ as has been done in CDCR.

Facility

10. Increase collaboration between health care and custody staff to eliminate barriers to health care access.

11. Improve sanitation of the health care units and satellite sick call areas.

12. Improve communication and collaboration between facility and medical administration regarding budget and personnel issues.

13. Implement the newly published health care policies.

14. Nurses and clinicians should improve the quality of clinical assessments and documentation.

Dated: September 13, 2007

_____
Madeleine LaMarre, MN, APRN, BC

Dated: September 13, 2007

_____
Joe Goldenson, MD

Appendix A – Medical Contracts Memorandum

MEMORANDUM

TO: Joe Goldenson, Madie LaMarre, *Farrell* Medical Experts
FROM: Donna Brorby, *Farrell* Special Master
RE: Medical contracting (revised)
DATE: June 15, 2007

* *

I requested from DJJ the following information about health services contract requests made this fiscal year (2006-07):

Dates sent to CDCR
Dates contracts executed
Proposed or actual contractor
Current status.

As I continue to monitor the contracts issue, I will request the dates contracts awarded also. (Award is done by CDCR, essentially naming the potential contractor whose bid is accepted. The contract then must be approved by DGS in order to be executed.) I will also try to get information about the status of CDCR processing of DJJ's contract requests (what happens between DJJ's contract request and award of a contract).

DJJ provided an excel report tracking about 18 Health Services headquarters requests and about 36 DJJ facilities contract requests. I sent that to you by email. The tracking document shows long lapses of time from contract request to execution of contract (and many requests pending for a year or longer without contracts being executed).

After I received the tracking document, I met with Dave Gransee, DJJ Health Care Administrator, Nick Burgeson, DJJ's point person on medical contracts requests, Katie Riley, CDCR attorney, and Doug Ugarkovich, Farrell Litigation Coordinator, on June 4, 2006. Then, on June 13, 2006, I met with the same four individuals plus
Robert Morris, Medical Director, David Hale, DJJ Business/Contract Services Manager (on a 24 months assignment from CDCR to assist with contracting issues), Karen V. Smith, Deputy Director CDCR Office of Business Services, Debra Jones, Associate Director CDCR Office of Business Services and Joseph Watkins, CDCR Manager DJJ Contracts Unit.

In the two meetings, we reviewed the tracking document and discussed DJJ's contract requests. I will not review all of them here, but the following are exemplary:

DJJ requested contracts for dentist and dental hygienist services in May 2006. It had no response until December 2006, when CDCR said that DJJ would be covered in CDCR master service contracts for these services. As of June 4, DJJ (Nick Burgeson and Dave Gransee) had heard that the master contracts have been

awarded for dentists and dental hygienists, but they did not know if DJJ was included in the contracts. At the June 13 meeting, we all learned that DJJ was not included. DJJ's next step would be to resurrect the May 2006 requests.

DJJ similarly request contracts for psychiatry, psychology, psychiatric technicians, nurse practitioners, and nursing services in May and June 2006. It had been told it would be covered by CDCR master contracts. At the June 13 meeting, DJJ learned that it was not and would not be included in those master contracts. The communication disconnect was partly due to the fact that the *Plata* federal court receiver had taken over CDCR's medical contracting function for the adult prison system in December 2006. The 34 or so CDCR medical contracts staff reported to the receiver since then. They did not communicate with CDCR or DJJ when they removed references to DJJ in the medical contracts.

DJJ requested a contract for acute psychiatric hospital services from Sierra Vista Hospital in September 2005. That contract has NOT been awarded yet. First, there was a mistake in how the contract was drawn up (single provider instead of multiple provider). Sierra Vista bid, but the contract had to be redone and rebid. The second time, there were no bids at all. DJJ investigated to determine why expected bidders had not bid, and then made another request for contract to CDCR. DJJ does not know its status. In the meantime, DJJ has entered numerous emergency contracts/amendments under which Sierra Vista has provided emergency psychiatric services.

DJJ requested a clinical laboratory services contract in July 2006. The contract was awarded "last week" (end of May 2007). It has to be approved by DGS still to be executed. The contractor Latara Enterprises dba Foundation Enterprises will take over from Unilab Corp./Quest Diagnostics which did not bid this year. The Unilab contract expires June 30. There is a question whether there will be a disruption in lab services during the change over, especially if execution of the contract is close to the end of June.

DJJ requested a contract for a HQ Pharmacy Manager in July 2006. It was never awarded. DJJ finally hired a Pharmacy Manager after salaries were raised in about May 2007.

DJJ requested a contract for Clinical Records Administrator (headquarters) in December 2006. (The position then had been vacant since the beginning of September 2006.) DJJ does not know the status of the request. This was one of DJJ's highest priority requests. Lesser priority requests have been processed to completion while this one has languished.

The June 13 meeting that was arranged at my request was *not* the first between many of the same people. There was a similar meeting in August 2006. At that time, CDCR's two top administrators in the contracts function, Director Steve Alton and Deputy Director Karen Smith, took notes and promised to improve service to DJJ. From then until January 2007, DJJ staff had

regular meetings with the CDCR business office DJJ contracts manager (Karen Dolan until December 2006, then Kathy Gilpin, now Joseph Watkins). From DJJ's perspective, DJJ would provide information to CDCR at the meetings, but CDCR never had information to give DJJ information about the progress towards awarding and executing contracts. DJJ discontinued the meetings as a result.

As I have told you, there was a large meeting of *Farrell* counsel, DJJ staff and CDCR secretary Jim Tilton on October 20, 2006. Secretary Tilton promised to create a team of liaisons from CDCR to DJJ to solve the problems of the interface between DJJ and CDCR for purposes of improving CDCR's services to DJJ, including contracts services. In about May 2007, CDCR did temporarily transfer a number of staff to make the relationship between CDCR and DJJ work to meet DJJ's legitimate needs. David Hale is on a 24 month assignment from CDCR. He seemed very knowledgeable about contracts issues and the CDCR process. He said he would have a staff, probably of five. This is a step beyond anything that has happened before in the area of efforts to create a working system for DJJ to develop and enter into contracts.

At the June 13 meeting, CDCR and DJJ agreed to a work plan for getting the most important contracts in place and improving the system for processing DJJ contract requests, and they promised to meet again in a month.

I will continue to monitor the progress and report to you.

Appendix B – Patient ID Numbers

Medical Care:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		
Patient 6		

OHU:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		
Patient 6		

Consultations:

Patient 1		
Patient 2		
Patient 3		
Patient 4		
Patient 5		

REPORT OF SITE VISIT AND AUDIT OF THE SEXUAL BEHAVIOR TREATMENT PROGRAM

PREPARED FOR
DONNA BRORBY, SPECIAL MASTER, *FARRELL v. TILTON*

CALIFORNIA DEPARTMENT OF CORRECTION AND REHABILITATION-
DIVISION OF JUVENILE JUSTICE

BY

Barbara Schwartz Ph.D.
Sexual Behavior Treatment Expert

August 2007

Introduction:

I conducted site visits at four facilities. The first site visit and audit was conducted at two CDCR-DJJ facilities located in Stockton, California on May 24 and 25. I was accompanied and assisted by Monitor Cathleen Beltz. On the first day of the visit I interviewed staff, observed a therapy group, met with the Personnel Department and reviewed files at O.H. Close. The second day was spent at Chaderjian where I met with staff and residents, observed a group and reviewed files. Exit interviews were conducted at both facilities.

The second visit occurred on July 26, 2007 at the Southern Reception Center and on July 27, 2007 at Stark. Present during the visits were Monitor Cathleen Beltz assisted me with the gathering of documentation and with interviews of staff and youths. Also present were Dr. Fred Martin, Dr. Paul Woodward, Barbara Edgar, Katie Riley and Rebeka Lachear.

May 24, 2007: Stockton Complex (O.H. Close and N.A. Chaderjian)

On this day myself and Monitor Beltz met with Drs. Stevens, Bowlds and Dr. Martin. There ensued a discussion of the proposed moves that have been postponed. Remodeling of the Humboldt Unit at Close and moving of the SBTP from the Feather Unit at Chaderjian have been delayed due to recent legislation and the Governor's budget. The Sex Offender Task Force continues to meet and will be convening in June, 2007.

The following issues emerged at the Humboldt Unit:

- There is still no organization chart for the SBTP and the staff still doesn't know whether SBTP will be under Mental Health, which was Dr. Martin's impression, or the Behavioral Program which was the impression of the Personnel Department.

- 60 staff attended CCOSO in San Diego within the past month. This included most of the staff working with the SBTP and represents exceptional support for training.

- Currently there are two psychologists working at Feather and next week Dr. Bowlds will be the only psychologist at Humboldt. Additionally she is being called out of the Program to sit on various committees and to supplement the Mental Health staff at DeWitt.

- Polices and procedures were being developed but the process was stopped in order to make sure that all DJJ policies were uniform and did not conflict.

- Legal issues on Informed Consent and Confidentiality have not been clarified.

- Dr. Bowlds is using a form that tracks the stages of the program for the Humboldt Unit. However, the form does not correspond to the specifics that exist in the curriculum. The form that the Task Force was developing has not been completed or implemented.

- Only 55% of the 60 program participants are in resource groups.

- Both process and resource groups are very small (4 to 6 participants). More program participants could be in resource groups if the groups were larger.

- The scheduling of groups is still vague. I attended a group that was theoretically supposed to run between 10am and 2:00pm. This group actually meets between one and two hours a session. This is not an optimal way to run groups. Traditionally groups are run on a set schedule of 90 to 120 minutes.

- The DJJ files remain inconsistent across facilities and confusing because documents are in four to five different files. Some staff keep soft files, which allow the therapist to document progress, file relevant assignments and do treatment planning. I recommend that DJJ create one SBTP file containing all information needed for effective treatment.

- I observed a group of four youths conducted by Dr. Herskovic. Three of the participants were relatively new in the program. They discussed personal issues but there was little discussion of sex offender specific issues although the participants did appear to be doing related homework.

The following issues were discussed with the Personnel Department:

- Dr. Martin is not in the loop regarding filling positions and has not been asked to sit in on hiring panels even for SBTP positions. Additionally he was not aware of how many vacancies exist in the SBTP, or that positions in his program were being allocated to general mental health duties. As just mentioned, the newly filled SBTP have been reassigned to Mental Health. I met with the psychologists at Humbodlt and Chad. I know all of these individuals and was repeatedly assured that these four psychologists were the only ones functioning in the program as per the date of the audit. I was also told by Dr. Martin, Dr. Bowlds, and two employees of the Personnel Department that psychologists including one who had begun to work for the SOTP were reassigned to Mental Health. No psychologists from Mental Health were reassigned to work for the SOTP.

- Salaries for psychologists have been increased, and this has resulted in an increase in applicants.

- Applications are delayed because live scans take 2 to 3 months in DJJ vs. a reported 10 days in the adult system.

- The post and bid system continues to present a challenge to the training and retention of Youth Counselors who are interested in working with this population. This is particularly concerning since they provide the bulk of the SBTP therapy and

they generally have little relevant education or previous training when they first come to work in the SBTP units.

May 25, 2007: N.A. Chaderjian

The visit to the Feather Unit revealed the following issues:

- Staff reports that the violence that once characterized Chaderjian has been transferred to DeWitt. The SBTP participants at Chad can now go to school without being in physical danger.

- Staff feels marginalized. In the process of renovating the Feather Unit, the youths were moved to a different housing unit. The SBTP staff reported that received no notification of this move and only found out about it when the youths informed them.

- The post and bid process has significantly impacted treatment. There have been instances where staff that were qualified, interested and experienced have been replaced with staff that were unfamiliar with program operations and had little interest in working with this challenging population.

- One of the majors (Steve Gardner) has been particularly supportive of treatment.

- Moving Parole Violators into the Mojave Unit which adjoins Feather has necessitated conducting educational classes for this population in a shared dining room which has windowed doors into both the SBTP living unit and group room. Residents from Mojave routinely peer through these windows and harass SBTP residents. The group room has become a hall through which staff routinely walk, disrupting the group in the process. Teachers have frequently interrupted groups including stopping to talk to group participants just as another group member was about to make a critical disclosure. This situation would have been corrected if the SBTP could have been moved as planned but the construction process has been delayed.

- A resource group on substance abuse was observed. Dr. Kirkwood was running this group although YCCs are supposed to conduct these groups. Dr Kirkwood told me that he felt this group was too important to leave to an untrained individual who would be relying on a set of handouts. The YCC who sat in this group was on a computer at least half of the group that made a statement to the group members about how much the group was valued.

- In the Individual Change Plan the only reference to treatment goals relating to their inappropriate sexual behavior was the statement, “I am a sex offender.” Not only does this statement challenge the philosophy that these youths are more than their

inappropriate sexual conduct but it is not helpful to treatment planning as it does not identify the specifics of the problem or indicate remedial plans.

- Documentation of individual participation:

    - E's group notes indicate that he participated in two hours of SBTP group per week with individual therapy one hour a week and three resource groups, at least two of which were not l related to the SBTP.
    - J's record shows that he attended four different resource groups in a week, at least two of which were not SBTP-related (IMPACT and Restorative Justice). He also attended 30 minutes of individual treatment. Between May 1 and May 24, 2007 he attended one 60 minute SBTP. In April he attended two 120 minute SBTP groups.
    - T's record showed attendance at five groups between 1/4/07 and 5/3/07 although four additional groups had been documented in May with the notes being completed on May 24, 2007.

- Youth 1 was interviewed as a program participant who has done well in the program. He would have been rated as a high risk offender. He initially was in Humboldt Unit but admitted to not participating seriously in the program. He was transferred to Preston where he participated in an informal program and was transferred to Chaderjian eleven months ago. He does show good comprehension of relapse prevention and was able to describe his high risk situations and his cognitive distortions. This youth appears to have benefited from the program.

- Youth 2 was ordered by the court to complete "sex offender treatment." He was sent to O.H. Close for three months in 11/04 and then to Preston where he was in an informal program that met once a month. He was then told that he would not receive credit for his participation in the Preston program, and his sentence was extended. He had been writing DJJ administrators to transfer him into a recognized program. Since his transfer, it appears that he is being rushed through the program to make up for the delay in his treatment. He has been rated at Stage 8 of the program but has little realistic idea of his high-risk situations. He sees no need to continue sex offender treatment. Youth 2 is at very high risk to re-offend sexually and/or violently. He is being rated as having almost completed the SBTP but shows little understanding of behavior or of risky situations. I am commenting on this as it reflects on the need for a clear policy on what "completion" of the program means and what is the process for deciding when one has or has not finished the SBTP.

July 26, 2007: Southern Youth Correctional Reception Center and Clinic

Initially we met with the above mentioned staff from Central Office as well as Dr. P. Courelli, Dr. D. Leong, E. Mejia, and Ted Bonzon at the Southern Youth Correctional Center and Clinic in Norwalk, CA. Our initial meeting focused on updating personnel issues for the SBTP. Encouragingly, six psychologists have been offered positions at

Close and Chad. Staff at Southern described how the youths were on a 30 day summer break and that 36 of the 49 youths in the SBTP were participating in a Leadership School. The staff believes that the decision has been made not to move the SBTP, at least in the near future. We attended a presentation prepared by the participants in the SBTP which included a description of a number of other institutional programs. It was a pleasure to see the young men looking very handsome in the clothing provided to them through the Dress for Success Program which focuses on improving the youth's self concept by teaching them hygiene, grooming, job interview skills, etc and provides them with appropriate dress clothing. The youths also gave a presentation on the California Cadet Corps and the Restorative Justice projects which have been done on Sutter Unit (SBTP). The residents of the program gave presentations demonstrated a knowledge of basic treatment concepts such as their cycles. One participant presented a poem he had written on thinking errors. The presentation lasted for several hours.

In the afternoon staff and youths were interviewed by Monitor Beltz. She was given a list of questions and interviewed youths which were chosen by me, recording their verbatim responses which I reviewed. This was done because an inordinate amount of time at SYCRCC was taken up with a formal presentation by the youths which dealt primarily with generic programs such as the "Dress for Success" Program, the Cadet Program, and Restorative Justice program. Consequently there was not time to interview both individual youths and attend groups. Additionally I chose to observe a family therapy session in which a youth and his family agreed to a Section 1800 being filed and not to challenge this in court.

The results of the interview reflected positive views towards the staff and the program. It also as mentioned below reflected mixed opinions about whether youths knew how they might be terminated or suspended from the program. Respnses to questions about relapse prevention varied depending upon the stage of the program the participant was in..

I attended a family therapy session that included a youth, his mother and his grandparents, Dr. Courelli and Ted Bonzon.

The following issues were noted:

- I observed a family therapy group that involved a young man who had done quite well in treatment and because he was doing well in treatment, he revealed that his inappropriate behavior had been more extensive than he had previously admitted. He had revealed that he had initially had not been completely candid with his treatment team or his family. It should be noted that this is completely predictable and is the pattern for almost all sex offenders in treatment. He was due to be released to a very caring family. However, Dr. Courelli and Mr. Bonzon recommended that this young man agree with the filing of an 1800 petition that would extend his commitment for up to two years. While additional offenses or additional victims should necessitate some revision of his previous work, it should not require two years of additional work. I am commenting on this as it reflects on the need for a clear policy on what "completion" of the

program means and what is the process for deciding when one has or has not finished the SBTP. While at a northern facility I observed a ward being rushed through the treatment program so that his time would not be extended, here was a youth who is doing well in treatment being recommended for a Section 1800.

- A review of records indicated that YCCs and psychologists are co-leading groups that is good. However, both individuals do notes on the groups and each files his/her group notes in different files. Therefore not only is this a duplication of efforts but the files may not be identical and may even contradict each other. Additionally psychologists record their notes on the WIN system but these are not copied and filed in the UHR per DJJ policy as there is no clerical staff to perform this function.

- YCC group notes were reviewed and the following average length of groups over the past three months were noted:

    - YCC #1=114 minutes/week
    - YCC#2=128 minutes/week
    - YCC#3=106 minutes/week
    - YCC#4=108 minutes/week
    - YCC#5=106 minutes/week

- The plan indicates that SBTP participants are to receive 180 minutes of group therapy per week. Mr. Bonzon stated that the program counts "prep time, briefing, face-to-face, debriefing." It is my opinion that this was not the intent of the plan which I believe calls for 180 minutes of actual group therapy.

- In June the following number of wards participated in the following resource groups:

    - Gang Awareness=4-6
    - Substance Abuse=7-8
    - Relapse Prevention=7 to 8
    - Stress Management =16
    - Criminal Thinking=7-8

- Some of these youths are participating in more than one of the above listed groups. Some of these groups are offered to all youths in a facility such as Gang Awareness, and it is not clear how generic all of these groups are. For example, stress management could be based on a curriculum designed for antisocial youth in general rather than specifically designed for individuals who manage stress by behaving in sexually inappropriate ways. The youth also participate in generic groups such as the Cadet Program, and Dress for Success.

- One of the most significant concerns is that although the staff that I observed appeared to be enthusiastic, devoted and skilled, they each appeared to be "doing

their own thing." For example, Dr. Courelli is offering a Multi-systemic Approach to working with families; it appears that this is limited to the families of the youth that she is treating rather than being something that has been adopted by the program as a whole. There was no documentation between staff suggesting that psychologists cross-refer youths to each other.

- Because the psychologists and the YCCs work under different departments, it is not clear who is providing leadership at the different SBTP sites. Therefore it is not clear who has the authority to form a uniform program. It is not even clear whether Dr. Martin has the authority to insist that YCCs and psychologists offer the amount of treatment required by the plan. When an organizational chart is provided, this should clear up the matter.

July 27, 2007: Heman G. Stark Youth Correctional Facility

We visited the Heman G. Stark Youth Correctional Center in Chino, California. We met with Drs. Poncin and Barrington, Ms. Hetherton and Mock. Files were reviewed, youths and staff were interviewed. I sat in on a group for special needs youth and later on in the afternoon on a resource group.

The following issues were noted:

- Reportedly all the positions on the SBTP have been filled with the exception of one position which is either YCC position or a parole agent position. The staff was not sure.

- It was reported that each YCC does two resource groups and four casework groups. The resource groups reportedly run two to four months with five to six members.

- In the files completed by the YCCs, there is no uniform notation of whether a note refers to a group or an individual session and rarely was there documentation of length of session.

- Psychologists were conducting groups that lasted on the average about one hour a week. Dr. Barrigan has directed them to provide three hours a week in two 90 minute sessions.

- Ms. Hetherton has developed curriculum for 17 classes as well as an extensive collection of experiential exercises. This would be a valuable tool for the whole program, provided that copyright issues can be resolved.

System Issues:

- Director of SBTP should be a Chief Psychologist position as it involves supervision psychologist staff in several institutions. These individuals may also be supervised by Chief Psychologists at their respective institutions and the Director of SBTP should be at a comparable level.

- The plan requires that the treatment be offered by "qualified staff." That could be mean mental health professionals who have specialized training in sex offenders. It could also mean that all staff have relevant college degrees with additional training in treating youth with inappropriate sexual behavior. It could also mean that whatever educational level, the staff has comprehensive specialized training and their duties are structured, based on carefully developed and approved curriculum and they receive appropriate supervision as outlined in the plan. Those staff that were interviewed indicated that they had college degrees with some training in dealing with sexually inappropriate youths. Because educational background and training records were not provided, it is not possible to determine if all staff that are providing treatment are qualified to do so.

- While attendance at conferences is one way of receiving training and the effort and expenditure to send 60 staff to a statewide conference is very commendable, adequate training must include at minimum a written training plan which outlines an initial training period for new staff and a plan for yearly in-service trainings.

- The SBTP Task Force is being expanded to include representatives from Parole and Education. Staff have mixed feelings about this, being concerned that there may be a lack of consistency with these representatives and this would hold up decision-making processes. I concur that unless consistent attendance by assigned professionals can be insured that it might confuse and delay decision-making processes

- Use of interns---Dr. Herskovic is transferring to a position supervising interns who are to rotate through different programs. This may prove to be a valuable recruiting venue for filling SBTP slots.

- Files continue to lack standardization needed to facilitate both the provision and the monitoring of treatment. In some facilities both YCCs and psychologists both do notes on the same group that are filed in different files. This is a duplication of effort and may be confusing as groups may not be similar. Also a lack of clerical staff has limited transferring notes from the WIN system to the UHR.

- Dr. Cellini has begun meeting with the Task Force, has completed most of the Healthy Living Curriculum which I saw and has scheduled its piloting. I also observed during this visit and had previously been aware that the portions of the curriculum written by DJJ were not uniform in style with the rest of the curriculum. In fact, one module was simply downloaded from the Internet. Thus these will need to be rewritten. I met with Dr. Cellini on July 28, and we held a conference call with Dr. Martin where the Healthy Living curriculum was discussed.

- Personnel Issues

    - A rise in salaries has resulted in more applicants for psychologist positions.
    - Although it is not clear, there initially appeared to be between 8 and 10 open psychologists positions in the SBTP. Dr. Martin reports that all but possibly one casework supervisor or parole officer position have been offered to qualified individuals.
    - Several SBTP positions have been filled but then transferred to fill mental health positions. This was confirmed by two personnel staff members in Stockton.
    - Dr. Martin had not been included in the hiring panels for SBTP positions. This appears to have been corrected.
    - The YCC positions can be filled by anyone who has one year experience as a correctional officer with no degree required. These individuals are supposed to provide the bulk of the SBTP treatment. DJJ is unable to provide YCC qualifications to the expert. Those interviewed did report academic qualifications beyond the minimum. This standard could also be met if evidence can be provided that YCCs are only providing treatment as supervised co-leaders of groups and only teach resource groups where a structured, approved curriculum is provided.

- There are reportedly treatment programs for youths with inappropriate sexual behavior being offered at other but these programs are not included in the SBTP. These programs should either by included under the SBTP jurisdiction, or their function clarified.

- The SBTP Task Force had not developed a form that outlines progress in the established treatment program. Dr. Martin has now provided me with a Treatment Matrix which is now ready to be implemented.

Conclusion:

This audit initially addressed the two northern facilities where SBTP is offered (Close and Chaderjian). The southern facilities were audited in July, 2007. Dr. Cellini was met with in July as well. Formal audits have been delayed in hopes that contract issues affecting Dr. Cellini's retention would be resolved, and that the program regained the progress that was made in 2005. Dr. Cellini is now back on board and working on finalizing the Healthy Sexuality curriculum and will begin work on either the Residential or Outpatient curriculum thereafter. It is my recommendation that the Residential curriculum be developed next for two reasons. It would be relatively easy to abbreviate the Residential curriculum, choosing the most relevant sections to use as the Outpatient curriculum. Additionally the Residential Programs are currently in existent but in desperate need of standardization. A program director has been hired. DJJ has sent several SBTP staff to a national conference and more recently sent 60 staff members to a

statewide conference. At the time of the first part of this audit, the Task Force had continued to meet regularly, projects such as contracting for training in the J-SOAP, development of a form to track treatment progress and development of policies and procedure had not progressed. However, the staff have now been trained on the J-SOAP and the treatment matrix has been finalized although not as yet implemented.

The planned move that would consolidate two of the four programs seriously impacted the morale of both the staff and the participants. The uncertainty of this major change continues to impact the program. Though persistent vacancies in psychologist positions undermined the program for some time, psychologist salaries were increased and it would appear that most of these positions have now been filled. Dr. Martin had not been involved in the hiring process for the SBTP positions but now he is. However, the designation of his position as a Senior Psychologist as opposed to a Chief Psychologist places him at a disadvantage in supervising staff that may also be taking orders from the Chief Psychologists at their respective institutions. Dr. Martin needed to be involved in the hiring of all of SBTP clinical positions, and the Personnel Department has agreed. This has happened.

The problems with the program are exemplified by the situation at O. H. Close that was previously the flagship of the SBTP with the strong leadership of Rosa Rivera, three psychologists and strong YCC staff. Ms. Rivera has retired and two of the three psychologists will have left by June 2007. As of the time of the site visit in May 2007, this left the entire program to be operated by Dr. Bowlds who was frequently called away in the middle of therapy sessions to cover other institutions. Were she to leave, the program would collapse.

The SBTP needs standardization in its operation as well as documentation. This requires uniform policies and procedures, formal training on assessment and treatment techniques as well as a comprehensive curriculum. A training program for psychologists and YCCs working within the SBTP would bring all of the current and future staff onto the same page regarding the treatment model. A comprehensive training plan for SBTP and other facility staff needs to be developed which would not only include hours of training as well as who is responsible at each facility but also the curriculum including pre- and post testing. Materials for resource groups could be standardized by adopting curriculums that have already been developed across institutions. For example, The Prepare Curriculum by Arnold Goldstein, which is a collection of detailed coursed for teaching pro-social skills to adolescents, could be implemented across institutions for less than $125.

The J-SOAP and the Treatment Matrix need to be implemented. Ethical issues such as Informed Consent and Confidentiality need to be clarified. The issue of the records remains unresolved; an effective treatment program can only be conducted and monitored if the records are accessible and useable. In general, SBTP has an excellent staff that are committed and enthusiastic but are working without direction, which results in inconsistency in approaches and an inability to spread the ideas and innovations of one staff to the program in general. The fact that the SBTP team works under different

organizational divisions creates a lack of communication, duplication of efforts and a failure to have a workable method of recording treatment progress and issues. However, SBTP has made some definite progress over the past several months.

September, 2007

_____

Barbara Schwartz, Ph.D.
Farrell Sexual Behavior Treatment Expert

Standard	Title	Description	Audit Criteria	Compliance Rate
1	**Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program**	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	a) The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Goal: Approved/Disapproved Rating: Disapproved The policies and procedures were started but DJJ has deferred them until all policies and procedures can be consistent This is preventing the SBTP from implementing uniform approaches, even on issues which would not impact other programs.
2	**Treatment Model**	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	a) Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs participants. While	Compliance Goal: 95% Rating: Partial [1] *While there are no special groups for special needs offenders, there are groups for Spanish-speaking offenders ** A group for special needs youths was observed at HGS. SRC reports that one Spanish-speaking youth was assigned to a caseload of a Spanish-speaking YCC. However, the groups are not conducted in Spanish and this youth actually speaks English well, according to

[1] * Indicates that this was observed on the visit to the northern facilities.
** Indicates that this was observed in visit to southern facilities.

Standard	Title	Description	Audit Criteria	Compliance Rate
				Dr. Uliani. She stated that he would benefit more from a special needs group but there are none available. Some youth with co-morbid conditions are receiving individual therapy for these issues.

Standard	Title	Description	Audit Criteria	Compliance Rate
3	**Screening and Assessment**	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be an evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	a) Expert will review the protocol for the development and/or selection and administration of appropriate screening and assessment tools	Compliance Goal: Approved/Not Rating: Not Approved *DJJ is continuing to use the SORD and this was present in all of the cases reviewed. The staff has reviewed an assessment instrument but this instrument does not meet the needs of the SBTP. ** DJJ-SBTP has scheduled training on the J-SOAP to be conducted in the middle of August. ** Despite the fact that Paul Woodward stated that SORD scores are emailed to all facilities with the intent that scores be placed in the youth's file, no SORD scores could be found at SRC. **At HGS eight of the nine files reviewed had both the SORD score as well as the SORD instrument.

Standard	Title	Description	Audit Criteria	Compliance Rate
			b) The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	Compliance Goal: 95% Rating: 50% This rating reflects the fact that psychological assessments were present in some of the files but they were not part of a consistent assessment approach that is utilized throughout the SBTP.
4	**Multi-modal Treatment** **Model-*Residential Component***	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model, which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, and Heman G. HGS YCF.	a) The expert will review 10% of files for the presence and appropriate-ness of group notes documenting individual progress in at least three hours of core group therapy per week.	Compliance Goal: 95% Rating: Partial *Neither O.H.Close nor Chaderjian are offering three hours of core group therapy a week. They appear to offering an average of two hours a week (See Narrative) ** Neither SRC nor Stark are offering three hours of core group therapy. They are currently offering less than two hours of core group therapy. However, Dr. Barrigan at HGS has instructed the psychologists to begin doing two 90 minute groups a week.

Standard	Title	Description	Audit Criteria	Compliance Rate
			b) The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week.	Compliance Goal: 95% Rating: Partial The records reflect that all of the records had evidence of case conferences but none of the participants are receiving individual therapy three times a week.

Standard	Title	Description	Audit Criteria	Compliance Rate
			c) The expert will review for presence and appropriateness of the resource group notes documenting that at least eight difference groups are offered on a ten-week schedule. The expert will review resource group schedule and lists of participants.	Compliance Goal: 95%[2] Rating: 30% *There are 9 Resource groups being offered at Close but only 21 out of 55 youths are participating in them, At Chad, 41 out of 49 youths were participating in at least one resource group but the majority of these groups were offered to all institutional residents and not operated by the SBTP. ** At SRC six resource groups were reported. However, some of these are generic groups which are offered to all of the facility residents and are not related to SBTP. at least one group was clearly related to SBTP but only accommodated 7-8 youths. **I observed a resource group at HGS but it is not possible to tell from the records which youth are in resources groups and which have completed resource groups. The notes co not consistently identify what they are about. Ms. Heatherton agreed to have the YCC's document in a title what the note is about. Several residents had certificates of completion in their files others did not. Notes on one resident indicated that he had completed 8 resource groups but there were no certificates.

Standard	Title	Description	Audit Criteria	Compliance Rate
			d) The expert will review 10% records for the presence and appropriateness of special resource group notes documenting that at least two different special resource groups offered on a ten week schedule	Compliance Goal: 95% Rating: Partial There were no group notes documenting special resource groups. These groups may be being conducted but there was no way to determine this from the records.
			e) The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Goal: 95% Rating: Partial *There is some work being done with families but there is little documentation of family sessions or attempts to contact families. ** SRC maintains a family contact log and contact with families was documented in 5 of 7 files. **HGS does not document family involvement.

Standard	Title	Description	Audit Criteria	Compliance Rate
			f) The expert will review for presence and appropriateness of relevant documentation of meetings with family members.	Compliance Goal: 95% Rating: Partial * There were no notes documenting this. **I observed a family group being conducted at SRC. I presume that will be documented in the mental health record. **Staff at HGS report that they regularly attempt to contact families; however, they report little success in involving families in youth treatment often are unable to reach youth families at all.
			g) The expert will review 10% of records for presence and appropriate-ness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	Compliance Goal: 95% Rating:0 % There are no maintenance groups

Standard	Title	Description	Audit Criteria	Compliance Rate
5	**Multi-model Treatment Model-** ***Outpatient Component***	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model, which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	a) The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week.	Compliance Goal: 95% Rating: 0% There are no outpatient groups as described in the master plan.
			b) The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks	Compliance Goal: 95%

Standard	Title	Description	Audit Criteria	Compliance Rate
			c) The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule.	Compliance Goal: 95%
			d) The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Goal: 95%
			e) The expert will review for presence and appropriate-ness relevant documentation of meetings with family members	Compliance Goal: 95%

Standard	Title	Description	Audit Criteria	Compliance Rate
			f) The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.	
6	**Milieu Therapy in Residential Treatment**	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	a) The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week.	Compliance Goal: Present/Not present Rating: Not present No documentation. While the staff of SYRCC reportedly gave the audit team a packet containing the signatures of youth participating in weekly Therapeutic Community groups, this was in the packet I received.

Standard	Title	Description	Audit Criteria	Compliance Rate
			b) The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program	Compliance Goal: 85% Rating: 0% No documentation
7	**Individuation of Treatment**	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	a) Expert will review a random selection of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided. b) Expert will review rosters of specialized resource groups and other therapeutic experiences.	Compliance Goal: 95% Rating: Partial * Northern programs did not have specialized groups **HGS did have a specialized groups. All of the programs provide some degree of individual therapy which can address special programs

Standard	Title	Description	Audit Criteria	Compliance Rate
8	**Treatment Plans with Objective Goals**	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	a) Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants b) Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	Compliance Goal: 95% RATING: 40% There are periodic treatment plans at all facilities but they are not coordinated with the levels of the SBTP. Dr. Martin has now provided me with a copy of the treatment matrix which will be used to do this. Compliance Goal: 95%
9	**Victim Outreach**	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	a) The expert will review the file of correspondence with community therapists. b) The expert will review documentation of outreach to victims' agencies	Compliance Goals: Present/Not Present Rating: Not present

Standard	Title	Description	Audit Criteria	Compliance Rate
10	**Staff Qualifications**	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	a) Expert will review the number and professional qualifications of SBTP staff.	Compliance Goal: 100% Rating: 50% All psychologists have academic qualifications. The expert was not provided with qualifications of YCC staff although interviews with a sampling of this staff showed that most had educational qualifications above the minimum required.
11	**Staff Training**	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	a) Expert will review training records of the SBTP staff.	Compliance Goal: 95% Rating: 50% DJJ sent 60 staff members to a conference but there is neither a training plan nor consistent or ongoing training in the SBTP approach. ** SRC provided evidence of an "all day team meeting and training" Training records were provided. **HGS also provided staff training records.
12	**Staff Supervision**	The program provides regularly scheduled	a) The expert will review a log of	Compliance Goal: 95% Rating: Not reviewed

Standard	Title	Description	Audit Criteria	Compliance Rate
		supervision for all staff working directly with wards.	supervision meeting. No log of supervised with provided.	
13	**Multi-disciplinary Team Reviews**	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	a) The expert will review minutes of the multi-disciplinary teams.	Compliance Goal: 95% Rating: 95% There are minutes of Multi-disciplinary team reviews, which focus on the overall program with few specific references to progress in SBTP.
14	**Ethics**	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that	a) The expert will review written procedures regarding confidentiality and informed consent	Compliance Goal: 100% Rating: 0% Legal has been consistently requested to clarify DJJ's stance on various ethical issues but this has never been responded to.

Standard	Title	Description	Audit Criteria	Compliance Rate
		confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	b) Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies	Compliance Goal: 100% Rating: 0%
15	**Program Completion**	Completion of the program reflects the completion of competency-based goals.	a) The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Goal: 95% Rating: 0% It was noted that the absence of this contributed to one youth having a Section 1800 filed

Standard	Title	Description	Audit Criteria	Compliance Rate
16	**Suspension/Termination from SPTP**	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	a) The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination. b) Audit will review 20% of records of terminated or suspended participants to insure the they comply with policy	Compliance Goal: 95% Rating: 0% ** Selected youth at SRC were interviewed and were not uniformly aware of what would get them suspended or terminated. No documentation in the records indicate that youth receive the orientation that the facility indicate that they receive. Compliance Goal: 95% Rating: Not Rated
			c)	

Standard	Title	Description	Audit Criteria	Compliance Rate
17	**Pre-release**	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	a) The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release	Compliance Goal: 95% Rating: Not Reviewed

Standard	Title	Description	Audit Criteria	Compliance Rate
			b) The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group	Compliance Goal: 95% Rating: Not Reviewed
18	**Aftercare**	CYA will contract with community vendors to provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment	a) The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract.	Compliance Goal: 95% Rating: Not Reviewed

Standard	Title	Description	Audit Criteria	Compliance Rate
		and informed supervision	b) The expert will review documentation that the SBTP has been involved in the training of parole personnel.	Compliance Goal: Present/Not Present
19	**Program Evaluation**	CYA will conduct an evaluation of the SBTP, which will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	a) The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines	Compliance Goal Present/Not Present

Standard	Title	Description	Audit Criteria	Compliance Rate
20	**Program Materials**	CYA will contract with a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	a) Audit will review written contract with publisher for compliance with contract	Compliance Goal: Present/Not Present Rating: Partially Present: this is presently being done partially by Dr. Cellni
21	**SBTP Program Coordinator**	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	a) The expert will evaluate whether this position has been filled.	Compliance Goal: Achieved/Not Achieved Rating: Achieved
22.	**Vocational Training**	The CYA will make vocational opportunities available for youths with sexual behavior.	a) The expert will evaluated vocational training opportunities for youth with sexual behavior.	Compliance Goal: Present/Not Present Rating: Not Evaluated
23.	**Physical Facilities**	CYA will insure that adequate and appropriate physical facilities for available	a) The expert will inspect the physical facilities to insure that they are	Compliance Goal: Present/Not Present Rating: Partial

Standard	Title	Description	Audit Criteria	Compliance Rate
		for both the residential and outpatient programs.	appropriate for conducting a therapeutic program.	The current facility at Chad is inadequate. The space is tiny and is used as a corridor. Facilities at other institutions are adequate.
24	**Behavioral Management System**	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward prosocial behavior and provide reasonable consequences for antisocial behaviors	a) The expert will review 10% of all records for documentation, which supports the use of such a system. b) The expert will review 10% of files containing disciplinary reports for documentation, which supports use of such a system.	Compliance Goal: 95% Rating: Not Rated Compliance Goal: 95% Rating: Not Rated
26	**Healthy Sexuality Programs for all wards**	CYA will establish Healthy Sexuality Programs for all wards of CYA.	a) The expert will review records, which document existence of such programs.	Compliance Goal: 95% Rating: 50% I went to Dr. Cellini's office and he showed me the Healthy Sexuality curriculum, which appears to be completed. The program will then need to be piloted, staff trained and

Standard	Title	Description	Audit Criteria	Compliance Rate
				the program implemented. .
27	**Training of Adjunct Staff in Needs of Youths with Sexual Behavior**	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior.	a) The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior.	Compliance Goal: Present/not Present Rating: Partial At Chad, this training was being conducted. This item was not monitored for at other facilities
			b) The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Goal: Present /not present Rating: Not present

In addition to review records, the expert will directly observe these activities and facilities.

Introduction

This report represents the second auditing report by the Disabilities Expert and Auditor, Logan Hopper, in response to the Consent Decree entered in the matter of *Farrell v. Tilton.* The Consent Decree requires that the Disabilities Expert visit each of the eight DJJ correctional facilities during each fiscal year and report on the progress DJJ is making in the implementation of the Wards with Disabilities Program (WDP) Remedial Plan, filed with the Court on May 31, 2005. From October, 2006, through June, 2007, the Disabilities Auditor visited these facilities in the following order:

O.H. Close Youth Correctional Facility
N. A. Chaderjian Youth Correctional Facility
El Paso de Robles Youth Correctional Facility
Ventura Youth Correctional Facility
Heman G. Stark Youth Correctional Facility
Preston Youth Correctional Facility
Dewitt Nelson Youth Correctional Facility
Southern Youth Correctional Reception Center and Clinic
Division of Juvenile Justice Headquarters

At each facility visited, the Disabilities Auditor completed an evaluation of the facility's compliance using the approved Disabilities Auditing Instrument, dated May 31, 2005. After each visit, the Disabilities Auditor prepared and submitted to the Office of the Special Master a detailed report providing the compliance rating and a commentary on the implementation progress for each item.

Executive Summary

At the most basic level, two separate but related components with respect to implementation of the WDP Remedial Plan appear to have evolved.

The first component involves the formation and implementation of a formal WDP program at each facility, as well as the supervision and coordination of DJJ's departmental efforts to comply with the plan. This component revolves around the filling of the WDP Coordinator positions at each facility and headquarters. For some facilities, this is the second fiscal year with an active WDP Coordinator, while others have had the position filled only during this fiscal year. Therefore, the extent to which the program has progressed at each facility is almost directly proportional to the length of tenure of the WDP Coordinator.

However, despite the varying degrees of experience with the details of the program, the actions of these WDP Coordinators represent one of the strongest aspects of the WDP Program. As a whole, the Disabilities Auditor would give the highest commendation to these individuals for their demonstrated dedication, knowledge, and effectiveness in undertaking the many difficult tasks involved in the WDP implementation. As the departmental WDP Coordinator, Karen Smith is believed to be performing her duties in an exemplary manner and has trained and provided many of the necessary skills to the facility WDP Coordinators. (It should be noted that her duties have been hampered by the lack of an assistant for much of the past fiscal year, although that position has recently been filled and should allow her more time to provide more efficient supervision.) The facility WDP Coordinators are eight different personalities who go about their tasks in very different

ways, but they have all demonstrated remarkable patience and skill in setting up processes that should work well over time for their unique facilities.

As a result of their combined efforts, the WDP program as an entity is becoming established (albeit, to varying degrees) at the facilities. The execution of basic WDP tasks, such as overseeing the Staff Assistant teams, providing individualized assistance to wards with disabilities, and monitoring the disciplinary and grievance systems, has made significant strides in accomplishing some of the goals established by the plan. Documentation of compliance efforts, as required by the remedial plan and otherwise necessary to proceed effectively with the auditing tasks, are moving forward, although standardization of these efforts is still needed. It should also be noted that the WDP staff has been very receptive to specific recommendations made by the Disabilities Expert for improving reports and activities, and this cooperation has been appreciated.

The second component involves the coordination of required WDP Remedial Plan elements into the day-to-day operations by all facility staff, particularly those in supervisory positions. The WDP Remedial Plan is a complex and comprehensive document that touches upon all operations of the DJJ as it relates to wards, since the overriding goal is for wards with disabilities to be integrated with and receive equal treatment and services consistent with those provided to all wards. In general, facility Superintendents are believed to be knowledgeable about and cooperative toward the goals of the remedial plan (again, to varying degrees). Organizationally, the WDP Coordinator is placed below a high ranking supervisor at each facility (usually either the Program Administrator or a Treatment Team Supervisor), who assists the WDP Coordinators in procedural and operational matters. All of these supervisors also deserve high commendation for exceptional commitment toward making the implementation of the plan filter into the various disciplines and departments.

However, it is with staff separate from this supervisory level that the understanding and commitment to WDP Remedial Plan goals and objectives, not to mention the everyday requirements and tasks, begin to be sporadic. DJJ organizational structure places various programs and activities under separate "departments" that are often beyond the control and authority of the WDP Coordinators and their supervisors. Full cooperation and coordination from all staff has been difficult, and the lack of such has been the major impediment to more significant progress. Beyond that, many DJJ staff are not aware of the details of the WDP Remedial Plan's requirements, or that these requirements even relate to their activities. Even more problematic, some do not echo the same commitment to its goals as those more closely affiliated with the WDP itself. Despite the facility WDP Coordinators' attempts to depict their role as a valuable resource in providing improved services to all wards, including wards with disabilities, too many other staff see them (and the program) as intrusive to the way that they perceive their program should operate. Although the departmental ADA Coordinator has been proactive and initiated ADA and sensitivity training at all facilities for staff members who are more closely involved with implementation of the plan, the lack of comprehensive ADA and sensitivity training to all staff, as required by the plan, is most likely a contributor to this phenomenon. It is hoped that this curriculum can be approved by the Office of Training and Professional Development in the near future and that the training can proceed for all staff, including new hires, during the next fiscal year, to help to alleviate these issues.

The first Auditor's report indicated that a major reason for not meeting some expected timelines centered largely on administrative changes from the somewhat autonomous former California Youth Authority to the current Department of Juvenile Justice, a part of the larger California Department of Corrections and Rehabilitation. While long-term efficiencies are still expected as part of this reorganization, it was noted in last year's report that short-term policies and procedures were more difficult to implement, and unfortunately, this continues to be the case.

The sections that follow summarize the successful implementation actions taken by the DJJ, as well as pinpoint some of the areas where more focus is needed, together with some recommendations intended to improve progress in these areas.

Wards with Disabilities Identification and Accommodation

During the second round of visits, facilities used various methods and achieved differing results in attempts to identify, classify, and assign appropriate accommodations to wards with disabilities. At some facilities, staff struggled with what they felt was a lack of clear direction from headquarters on this process. At other facilities, staff forged ahead using their best, reasonable efforts to implement this difficult process, and the results were laudable. During the last few months, headquarters has made progress on completing assessment and identification criteria and tools, although the Disabilities has not formally reviewed these criteria and procedures. The next round of monitoring will focus on the implementation of these procedures to monitor their effectiveness and usability.

Staff Assistants for Wards with Disabilities

The WDP Remedial Plan requires the establishment of staff assistants (SA's) at each facility, for the purpose of assuring that reasonable accommodations are provided to wards during disciplinary and grievance procedures, Board hearings, parole planning, and other specified activities. These SA teams are now set up and active at all facilities, with some teams having greater participation than others. Meetings with these teams were held at most facilities, and they are believed to be committed and enthusiastic in the tasks before them.

Physical Accessibility Modifications

The WDP Remedial Plan requires more comprehensive architectural modifications during the second year of the plan, and DJJ has been effective at completing most of the required modifications, as well as proactive in completing smaller projects ahead of schedule.

ADA Staff Training

The WDP Remedial Plan requires that staff training be completed by the end of May 2006 (within 12 months of adoption of the WDP Plan). A training module for sensitivity training, discrimination, and harassment has been developed. I would recommend that a disability advocacy agency be consulted, as required by the remedial plan, to assist in not only developing the final curriculum elements but also as a means to proceed with the comprehensive staff training, which due to strenuous time commitments, may be beyond the ability of the departmental WDP Coordinator to perform alone.

WIN Information Systems

DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. The remedial plan requires that various types of information about wards with disabilities, including the nature of any disabling condition and any reasonable accommodations necessary to provide services and programs to a specific ward, be readily available to staff. It appears that DJJ has made reasonable progress to this end, but the required items of information relating to wards with disabilities that are currently available should be incorporated into the WIN system, and staff should be trained to access this information, as soon as possible.

Coordination with Special Work Groups and other Remedial Plans

The WDP Remedial Plan contains a number of activities that require this type of coordination, but with no specific schedule for implementation. These required activities include: (1) a special educational working group to make recommendations regarding improvements to IEP accommodations and parent participation, (2) a special working group to study and provide recommendations for residential programs for wards with developmental disabilities, (3) coordination with those working on the health care remedial plan to document the inclusion of several specific items for wards with disabilities, (4) a special working group and coordination with the mental health experts to study the effects of certain psychotropic drugs on wards, and (5) coordination with safety and welfare issues for wards with disabilities, as they would be included in the safety and welfare remedial plan. To date, only the working group described in (1) above has occurred, and this group is hopefully proceeding to resolve the outstanding issues. The other working groups are scheduled to begin work this summer.

Educational Issues for Wards with Disabilities

There is overlap between the requirements of the WDP Remedial Plan and educational services, particularly in the area of educational services for wards with disabilities enrolled in special education programs. The educational experts have discussed the issue of reduced school participation, and since many wards with disabilities are housed in special treatment or restrictive programs, this situation tends to negatively affect educational services for these wards to a significant degree. I would recommend that remedial strategies developed by the educational experts be implemented to improve the number of hours of instruction for these wards. Also, monitoring activities indicated some consistent problems in the preparation of high school graduation plans and individualized education programs (IEP's). I would recommend particular attention to the requirements of the WDP Remedial Plan, such as the use of staff advocates (possibly using trained Staff Assistants from the SA teams) prior to and during IEP meetings, to resolve these issues.

Report respectfully submitted,

_____

Logan Hopper, Disabilities Expert and Auditor

Facility Compliance Chart

This chart represents the combined auditing report for the second round of site visits during the 2006-2007 fiscal year to the eight DJJ correctional facilities and Headquarters by the Disabilities Auditor, Logan Hopper. Facilities are listed in the chart using the following abbreviations:

DN DeWitt Nelson Youth Correctional Facility
Ven Ventura Youth Correctional Facility
Pas El Paso de Robles Youth Correctional Facility
HS Heman G. Stark Youth Correctional Facility
Cha N.A. Chaderjian Youth Correctional Facility
SY Southern Youth Correctional Reception Center and Clinic
Clo O.H. Close Youth Correctional Facility
Pre Preston Youth Correctional Facility and Reception Center
HQ Headquarters

The reports attempted to determine a general level of compliance for the applicable items from the disabilities remedial plan and the disabilities audit instrument, using the following codes:

SC = Substantial Compliance; PC = Partial Compliance; NC = Non-Compliance; NAv = Not Available, -- = Not Applicable.

SC* = Second consecutive "Substantial Compliance" rating; the Auditor recommends no further independent auditing, but rather continuing auditing by the Departmental WDP Coordinator.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Headquarters											
I. Directorate											
Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director's office.	Verify current copy is retained.	--	--	--	--	--	--	--	--	SC*	A current copy of the Wards With Disabilities Program Remedial Plan was present in the Director's office.
A. Departmental 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 program.	Verify positions are in place and filled.	--	--	--	--	--	--	--	--	SC	At the present time and throughout the fiscal year, Karen L. Smith has been the full-time Departmental WDP Coordinator, and Maria Correa is currently the full-time WDP Assistant, with other staff being available as needed.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Ensure duty statement encompasses all Departmental WDP Coordinator duties as defined in the WDP Remedial Plan.	Review duty statement.	--	--	--	--	--	--	--	--	SC*	Karen L. Smith has signed appropriate duty statements for the Departmental WDP Coordinator positions.
The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the Departmental WDP Coordinator.	--	--	--	--	--	--	--	--	SC*	Karen L. Smith is believed to be performing the required oversight functions.
Establish and maintain full-time WDP Coordinators at each facility by February 2006.	Verify positions are in place and filled.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*		Each facility currently has an active WDP Coordinator in place.
The Departmental WDP Coordinator will develop a standardized emergency announcement protocol by December 2005.	Review emergency announcement procedures to ensure procedures are in place to provide the needed assistance for wards w/ disabilities. Determine timeliness of announcement.	--	--	--	--	--	--	--	--	PC	Karen Smith completed a draft emergency announcement protocol in November, 2006, but it has not yet been approved by the DJJ. A preliminary review by the auditor indicates the protocol to be acceptable, with a recommendation to include more specificity on the assistance necessary for wards with physical and psychiatric disabilities.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	SC	SC	SC	SC	SC	SC	SC	SC	SC	WDP Coordinators' monthly reports have been prepared for most of the fiscal year, and at all facilities within the last six months. Some facilities use only the basic "population" report, while others have progressed to an expanded format that includes more information on the services actually provided to wards with disabilities, as well as information on wards with disabilities grievances, disciplinary actions, and those placed in restrictive settings. It is assumed that these reports are combined to form an overall monthly report, although these have not been submitted to the Auditor. DJJ as a whole has completed quarterly reports, with the April, 2007 report being sent to the Auditor by the Office of the Special Master.
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 implementation and review documentation to ensure compliance.	--	--	--	--	--	--	--	--	NC	This consultation has not yet occurred, nor has an appropriate "Action Plan" been developed.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	--	--	--	--	--	--	--	NC	This consultation has not yet occurred, nor has a systematic approach for monitoring psychotropic medications been presented to the Auditor.
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.	Verify completion of annual compliance reviews.	--	--	--	--	--	--	--	--	PC	The DJJ completed its last quarterly report on about April 30, 2007. It is believed that this report forms a part of the annual report required by this item, although the annual report may not be required until the end of this (2007) calendar year. "Corrective Action Plans" covering the 06/07 fiscal year and the second round of facility audits have been completed and submitted to the Auditor for three of the nine facilities. Quarterly or annual reports have not typically provided assessments of the level of staffing and training needed to comply with the WDP Remedial Plan.
Within six months of the court approval and adoption of this plan the Department's Ward Disability Program Coordinator will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review the outside consultants training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedule to ensure all individuals complete the required training.	--	--	--	--	--	--	--	--	SC	Karen Smith has attended several training sessions, both in-house and from a national ADA coordinator's association. While these have been helpful in meeting the training goals, we have jointly discussed some additional training resources and have agreed to continue discussions of what other trainings may be helpful.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Develop the Disability Health Services Referral Form.	Monitor for completion by December 2005.	--	--	--	--	--	--	--	--	PC	A form entitled "Health Care Services Request" has been developed by Health Care Services and submitted to the Auditor. The form was not used by facilities during the monitoring visits, as it was only recently finalized as part of the of the Health Care Services policy. It is unclear if this form meets the intent of the WDP Remedial Plan (page 6), since the plan seems to indicate that the Disability Health Services Referral Form is only used for disability-related referrals. It is our understanding that the new form is to be used for a ward's self-referral, and that staff will use the WIN system for staff referrals. Further review by the parties may be needed, and further monitoring is necessary to determine if the form (and other methods, such as the WIN system) is used effectively for referrals.
C. Headquarters Policies											
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 and within established timeline.	--	--	--	--	--	--	--	--	SC	DJJ has submitted substantial evidence that the two vans have been "procured", although they have not actually been delivered and are not yet in use. Documentation of delays in chassis production by the manufacturer indicates that DJJ is not responsible for the delays in full implementation.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	--	--	--	--	--	--	--	PC	The monthly reports adequately (though not systematically) document the actual mental and physical impairments of wards at an aggregate, but not individual, level. The specific accommodations are less formally documented, varying by facility. DJJ has been working on comprehensive documentation through the WIN system upgrades and is believed to be close to completing the task.
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.	--	--	--	--	--	--	--	--	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 has not yet been accomplished.
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 placements and access to special programs for wards with disabilities.	--	--	--	--	--	--	--	--	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 (see above).
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.	--	--	--	--	--	--	--	--	PC	It is recommended that specific policies and procedures be documented in writing to evaluate a ward's (with or without a disability) placement into any restrictive program.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 and develop appropriate implementation plans.	--	--	--	--	--	--	--	--	SC	The working committee has been established and has met several times, although no final recommendations have yet been made.
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 recommendations and provide support if applicable.	--	--	--	--	--	--	--	--	SC	The working committee has been established and has met several times, although no final recommendations have yet been made.
The Education Branch working committee shall also study the need to include a wider variety of individualized accommodations in IEP's.	Review recommendation develop appropriate implementation plans.	--	--	--	--	--	--	--	--	SC	The working committee has been established and has met several times, although no final recommendations have yet been made.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	--	--	--	--	--	--	--	NC	This consultation and the resulting study have not yet occurred.
The visiting facility at Ventura is currently under construction & will be fully operational by 1/06. The new facility at Preston will be fully opera-tional and safe for all wards, visitors and staff by July '06. The CYA will confer with the Disability Expert to explore and implement, as appropriate, interim solutions to address architectural barriers at the existing Preston visiting area until new facility is opened by 7/06.	Visit locations to determine comple-tion/level of oper-ation by estab-lished dates.	--	NC	--	--	--	--	--	NC	NC	Even though some additional accessibility improvements have been made to these two facilities, these two new visiting facilities are not yet staffed or operational.
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.	--	--	--	--	--	--	--	--	PC	CSU Chico prepared a basic outline for how the training should be developed. A course curriculum for sensitivity & awareness portions of the training has been developed and reviewed by the Disabilities expert, with some pending recommendations, but has not yet been approved by the Office of Training and Professional Development. It is still recommended that an outside (non-State) disability advocacy agency be consulted, as required by the remedial plan, to assist in developing the final curriculum for all training modules. The departmental ADA Coordinator has initiated training at all facilities, despite the lack of formal curriculum approval.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 Dec., 2006.	Review screening tool to ensure validation. Ensure that the assessment is completed within the given timeframe.	--	--	--	--	--	--	--	--	PC	This screening tool is under development, but not yet completed.
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.	NC	NC	NC	NC	NC	NC	NC	NC	NC	A course curriculum for the sensitivity, awareness, and harassment portion of the training has been developed and reviewed by the Disabilities expert, with some pending recommendations but has not yet been approved by the Office of Training and Professional Development. It is still recommended that an outside (non-State) disability advocacy agency be consulted, as required by the WDP remedial plan, to assist in developing the final curriculum for all training modules. The departmental ADA Coordinator has initiated training at all facilities, but to date, no records of specific training sessions for new hires have been provided to the Auditor.
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.	--	--	--	--	--	--	--	--	SC	Reviews of random files and interviews did not indicate any exclusion from camp or work programs. It has been recommended that the Department prepare a documentation form to aid in assurances of equal access. This review does not include fire camps.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005.	Review form for completion.	--	SC*	--	--	--	SC*	--	SC*	SC*	The provisional form was completed and sent to the Auditor prior to the site visits. The form was included in the WDP Coordinator's Disabilities Remedial Plan Manual and was used during intake at all three facilities.
D. Headquarters Programs/Screening											
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.	SC	SC	SC	SC	SC	SC	SC	SC	SC	Headquarters has a standard purchase order available, although some facilities might use their own form.
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.	--	--	--	--	--	--	--	--	SC	Review of files and interviews indicated that arriving documentation is adequately reviewed, although I would recommend additional documentation verifying such within the Intake and Court Services Unit.
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.	--	--	--	--	--	--	--	--	SC*	The form has been revised, and the revised form was present at all facilities.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	--	--	--	--	--	--	--	SC	Review of files indicated that staff members generally complete the section, although sometimes at a cursory level. I would recommend additional documentation be provided by the Intake & Court Services Unit, a procedure that should be aided in the future with the completion of the WIN system upgrades.
Facility Administration											
A. Superintendent											
Maintain a current copy of the Wards With Disabilities Program Remedial Plan retained in Supt.'s office.	Verify current copy is retained.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*	--	The Superintendent's Disabilities Remedial Plan Manual was present in the Superintendent's office at all facilities.
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.	SC	SC	SC	PC	PC	SC	PC	PC	--	Even though no formal orientation program occurs at most facilities (except SY), this item is obviously facility-related. All new wards sign the ADA Rights Notification Form, but it could not be determined that wards are provided with information regarding these particular accessible features in all cases. At some facilities, the facility WDP Coordinator has provided wards (and the Auditor) with a written memo with information regarding these and other accessible features.
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 and SAs. Audit TD forms for compliance. Review Special Incident Reports (YA 8.401) related to Administrative Lockdowns.	SC	SC	SC	SC	SC	SC	SC	SC	--	At all facilities, YA 8.401 "Serious Incident Reports" and a list of wards on TD were provided to the Auditor. A formal system of reporting by e-mail was not necessarily in place at each facility at the time of the audit, but it is believed to be in use at all facilities at the present time.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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	SC	SC	SC	SC	SC	--	"Case Report Transmittal" forms are not currently used at most facilities, as they were only available at Chaderjian during the second round of audits. These forms should be used in the future to standardize procedures agency-wide and to provide more details on the specific accommodations required and to document due process, equal access, and the provision of accommodations, as required by the remedial plan. Nevertheless, it is believed that accommodations are being provided as required for YAB hearings, since the YAB, in coordination with DJJ staff, has instituted its own procedures based on the *Armstrong* case to assist in accommodating wards with disabilities, although review of YAB procedures is beyond the scope of this audit.
B. Facility's Ward Disabilities Coordinator											
Maintain WDP Coordinators at each facility.	Verify positions are in place and filled.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*	--	Each facility had an active WDP Coordinator in place at the time of each site visit.
Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	Review duty statement.	SC	SC	SC	SC	SC	SC	SC	SC	SC	Each WDP Coordinator has signed an appropriate duty statement.
The facility WDP Coordinator shall perform the over-sight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the facility WDP Coordinator.	SC	SC	SC	SC	SC	SC	SC	SC	SC	Each WDP Coordinator is believed to be performing the required oversight functions.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 the requirements in the WDP Remedial Plan. Review and confirm training schedule to ensure all individuals complete the required training.	SC	SC	SC	SC	SC	SC	SC	SC	--	WDP Remedial Plan and general ADA training has been provided to the facility WDP Coordinators, primarily by the Departmental WDP Coordinator, and they have attended additional training at seminars presented by the National Association Of ADA Coordinators. The Auditor has not specifically reviewed the content of the NAADAC training materials.
The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	Review monthly reports.	SC	SC	SC	SC	SC	SC	SC	SC	--	Monthly reports have been prepared in a timely manner by the facility WDP Coordinators, although the expanded report format as recommended by the Auditor has not been utilized by all facilities. It has been reported that all facilities will use the expanded format in the future. A short executive summary or narrative and some more detailed service-related information would also be an excellent addition to this report.
C. Facility's Policies											

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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	SC	PC	SC	SC	SC	NC	--	There continued to be a relatively wide range of compliance related to identification of wards with disabilities between the facilities. Lists of wards with disabilities were typically identified by DJJ and provided to the Auditor at the facilities. Wards with physical disabilities were usually, but not always, specifically identified. Some wards with mental or emotional disabilities were identified. Wards with educational disabilities were usually, but not always, identified through the Student Study Team (SST) and/or the IEP processes. In general, it is believed that the WDP staff is using their best efforts to identify affected wards, but (1) clarifications from headquarters are needed to make the proper determinations (these have been developed but not reviewed or approved by the Auditor), and (2) better cooperation from the various departments is needed. Few special case conferences were held during the site visits, and it is evident that these are not being utilized effectively to assist in identification efforts.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 documentation.	SC	PC	SC	SC	SC	PC	SC	PC	--	While there were no documentation or specific instances encountered where ward's assistive device was "taken away", there were a number of instances where an assistive device needed by a ward was not provided, or was otherwise unusable by the ward. There was no indication that either safety or security was jeopardized in these instances. Also, there were indications that medical staff were not always directly involved in the decision making process..
Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	Interview wards and WDP coordinators to verify presence of operational TDD.	SC	SC	SC	SC	SC	SC	SC	SC	--	TDD's were present at all of the facilities, but were not necessarily operational if no deaf wards were present. No wards reported the inability to have an operable TDD available.
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.	Interview wards and WDP coordinators to verify presence of operation closed captioning function TV.	SC	SC	SC	SC	SC	SC	SC	SC	--	Closed captioned TV's were present and operational at all facilities. No ward reported the inability to have an operable closed captioning TV available.
Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities.	Conduct site visits to verify presence of accessible posted materials.	SC	SC	SC	SC	SC	SC	SC	SC	--	Informational materials were generally noted to be at accessible heights and locations. For future reference, these should be centered 48" above the floor, and any materials that require reaching should be no higher than 54" above the floor.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 (SRSCT) form.	Review submitted RSC (YA 8.229) and SRSCT (YA 7.464) forms and determine appropriateness of disposition. Observe random interviews at intake.	NC	PC	SC	PC	PC	PC	PC	NC	--	In general, it was not common that forms YA 7.464 and YA 8.229 were being used by either wards for self-referrals. The sick call form does not specifically list the ADA or the presence of a disability as a reason for referral, which is recommended. Forms are in the process of revision, and it is recommended that this form or any revision also list the ADA and/or presence of a disability as a reason for the request. The "Health Case Services Request Form" was used at some facilities in lieu of the RSC form YA 8.229, but it is unclear that wards are being advised of its proper use. Typically, very little documentation was provided to the Auditor by the Education Department to indicate that the SCT form YA 7.464 was being used by wards for self-referrals. The remedial plan requires a more formal system of record-keeping for self-referrals.
The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	Interview wards and Principal for proof of practice.	SC	SC	SC	SC	SC	SC	SC	SC	--	Although wards with physical disabilities that would be affected by this item were specifically identified by DJJ, the facilities appeared prepared to provide the necessary and appropriate training, if needed.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.)	--	--	--	--	--	--	--	--	--	Since the requirement for passing the CAHSEE was deferred for special education students for the '06-'07 school year and the "waiver request" process was not applicable, final determination of this requirement should also be deferred. The CAHSEE was typically administered twice during the school year, as required by the applicable regulations. It was not evident that all wards with disabilities were provided with the accommodations contained in their IEP's, as at least one site reported that only two of the twenty students who took the test were reported to have had accommodations. It is also unclear why a relatively low percentage of special education students took the test at some sites. While some wards signed a refusal form, it is not clear that they were fully apprised of the prevalent CAHSEE legislation that exempted them from having to pass the test.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	NC	PC	SC	NC	NC	PC	SC	PC	--	Of the student files reviewed, some did not have had properly prepared graduation plan forms completed within the last year. The degree of problems varied for each facility, as shown in the previous columns in this row. Some files that did have plans did not have all of the necessary information, nor specificity how goals were to be accomplished. Other issues needing further review included: (1) graduation plans not being followed once updated and (2) graduation plans that did not lead toward the graduation goal.
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%; whichever is greater, of students with IEP's graduation rates and uses of the exception to the graduation requirements.	SC	SC	SC	SC	SC	SC	SC	SC	--	Some facilities provided lists of students with disabilities graduating in the last year, while others did not. There were no specific indications that any of the four graduation exceptions listed in the remedial plan was denied.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	NC	NC	PC	NC	NC	PC	PC	NC	--	Based upon the student files reviewed and interviews, there were indications that some wards with disabilities, particularly those at restricted units, had limited access to full-day educational programs, vocational programs, and other special educational activities. In addition, some special education students had outdated or incomplete IEP's, which would limit proper access to these programs. The degree of problems varied for each facility, as shown in the previous columns in this row. A number of wards had some specific complaints about lack of access to academic programs.
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.	Review operational procedures. Interview wards with disabilities to determine effectiveness of non-emergency communications.	SC	PC	SC	SC	PC	SC	PC	SC	--	At some facilities, specific written operational procedures were provided to the Auditor. Interviews and observations indicated no significant but some minor problems in this area. It should be noted that the Department WDP Coordinator has completed a draft document for emergency protocols, subject to further DJJ review and approval, which would be also applied to these issues.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
CYA staff shall be aware of accommodations afforded to wards with disabilities in developing and implementing security procedures including use of force, count, searches, transportation, visiting and property.	Interview 10 security personnel and wards yearly for specific inquiry regarding security issues.	PC	PC	PC	PC	PC	PC	PC	PC	--	Interviews and observations indicated some ongoing problems in this area. Additional guidelines contained in the Safety and Welfare Plan were approved during the fiscal year, but a complete review of how these will affect security procedures related to wards with disabilities has not been fully analyzed by either the Auditor or DJJ.
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	SC	SC	SC	SC	SC	SC	--	Lists of wards placed in restricted settings were usually provided to the Auditor. There were indications that such placements were beginning to be reviewed as required by the remedial plan, although these procedures will require further review by DJJ and monitoring.
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.	NC	NC	NC	NC	NC	NC	NC	NC	--	There were no specific indications from IEP records and discussions with the educational staff that this policy has yet been implemented. A number of IEP meetings were scheduled during the Auditor's visits, and the advocate position was not utilized during these meetings, and only one IEP leader had met with the ward prior to the IEP meeting, as required by the remedial plan.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 as part of the training and the training will also encourage active participation.	Review training curriculum to ensure compliance with the State Department of Education criteria. Attend training sessions provided to surrogate parents.	PC	NC	SC	NC	PC	NC	NC	SC	--	A copy of the surrogate training materials, as prepared by the California Department of Education, has been provided to the Auditor. The Auditor has not been notified and thus has not attended this training, and in order to review the actual training provided, the Auditor plans to request attendance for a future training. The degree of training for surrogates varied for each facility, as shown in the previous columns. An adjunct to this item includes the issue that surrogates are not always provided at IEP meetings, where required.
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 coordinators to determine level of availability and accessibility of assistive devices.	NC	PC	SC	SC	SC	PC	SC	NC	--	The degree to which facility WDP Coordinators have been able to track and document required accommodations varied between facilities. The compliance rates usually had more to do with the degree of assistance and cooperation form other departments as opposed to the efforts of WDP staff. Better assistance and transfer of necessary information from other departments, as well as specific guidance from headquarters, is needed. Some assistive devices for equally effective communication were usually available, but procedures for providing the required variety of devices have not been fully developed at the facilities, or department-wide.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards. Accommodations shall be made to afford equal access to the court, to legal representation, and to health care services for wards with disabilities.	Interview wards with disabilities and WDP coordinators to confirm accommodations.	PC	PC	SC	SC	SC	PC	SC	PC	--	Reasonable accommodations or modifications were usually provided, though systematic written documentation was typically provided. Ward interviews indicated some problems in this area. I would recommend that procedures for providing the required variety of reasonable accommodations or modifications be more fully developed at the facilities and department-wide and documented in the WIN system.
Qualified sign language interpreters shall be provided as necessary to ensure effective communication and at a minimum for all due process functions, medical consultations, video-conferencing and special programs.	Review record of use logs for qualified interpreters.	--	--	--	--	--	--	--	--	--	Qualified sign language interpreters were available for contracting at all facilities, if needed. A departmental use log has been prepared and distributed to the facilities for use when interpreters are active. It was impossible to verify that interpreters were actually provided since few wards required one during this monitoring period.
Reasonable accommodations may only be denied if the accommodation 1) poses a direct threat to the Health and Safety of others, 2) constitutes an undue burden, or 3) if there is equally effective means of providing access to a program, service, or activity through an alternative method that is less costly or intrusive. Alternative methods may be used to provide reasonable access in lieu of modifications requested by the ward as long as those methods are equally effective. All denials of specific requests shall be in writing.	Review (written) denied requests for accommodation to determine if alternative method provided reasonable access.	SC	SC	SC	SC	SC	SC	SC	SC	--	Refer to two items above for the basic provision of reasonable accommodations. For this specific item, there were no instances encountered where written requests for accommodation were denied in writing.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings.	Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	At the present time, the YAB has instituted its own procedures based on the *Armstrong* case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. Reasonable accommodations are more commonly provided by the facility WDP Coordinator or a member of the SA team.
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 compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	Assistance is adequately provided in parole planning, although the identified Staff Assistants are not yet fully involved in this process.
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 institutional parole agents / Casework Specialists to ensure compliance.	PC	PC	PC	PC	PC	PC	PC	PC	--	While a general degree of information about wards with disabilities needs were included in parole reports, there were no specific guidelines in this area, nor any specific indications that community groups were utilized based upon a specific ward's disability. I would recommend that parole reports provide more detailed information on ward's with disabilities specific needs for the continuation of accommodations and special services.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 develop-mental 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.	--	--	--	--	--	--	--	--	--	No wards with developmental disabilities were identified as recently paroled.
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 PA III or Supervising Casework Specialist II, when scheduling a YAB hearing. PA 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 PA I/Casework Specialist 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 compliance.	PC	PC	PC	PC	PC	PC	PC	PC	--	At the present time, the YAB has instituted its own procedures based on the *Armstrong* case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. "Case Report Transmittal" forms printed from the WIN system, as required by the remedial plan, are not specifically provided to the YAB. I would recommend that this transmittal form be revised to document the necessary accommodations, as required by the remedial plan
The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings.	Interview wards with disabilities and SA's to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	At the present time, the YAB has instituted its own procedures based on the *Armstrong* case that would assist in accommodating wards with disabilities, although the review of YAB procedures is beyond the scope of this audit. Reasonable accommodations are more commonly provided by the facility WDP Coordinator or a member of the SA team.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	Review DDMS documents concerning wards with disabilities to ensure SA assistance.	SC	SC	SC	SC	SC	SC	SC	SC	--	A number of YA 8.401 "Serious Incident Reports" were usually provided at each of the facilities. The facility WDP Coordinators typically review all Level 3 violations. The SA team has been set up at all facilities, and accommodations are usually provided, although some facilities visited earlier had not yet fully implemented the procedures. Another round of monitoring is necessary to verify that all wards requiring accommodations are actually provided them.
Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education.	Review composition of SA teams.	SC	SC	SC	SC	SC	SC	SC	SC	--	SA teams had been set up at all of the facilities at the time of the visits. Some SA lists were longer than others, varying from 4 to 25, and it is recommended that SA lists be expanded to provide additional coverage, where appropriate. Some SA teams were more active than others.
Disposition chairperson shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of disposition chairperson for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	The disposition chairperson has typically been trained along with the SA team by the Departmental WDP Coordinator, although no specific training module been reviewed and approved by the Auditor.
The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive/emotional disabil-ities & present an overview of the DDMS process.	Audit training module and review training record of SA for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	The SA team received training from the Departmental WDP Coordinator, although no specific training module been reviewed and approved by the Auditor.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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	SC	SC	SC	SC	SC	SC	SC	--	All facility WDP Coordinators are aware of the requirement and are beginning to review DDMS forms. Documentation has varied, ranging from no written documentation, to meeting notes, to an excellent study and narrative describing patterns of misbehavior being prepared by one WDP Coordinator.
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.	Review completed grievance documents (Grievance Form-YA 8.450, Appeal Form-YA 8.451) concerning wards with disabilities to ensure SA assistance through confirmed signature.	PC	PC	PC	PC	PC	PC	PC	PC	--	A number of YA 8.450 and 8.451 grievance forms were reviewed at each facility. The Grievance Coordinator and the WDP Coordinator typically review grievances, sometimes tracked through the WIN system. The SA team has been set up, but it has been uncommon for an SA to be involved at filing, a situation that should be resolved due to a new grievance filing procedure. Accommodations are typically provided only at the resolution stage. There were a few indications that a SA assignment might have been warranted and not provided.
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.	NC	NC	NC	NC	NC	NC	NC	NC	--	This is an open-ended item, since a number of staff members may be involved in the initial grievance. General staff training at the departmental level, not fully implemented, would be needed to comply with this requirement. No specific training module related to grievances has been reviewed by the Auditor.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental / physical disabilities and present an overview of the grievance process.	Audit training module and review training record of SA for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	The SA team received training from the Departmental WDP Coordinator, although no specific training module been reviewed and approved by the Auditor.
The WDP Coordinator shall review all grievance forms at least monthly to identify any patterns of repetitive involvement that may be related to mental / physical disabilities and refer such cases to the appropriate supervisory staff.	Review monthly audit documents to confirm compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	The facility WDP regularly reviews grievance forms.
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 Coordinators.	SC	SC	SC	SC	SC	SC	SC	SC	--	All facility WDP Coordinators are aware of the requirement and are beginning to review DDMS forms. Documentation has varied, ranging from no written documentation, to meeting notes, to an excellent study and narrative describing reasons for filing grievances being prepared by one WDP Coordinator.
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 accommodation related grievances.	PC	PC	SC	PC	SC	PC	SC	PC	--	The screening process is being implemented, although records indicated past problems of assuring medical disability issues were resolved in a timely manner at some facilities.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	Sample of 10 or 10%, whichever is greater, of grievances filed during the last quarter.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances regarding accommodations or discrimination based on disability have been rare, although some problems have been noted in the rapid resolution regarding allegations of denial of services that could be related to a disability. It is recommended that procedures to facilitate the Wards Rights Coordinator's review of these grievances be prepared and implemented.
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.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances regarding accommodations have been rare. It is recommended that procedures to facilitate the screening process be prepared and implemented.
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 accommo-dations or allege discrimination to determine compliance of protocol within time constraints.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances requiring medical verification have exceeded time limits and exhibited other problem. It is recommended that procedures to facilitate the medical verification process be prepared and implemented.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 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 a disability and any limitations that exist on YA grievance form, and in the UHR of a ward.	Review grievances from wards with disabilities (Grievance Form – YA 8.450) that request accommodations or allege discrimination and their UHR to determine compliance of protocol within given time constraints.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances requiring medical verification have had some instances where outside assistance from an expert consultant was necessary, but not necessarily the result of a grievance. It is recommended that procedures to facilitate the outside verification process be prepared and implemented.
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 the criteria for review and response within 48 hours of receipt from Health Care Services staff.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination to determine compliance of protocol within given time constraints.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances requiring medical verification have exceeded time limits and exhibited other problem. It is recommended that procedures to facilitate the medical verification process be prepared and implemented.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 or allege discrimination.	PC	PC	PC	PC	PC	PC	PC	PC	--	Grievances regarding non-medical verification have been rare. However, this policy has not yet been fully implemented. A departmental report form has not yet been prepared. Most newly appointed Assistant WDP Coordinators are aware of the requirement and are beginning to review such grievance forms.
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.	--	--	--	--	--	--	--	--	--	There was no indication that a ward had a grievance relating to this item during the auditing period.
Wards with disabilities shall be granted reasonable accommodations with respect to timeframes, consistent with the Ward Safety and Welfare Plan, for processing of grievances.	Interview wards with disabilities. Review grievances to determine compliance.	--	--	--	--	--	--	--	--	--	There was no indication that a ward had a problem with time lines associated with grievances during the auditing period. The Ward Safety and Welfare Plan has not been fully reviewed by DJJ/WDP or the Auditor, although a quick review has indicated that the plan does not appear to address this issue.
D. Programs											
1. Reception Center and Clinic Functions											
Begins on next page.											

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 (YA 1.411) in ward field files.	--	NC	--	--	--	NC	--	NC	--	Current DJJ practice has the screening for developmental disability performed during the Headquarters acceptance process, although no formal testing is done, only a records review. Wards are not formally screened at the facility's reception center for the presence of a developmental disability, although past screenings (e.g., IQ testing) are sometimes reviewed. These procedures do not coincide with WDP Remedial Plan requirements, and DJJ may want to review these and propose revisions where appropriate. It is my understanding that meetings have been recently held at headquarters to discuss the issues related to this topic
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.	Observe random interviews at intake facilities.	--	SC	--	--	--	SC	--	SC	--	Although only a few initial ward interviews were attended, it is believed that the ADA Rights Notification form is presented to and signed by all wards during initial intake. The extent to which they understand all aspects of the form is unclear.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	SC	--	--	--	SC	--	SC	--	At Ventura and Preston, Casework Specialists use a "Mental Health Services Referral" form and a "Critical Factors Assessment for Determining Need for Mental Health Evaluation" form to refer wards to a mental health professional during intake and at other times. At SYC, Casework Specialists use a "Ward Initial Intake Information" form, unique to this facility. This form has a check box for physical or mental disability, although it is unclear exactly what criteria is used to make these determinations. The "Ward's Request for Reasonable Accommodation" form is also used to refer wards to a mental health professional during intake and at other times. It is unclear how the newly approved "Health Care Services Request" form (see page 8) will fit into these processes. All reception centers received an "SC" compliance rating since it was believed that mental health referrals were generally made appropriately, but it should be evident that with the uses of varying forms, standardization and guidance from headquarters is needed assure long-term compliance.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	PC	--	--	--	PC	--	PC	--	Casework Specialists use various methods to refer wards with disabilities to the appropriate medical staff during intake. At SYC, Casework Specialists use the "Ward Initial Intake Information" form, unique to this facility (see item directly above). It is unclear how the newly approved "Health Care Services Request" form (see page 8) will fit into these processes; standardization and guidance from headquarters is needed assure long-term compliance.
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.	--	PC	--	--	--	PC	--	PC	--	Casework Specialists use other methods to refer wards with learning disabilities to educational services during intake and at other times, but the RSCT form YA 7.464 form is not used for this purpose, nor is the School Consultation Team (SCT) routinely utilized to document a learning impairment referred during intake. As also discussed in the Education experts' reports, SCT's are not currently operating at an effective level at many facilities.
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 complete-ness and timeliness: MH – SPAN/ YA 8.216; Med – Medical HX/YA 8.260.	--	SC	--	--	--	SC	--	PC	--	Based upon records provided to the Auditor, medical and mental health screenings typically occur within 10 days of the referral at two facilities. At the other, medical screenings typically occur within 10 days of the referral, but mental health screenings typically do not, and can take up to 6 weeks.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for complete-ness and timeliness: Ed – CASAS, CELDT, High Point Testing, HX in file	--	PC	--	--	--	PC	--	SC	--	The initial intake interview includes a checklist for educational needs. Based upon interviews and records review, it appeared that assessment plans were usually developed if indicated by the checklist, but not always within 15 calendar days. (refer to columns at left).
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, medical, dental practices to assess wards.	Review appropriate documentation for completeness and timeliness.	--	PC	--	--	--	PC	--	PC	--	It is unclear to what extent psychological testing of all wards is required by this section of the remedial plan. The initial intake interview highlights further needs for psychological assessment, including possible testing, that may be necessary, but this is individualized and not a standard procedure. Further clarification is needed.
Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness.	--	SC	--	--	--	SC	--	SC	--	Records provided to the Auditor indicated that a wide variety of educational assessments are either utilized or developed. In some cases, recent assessments from other sources are used to provide interim placement or schedule the IEP. More guidance from Headquarters and standardization is needed. The assessments are typically completed within the 50-calendar-day requirement, but not always.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
If it is determined prior to or during the ICR that a ward is in need of an accommodation in order to allow for effective participation, the Supervising Casework Specialist II shall ensure that such accommodations are provided.	Review random ICR reports for wards with disabilities.	--	PC	--	--	--	PC	--	PC	--	The Initial Case Review (ICR) provides the opportunity for such accommodations, and these appear to be provided at a very general level, but it is unclear that appropriate procedures or documentation have been instituted, particularly with respect to medical accommodations. 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. It is also recommended (as implied by the WDP Remedial Plan) that an actual ICR meeting be held with the ward and all of the various disciplines; this is occurring at some of the facilities, but not all.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	NC	--	--	--	PC	--	PC	--	A formal "orientation process", as described in the WDP Remedial Plan (Section III.J.), has been historically presented at only one site, and the process continues. At other sites, the counselor at the intake living unit may provide an individual ward with a general orientation to the WDP program, but no formal "orientation process" is currently provided. A very basic "standardized Disability module" has been developed as part of an orientation package, but it is not presented on a systematic basis and it needs additional information, particularly with respect to applicable disability law, the IDEA, and the referral process. I would recommend that the Departmental WDP Coordinator assist in coordinating and supplementing these past efforts, and possibly even present the first few orientations, to effect implementation of this provision.
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 accommodations.	--	NC	--	--	--	NC	--	NC	--	The ADA orientation module was not currently being provided to all new wards. No ward-signed orientation forms documenting information on accommodations have been provided to the Auditor.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	On-going audit, based on detailed factors listed in the plan. Visit special program locations yearly.	SC	PC	PC	SC	SC	SC	--	SC	--	Visit to the unique, non-educational programs and interviews with the program directors gave no specific indications that wards with disabilities were not included on an equal basis in special program. However, for some programs, there was also no specific documentation to show that wards with disabilities were included on an equal basis in the programs. While it is understood that participation in many of these programs is appropriately behavior-based, it is unclear how wards in special management or counseling programs are able to participate in many of these programs. Relatively new criteria (January, 2006) for assignment to the fire camp program was also reviewed by the Auditor. Two factors that would require exemptions or permanently exclude entrance are listed as (1) mental health history (free from psychotropic medications for four months), and (2) medically unfit. While these are potentially exclusionary, safeguards appear to be in place at the present time. However, these criteria require further monitoring and input from other parties if deemed necessary.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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 appropriateness of disposition.	PC	PC	PC	PC	PC	PC	PC	PC	--	Various methods, some written and some e-mail, were used for staff to refer wards for screening. However, it was rare that the Referral for Sick Call (RSC) form YA8.229, or any other standard referral from, or the referral to the School Consultation Team (RSCT) form YA 7.464 were being used by staff for referrals for health care services or educational assessment, as required by the remedial plan. Some facilities were using a new form entitled "Ward Disability Staff Referral Form", presumably DJJ-wide form (no standard number assigned) that was presented to the Auditor for the first time near the end of the site visits. Guidance and training is needed from the parties and Headquarters to demonstrate appropriate use of these forms consistent with the WDP Remedial Plan, and some revisions to the plan may be necessary. There were instances where wards were referred to various service components (education, mental health, etc.), but referrals were informal and did not generally follow the time lines or procedures described in the WDP remedial Plan. I would recommend that a system of documentation be developed to track ward and staff referrals.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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	SC	SC	SC	SC	SC	--	Very few or special case conference forms or reports were provided to show compliance. While few referrals were reported, it is believed that the facility WDP Coordinators (not the Treatment Team Supervisors / Supervising Casework Specialists) are beginning to monitor the timely resolution of screening, although the exact time limits could not be verified.
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 required; (7) Need for a Staff Assistant; (8) Level of care designation; (9) Classification code.	Review documentation for completeness of information.	PC	PC	PC	PC	PC	PC	PC	PC	PC	DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. While the exact time line for having the system ready and available for use is still unknown, it was inherent that perfecting the system would take some time. I believe that the DJJ has made reasonable progress to this end, but would also recommend that the first 8 required items of information relating to wards with disabilities that are available be incorporated into the WIN system, and that staff be trained to access this information, as soon as it is practical.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities.	Review modified materials.	SC	SC	SC	SC	SC	SC	SC	SC	--	While only some specific procedures for modifying materials were provided to the Auditor at some facilities, there were no indications that wards with disabilities did not have equal access to informational materials.
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.	SC	SC	SC	SC	SC	SC	SC	SC	--	The facility WDP Coordinator (not the Program Manager) typically reviews the need for individualized assistance. The SA teams have been set up at each facility, and accommodations are beginning to be typically provided.
The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities.	Interview wards with disabilities to determine access and participation.	SC	SC	SC	SC	SC	SC	SC	SC	--	There were no indications that wards with a disability did not have equal access to the non-educational services as listed .
3. Developmental Disabilities											
No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	Tour facilities to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	No such signs of identification were encountered.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	--	--	--	--	--	--	--	--	--	No wards were specifically identified by the DJJ or listed on YA 1.503 forms as being developmentally disabled, although it is unclear how and to what extent such determinations would be made. See also first item on page 13 and first item on page 35.
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.	Monitor the project completion timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*	--	At least one accessible room has been completed to provide an accessible housing unit for wards with disabilities. The rating of SC for this item does not necessarily indicate that the accessible room provided would serve as the most appropriate and least restrictive housing unit for a particular ward.
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 in FY 2005/06 and eight areas in FY 2006/07.	Monitor the project timeline and visit each facility area upon completion to ensure compliance with accessibility criteria.	SC	SC	SC	SC	NC	SC	SC	SC	--	The nine areas for FY 2005/06, providing at least one accessible shower/ lavatory area in close proximity to the accessible room, have been completed at all but one facility. The additional eight areas for FY 2006/07 will be audited during the next round of visits.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The Department committed to the removal of critical disability related structural barrier projects that will be completed each year from FY 2005/06 to FY 2008/09. These projects are part of the barriers that were identified by the survey completed by Access Unlimited and are identified in Appendix B to the Disability Remedial Plan.	Monitor the project timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC	PC	SC	SC	SC	SC	SC	SC	--	The compliance rating shown indicates the general degree of compliance only for those items scheduled to be completed during FY 2005/06.
The Department committed to analyze 3000 additional barriers identified in the report prepared by Access Unlimited and provides a report that would categorize the barriers into three distinct areas. This report is due July 15, 2005, and will be filed at Appendix C to the Disability Remedial Plan.	Review, approve and submit required report.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*	--	Appendix C of the WDP Remedial Plan has been completed and filed.
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.	PC	SC*	PC	SC*	PC	SC*	PC	PC	--	Most of these projects have been effectively completed, but not all.
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.	--	--	--	--	--	--	--	--	--	Since the required critical barrier removal completion date of September 30, 2008, has not yet arrived, site visits only provided a general review of certain areas of future barrier removal.