SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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<tr><td>MARGARET FARRELL,

Plaintiff,

vs.

MATTHEW CATE,

Defendant.
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CASE NO. RG03079344</td></tr>
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TENTH REPORT OF SPECIAL MASTER

Donna Brorby, Special Master
Aubra Fletcher, Monitor
Zack Schwartz, Monitor
605 Market Street, Ninth Floor
San Francisco, California 94105
(415) 348-0853
(415) 495-7204 (facs.)
dbrorby@brorbylaw.com

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I. INTRODUCTION

This report reviews and attaches the fiscal year 2008-2009 reports of the education and disability access experts, summarizing the status of compliance with the remedial plans in those areas. It also attaches a revised version of medical experts‟ comprehensive report for fiscal year 2007-2008; this replaces the original version filed with the Ninth Report of the Special Master. The mental health experts have submitted a comprehensive report that is under review by the parties and the special master, and it will be filed with the special master‟s next report.

II. EDUCATION

The education experts, Drs. Robert Gordon and Thomas O‟Rourke, conducted their fourth round of compliance audits at all DJJ facilities between October 2008 and May 2009. Their fourth "Summary Education Program Report" is appended to this report as Appendix A.[1] The summary report provides an overview of DJJ‟s progress and challenges under each section of the Education Services Remedial Plan. The attachment to the report displays each facility‟s compliance status for each compliance criterion. The education experts have reviewed and approved this section of the special master‟s report.[2]

A. Progress toward Compliance

The experts note various areas of improvement since their prior audit round. Teachers are well-qualified in the appropriate fields of study at five of six facilities, compared with three of seven facilities last year.[3] Fewer classes are cancelled due to lack

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[1] The experts provided the special master, and the special master provided the parties, with the individual facility audits as they were completed.
[2] *See* e-mail of Tom O‟Rourke to the special master, July 29, 2009.
[3] *Compare* Appendix A (O‟Rourke/Gordon 2008-2009 Report), Attachment 1, p. 1 [hereinafter O‟Rourke/Gordon 2008-2009 Report, Attachment 1] *with* Eighth Report of the Special Master, Appendix A (O‟Rourke/Gordon 2007-2008 Report), Attachment B, p. 1 [hereinafter O‟Rourke/Gordon 2007-2008 Report, Attachment B]; *see also* O‟Rourke/Gordon 2008-2009 Report, p. 5. Note that the DeWitt Nelson

of substitute teachers.[4] Five of six schools have implemented structured classroom behavior management systems, whereas only two schools had such systems last year.[5] Four of six sites have entered into cooperative agreements between custody, education, and treatment staff to ensure students‟ school access;[6] during the previous audit round, only two sites had such agreements.[7] The Chaderjian and Preston facilities now have adequate instructional space, which they lacked last year.[8] All schools substantially comply with requirements related to educational technology and "Global Classroom" distance learning courses.[9] All schools now track school consultation team meetings,[10] and five of six schools are documenting progress on the intervention plans created at these meetings.[11] All but one facility consistently conduct quarterly teacher observations, a significant improvement upon past years‟ performance.[12]

Improvements in the area of special education include an increase in timely held IEP eligibility meetings.[13] Five of six schools now have memoranda of understanding

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facility closed between the experts‟ third and fourth audit rounds. The aberrant facility is Stark, which is discussed in greater detail, below.

[4] *Compare* O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 1 *with* O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 1.

[5] *Compare* O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2 *with* O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 2.

[6] O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2; *see also* O‟Rourke/Gordon 2008-2009 Report, p. 6.

[7] O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 2.

[8] *Compare* O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2 *with* O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 2.

[9] *See* O‟Rourke/Gordon 2008-2009 Report, p. 7. The Global Classroom courses are new at four of the six facilities this year. *Compare* O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 3 *with* O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 3.

[10] O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2. School consultation teams are similar to parent-teacher conferences; the teams review problems with the student‟s progress and develop intervention plans. Education Services Remedial Plan, p. 2. The teams include the student, an administrator, the referring teacher, other education staff, and treatment staff. *Ibid.*

[11] O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2.

[12] *See id.*, p. 3; Eighth Report of the Special Master (February 2009), p. 3.

[13] All information in this paragraph is based on a comparison of O‟Rourke/Gordon 2008-2009 Report, Attachment 1, p. 4 with O‟Rourke/Gordon 2007-2008 Report, Attachment B, p. 4. *See also* O‟Rourke/Gordon 2008-2009 Report, p. 7.

with DJJ‟s intake services branch regarding acceptance of special education students. Last year, five of the six schools were non-compliant with this requirement. Three schools now have written procedures regarding the acquisition of pre-existing IEPs prior to acceptance of physical custody of students. Four schools are providing students with services according to the requirements of pre-existing IEPs, and the remaining two schools are partially compliant with this requirement. Last year, only one of the six schools was substantially compliant, and two were non-compliant. Two schools improved their practice of documenting changes in IEPs, and all schools now determine special education eligibility prior to IEP meetings. In addition, all sites now hold quarterly education stakeholders‟ meetings. Across the state, DJJ teachers are identifying special education students in their classrooms.

DJJ‟s improved education program appears to have yielded tangible results. The percentage of youth who earn high school diplomas appears to have increased, as has the percentage of youth enrolled in distance learning college courses.[14]

B. Areas of Concern

DJJ still fails to provide many youth with 240 minutes of instruction (five class periods) per day.[15] Some youth are simply not scheduled for five periods, and others are

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[14] The special master reviewed a document entitled "California Education Authority Education Services AY Progress Report: 2004-2009," undated. This document depicts the number of diplomas, GEDs, vocational education certificates, and college enrollment by fiscal year. The document lists the source of this information as "June Principal‟s Monthly Report, 2004-2009." The special master has not yet verified the accuracy of the data. The special master calculated percentages based on the end of fiscal year population reported on DJJ‟s website, http://www.cdcr.ca.gov/Juvenile_Justice/Research_and_Statistics/index.html. The percentages thus do not reflect the percentage of school-eligible youth, but the proportion of DJJ‟s total population, who earned diplomas and GEDs. If DJJ‟s data is accurate, six percent of DJJ‟s population earned high school diplomas in 2005-2006; seven percent earned diplomas in 2006-2007, eleven percent in 2007-2008, and twelve percent in 2008-2009. Four percent earned GEDs in 2005-2006, seven percent in 2006-2007, ten percent in 2007-2008, and five percent in 2008-2009. Ten percent earned vocational certificates in 2005-2006, sixteen percent in 2006-2007, 25 percent in 2007-2008, and 44 percent in 2008-2009. Six percent were enrolled in a college course in 2005-2006, twelve percent in 2006-2007, 25 percent in 2007-2008, and seventeen percent in 2008-2009.

held back or pulled from school by staff. As of January 2009, only 48 percent of eligible students at Stark were scheduled for five periods per day.[16] Non-educational staff at O.H. Close frequently pull students out of classes.[17] As of October 2008, Chaderjian staff were holding youth back from the main school for non-educational purposes.[18] Youth in Chaderjian‟s restricted housing unit were also not receiving 240 instructional minutes per day.[19] At Preston, the experts observed a non-graduate walking to school after classes had begun; he indicated that his living unit staff had "forgotten to call him out for school."[20] And staff on Preston‟s new restricted housing unit had been holding three youth back from school for at least one week, to prevent them from re-affiliating with gang members.[21]

Even where staff do not directly prevent youth from receiving 240 instructional minutes per day, DJJ personnel and practices indirectly contribute to attendance problems.[22] Reasons for youth absences are varied and include security concerns, lack of

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[15] Statements of Tom O‟Rourke during Case Management Conference, July 9, 2009. State law and the education remedial plan require DJJ to provide eligible youth with 240 minutes of instruction per day, for 220 days per year, in subjects leading to high school graduation. The experts have identified this as a priority area for DJJ. *See* Ninth Report of the Special Master (June 2009), Appendix A (Expert Priorities), p. 1.

[16] Tom O‟Rourke and Robert Gordon, Site Compliance Report: H.G. Stark, January 2009, p. 1.

[17] Tom O‟Rourke and Robert Gordon, Site Compliance Report: O.H. Close, October 2008, p. 6. DJJ staff report that non-educational personnel at O.H. Close continue to pull students from class. Statements of O.H. Close teacher during DJJ Court Compliance Task Force Meeting, May 21, 2009 (referencing a spike in "treatment absences" according to SWAT attendance data); statements of Joan Loucraft during Case Management Conference, July 9, 2009 (describing ongoing scheduling conflicts with school hours at O.H. Close).

[18] Tom O‟Rourke and Robert Gordon, Site Compliance Report: Chaderjian, October 2008, p. 8.

[19] *Id.*, p. 11. DJJ reports that these youth are currently scheduled for five periods per day, but the problem identified by the experts was adherence to the five-period schedule: "[s]tudents on the units continue to be registered for 5 class periods daily, but they do not consistently receive mandated educational services." *See* Tom O‟Rourke and Robert Gordon, Site Compliance Report: Chaderjian, October 2008, p. 11; statements of Susan Harrower during Case Management Conference, July 9, 2009.

[20] Tom O‟Rourke and Robert Gordon, Site Compliance Report: Preston, February 2009, p. 10.

[21] *Ibid.*

[22] O‟Rourke/Gordon 2008-2009 Report, p. 6. DJJ‟s attendance data are not clearly reliable. The experts have particularly noted flawed attendance reporting practices at O.H. Close and H.G. Stark. *See* Tom O‟Rourke and Robert Gordon, Site Compliance Report: O.H. Close, October 2008; Tom O‟Rourke and

substitute teachers, and youth refusals.[23] Refusals may be due to fear of violence in the school area.[24] Other refusals may result simply from youths‟ knowledge that living unit staff do not consistently enforce sanctions for refusing to attend school.[25] The experts note that Preston, Ventura, and SYCRCC have improved in this area over the years, due largely to improved management of youth misbehavior,[26] though difficulties remain. At Preston, two students were observed entering a living unit during school hours, having left their classes because "they wanted to."[27] At Ventura the experts observed five female students leaving school mid-afternoon and returning to their living units to schedule doctor appointments; interviews with living unit staff indicated that this was a common occurrence.[28]

Many youth continue to be deprived of a full range of educational alternatives.[29] For instance, enrollment in vocational classes "continues to be very low."[30] Staff remove graduates and GED-holders who are enrolled in vocational education from class for non-educational purposes.[31] Student access to GED programs has also been limited, though DJJ reports that it recently enhanced GED preparation access in response to the experts‟

Robert Gordon, Site Compliance Report: H.G. Stark, January 2009. The experts and DJJ leadership have urged all sites to use the WIN database, rather than hand-counts or other databases, to record attendance data. E-mail of Tom O‟Rourke to special master, July 29, 2009.

[23] Statements of Tom O‟Rourke during Case Management Conference, July 9, 2009.

[24] *See* Barry Krisberg, Informal Report: H.G. Stark, April 2009, p. 1; memorandum of Aubra Fletcher to Donna Brorby, April 28, 2009, p. 7.

[25] *See, e.g.*, statements of Robert Gordon during Case Management Conference, July 9, 2009.

[26] Statements of Tom O‟Rourke during Case Management Conference, July 9, 2009 (citing the gradual implementation of behavior management classrooms and the reduced practice of complete school closure in response to relatively contained fighting).

[27] *Ibid.*

[28] Tom O‟Rourke and Robert Gordon, Site Compliance Report: Ventura, May 2009, p. 7; e-mail of Tom O‟Rourke to Aubra Fletcher, August 28, 2009.

[29] O‟Rourke/Gordon 2008-2009 Report, p. 6.

[30] *Ibid.* DJJ staff have stated that unavoidable scheduling problems contribute to low enrollment in vocational classes, yet the experts have found that DJJ could feasibly alter its vocational education schedules. Statements of Drs. Gordon and O‟Rourke during *Farrell* experts‟ meeting, August 21, 2009.

[31] *Id.* DJJ‟s policy is to provide vocational education to graduates and youth with GEDs as space permits; the experts report that sufficient space and faculty exist, yet DJJ is not providing this level of education to all eligible youth. *Id.*

recommendations.[32] In the area of special education, DJJ has decreased its efforts to monitor IEP development and implementation, apparently because a key staff member moved from education to the court compliance team, and DJJ did not replace her in the position she vacated.[33] Also, schools do not provide all segments and services listed in youths" IEPs, and DJJ has not implemented a system to document IEP progress reviews.[34]

In restricted settings, education for both regular and special education students remains inadequate.[35] The majority of youth in restricted settings do not receive 240 minutes of instruction per day, nor do they have sufficient opportunities to progress toward high school graduation.[36] This is due, in part, to inadequate use of staff and lack of appropriate instructional space.[37] It is due also to DJJ"s generic approach to discipline, which results in restricted setting placements that may be unnecessary.[38]

The remedial plan requires each school to operate an alternative behavior learning environment (ABLE) classroom for youth who misbehave in school, instead of sending them back to their living units.[39] All six schools have opened ABLE classrooms, compared with three last year.[40] However, staff at some sites do not operate the

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[32] O"Rourke/Gordon 2008-2009 Report, p. 9; statements of Michael Brady during Case Management Conference, July 9, 2009.
[33] Statements of education experts to the special master during teleconference, July 1, 2009; O"Rourke/Gordon 2008-2009 Report, p. 8.
[34] O"Rourke/Gordon 2008-2009 Report, p. 8.
[35] *Id.*, p. 6.
[36] Statements of Robert Gordon during Case Management Conference, July 9, 2009.
[37] O"Rourke/Gordon 2008-2009 Report, p. 6.
[38] Statements of Robert Gordon during Case Management Conference, July 9, 2009; *see also* statements of education experts during Stark exit interview, January 14, 2009. For example, a youth in possession of contraband and a youth who assaults staff are identically restricted from school and programs. Statements of Robert Gordon during Case Management Conference, July 9, 2009.
[39] *See* Education Services Remedial Plan, p. 30.
[40] *Compare* O"Rourke/Gordon 2008-2009 Report, Attachment 1, p. 2 *and* O"Rourke/Gordon, Lyle Egan High School Corrective Action Plan Summary, May 18, 2009, pp. 2-3 *with* O"Rourke/Gordon 2007-2008 Report, Attachment B, p. 2.

classrooms in accordance with established guidelines.[41] DJJ is not systematically tracking the operation of each school‟s ABLE classroom.[42]

The experts continue to stress the importance of youths‟ transition to the community. Although the experts have praised individual transition coordinators, they stress that DJJ must standardize its transition services across the state.[43] DJJ does not obtain community feedback regarding the success of its educational programs.[44] The experts have called for a system by which DJJ will monitor whether released students are enrolled in school, employed, or returned to state custody, in order to evaluate program effectiveness.[45] In June 2009, DJJ began the process of standardizing its transition services and has consulted with Drs. Gordon and O‟Rourke.[46] In August 2009, DJJ informed the special master that it will work with Parole Services to collect information about parolees‟ employment and education activities.[47]

The special master previously reported that DJJ‟s education policies were fully adequate as of the end of the 2007-2008 school year.[48] This year, however, the policies fell out of date.[49] As of the end of the experts‟ audit round, DJJ still had not updated its special education manual to reflect 2004 federal legislation.[50] This demonstrates that DJJ

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[41] O‟Rourke/Gordon 2008-2009 Report, p. 6; e-mail of Tom O‟Rourke to special master, July 29, 2009. The operation of the ABLE classroom at Stark is discussed in more detail in section II.C.1.f, below.
[42] O‟Rourke/Gordon 2008-2009 Report, p. 6.
[43] *Id.*, p. 5.
[44] *See ibid.*
[45] *See ibid.*
[46] Statements of Leda Medearis during DJJ Court Compliance Task Force meeting, June 11, 2009. The acting superintendent of education stated that she was coordinating the process and had scheduled a mid-June meeting with some facilities‟ transition coordinators to establish statewide standards. *Id.*
[47] Memorandum of Van Kamberian to special master, August 19, 2009 (providing DJJ comments on a draft of this report).
[48] *See* Eighth Report of the Special Master (February 2009), p. 2.
[49] O‟Rourke/Gordon 2008-2009 Report, pp. 7-8, 10.
[50] *See* O‟Rourke/Gordon 2008-2009 Report, pp. 7-8, 10. DJJ has since provided the experts with an updated version for their review. *See* DJJ Special Education Manual, 2009 (PoP # 479, August 17, 2009). Dr. Gordon has approved the manual and asked DJJ to request its approval by the California Department of

needs to establish and follow a schedule for future policy reviews in order to maintain up-to-date policies.[51] The experts also call for increased attention to policy implementation and enforcement.[52]

The experts report again this year that stable leadership at the central office level is needed for improvement in all identified problem areas.[53] As of the end of the experts‟ audit round, DJJ still lacked a permanent superintendent of education.[54] A very qualified acting superintendent was in place, but the experts consider it critical for DJJ to have a permanent superintendent to "provide consistent leadership, direction and supervision of the education program."[55] After years of unsuccessful recruiting to fill the position, DJJ identified a candidate.[56] Because the position is a gubernatorial appointment, DJJ provided the candidate‟s name to the governor and received no response until August 2009.[57] The newly appointed superintendent of education reportedly began work on September 1, 2009.[58]

Other central office positions in education services also remain vacant. In response to the reduced number of DJJ facilities and shifting job responsibilities, the experts have called for a review and revision of the Educational Services organizational chart.[59] The experts have also noted that should additional hiring be necessary, DJJ‟s use

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Education, to ensure its compliance with state requirements. *See* e-mail of Tom O‟Rourke to Aubra Fletcher, August 28, 2009.

[51] O‟Rourke/Gordon 2008-2009 Report, pp. 7-8, 10. As of the time of the experts‟ report, DJJ‟s policies were not accessible electronically to staff. *See* O‟Rourke/Gordon 2008-2009 Report, pp. 7-8, 10. DJJ has since corrected this problem. E-mail of Tom O‟Rourke to special master, July 29, 2009.

[52] *See* O‟Rourke/Gordon 2008-2009 Report, pp. 7-8, 10.

[53] *See* O‟Rourke/Gordon 2008-2009 Report, pp. 5, 11. The experts have identified this as a priority area for DJJ. *See* Ninth Report of the Special Master (June 2009), Appendix A (Expert Priorities), p. 1.

[54] O‟Rourke/Gordon 2008-2009 Report, pp. 5, 11.

[55] *Id.*, p. 11.

[56] Statements of Doug McKeever to special master during telephone conference, July 27, 2009.

[57] *Id.*; statements of Bob Gordon to Aubra Fletcher during teleconference, September 1, 2009.

[58] Statements of Bob Gordon to Aubra Fletcher during teleconference, September 1, 2009.

[59] *See* e-mail of Tom O‟Rourke to Aubra Fletcher, August 28, 2009.

of limited-term positions will "greatly inhibit[]" its ability to recruit and retain qualified staff.[60]

C. Program Service Day

The purpose of the program service day is to minimize scheduling conflicts among education and other programs and services, while increasing time spent in structured activities.[61] DJJ finalized a program service day policy in early 2009 and implemented it on March 31, 2009,[62] following a fall 2008 pilot at the Preston facility.[63] This is an important step toward increasing youth access to education, treatment programs, and other services. However, many remedial requirements related to the program service day remain to be met.

First, facility schedules do not conform to all aspects of the program service day "statewide standards." The safety and welfare plan required DJJ to develop statewide standards for facilities prior to the development of their program service day schedules.[64] DJJ finalized the standards over one month after implementing the program service day policy,[65] which meant that facilities created their schedules without the benefit of the

[60] O'Rourke/Gordon 2008-2009 Report, p. 5. The experts are in communication with DJJ's director of programs regarding both recruitment and the need for a staffing analysis that may yield changes in organizational structure. *See, e.g.*, e-mail of Doug McKeever to special master, et al., July 22, 2009.
[61] *See* Education Services Remedial Plan, p. 29; Mental Health Remedial Plan, p. 30; Safety and Welfare Remedial Plan, pp. 44-45, 51.
[62] *See, e.g.*, statements of facility managers during DJJ Court Compliance Task Force meeting, April 2, 2009. The program service day policy is found at Appendix B.
[63] *See, e.g.*, memorandum of Sandra Youngen and Doug McKeever to superintendents, et al., March 25, 2009 (PoP # 368, March 26, 2009).
[64] Safety and Welfare Remedial Plan, pp. 45, 57; Safety and Welfare Standards and Criteria, items 6.2a-c, 6.6.
[65] *See* Appendix C, DJJ, Program Service Day Standards, May 11, 2009, p. 2 (PoP # 402, May 15, 2009). Draft statewide standards were provided to OSM in January 2008. *See* memorandum of Tami McKee-Sani to DJJ Executive Team, January 10, 2008 (PoP #118, January 24, 2008). DJJ did not provide these standards to the education experts. E-mail of Tom O'Rourke to special master, July 29, 2009.

standards.[66] At least two facilities do not adhere, for instance, to the standard prohibiting the regular removal of youth from the same class and the standard prohibiting facilities from scheduling students for non-educational activities during an instructional period.[67] Another standard requires that "Hour of Sleep (HS) pill call shall not occur until program activity is completed and shall not begin before 2000 hours and preferably at 2100 hours."[68] Multiple living units at Stark schedule the final pill call of the day for as early as 1600 hours.[69] When the special master raised a concern about this, DJJ provided a one-page, unsigned document indicating a policy to provide HS medications at 2100 hours.[70] At the request of experts Madeleine LaMarre and Terry Lee, OSM will monitor hour-of-sleep medication administration during the next audit round.[71]

More broadly, the new facility schedules do not uniformly achieve the purpose of the program service day: to "allow[] time for all treatment programs, educational programs, medical services, training and routine maintenance needs to be met during the work day/week without loss of mandatory program time"[72] and to ensure that DJJ

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[66] *See* Seventh Report of the Special Master (April 2008), p. 23. DJJ has informed OSM that the statewide standards "were purposely excluded [from the policy] because we knew they would have to be revised and approved." Ninth Report of the Special Master (June 2009), Appendix D (Schwartz and Fletcher Report), p. 7. DJJ indicates that facilities "were expected to modify their living unit PSD schedules if necessary once the PSD Standards were approved and sent out." Memorandum of Van Kamberian to Donna Brorby, September 1, 2009, p. 1 (providing comments on a draft of this report).
[67] *See* DJJ, Program Service Day Standards, May 11, 2009, p. 2 (PoP # 402, May 15, 2009). Observed schedules at Stark and SYCRCC assign youth to non-educational activities during the school day, which results in the regular removal of youth from the same class. Greater detail is provided below.
[68] *See id.* The standard continues, "HS meds must be administered after program activity has stopped in order to avoid having youth who received sedating medications engaging in program activities."
[69] See, e.g., schedules for the following living units at Stark, provided to the special master on April 29-30, 2009: "A" (1600 hours), "B" (1600 hours), "G" (1600 hours), "H" (1600 hours); "I" and "J" (1800 hours), "K" and "L" (1900 hours), "M" and "N" (1600 hours), and "O" and "R" (1900 hours).
[70] *See* document entitled "New Dosing Periods," undated; e-mail of Dr. Laura Poncin to special master, August 12, 2009 (stating that the schedule became effective in March 2008).
[71] *See* e-mail of Terry Lee to Aubra Fletcher, August 13, 2009; e-mail of Made LaMarre to Aubra Fletcher, August 15, 2009. In response to a draft of this report, DJJ"s central office instructed management at Stark to ensure that every living unit"s pill call is scheduled for 2100 hours. *See* memorandum of Van Kamberian to Donna Brorby, September 1, 2009, p. 1 (providing comments on a draft of this report).
[72] *See* Education Services Remedial Plan, p. 29.

engages youth in "structured activity based on evidence based principles for 40 to 70 percent of their waking hours."[73] Toward these ends, DJJ is to "ensure that coverage by every discipline – including psychologists, case managers, teachers, and other service providers – includes some evening and weekend time."[74] Across the state, the work schedules of most mental health, medical, and case management staff leave them with few work hours outside of the school day.[75]

With staff coverage largely confined to weekday school hours, DJJ cannot both provide mandatory program time and comply with the requirement that scheduled education and treatment time not be used for other purposes.[76] For example, the Sexual Behavior Treatment Program (SBTP) Remedial Plan requires that SBTP youth receive three hours of clinician-led group therapy each week,[77] and according to national standards, these hours must either be consecutive or broken into two 90-minute sessions.[78] DJJ cannot achieve compliance with this requirement if it separates the three-hour period into three one-hour sessions.[79] Stark attempts to fit educational and treatment services into the schedule by allotting a one-hour "treatment period" during the school day.[80] One of Stark"s three SBTP units nevertheless schedules each youth for a weekly three-hour group session that overlaps with educational classes.[81] Another of Stark"s

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[73] Mental Health Remedial Plan, p. 30; *see also* Safety and Welfare Remedial Plan, pp. 44-45, 51.
[74] Safety and Welfare Remedial Plan, p. 45.
[75] *See, e.g.*, statements of Jay Aguas during DJJ Court Compliance Task Force meeting, April 30, 2009.
[76] *See* Education Services Remedial Plan, p. 29.
[77] Sexual Behavior Treatment Program Remedial Plan, p. 12.
[78] Statements of Dr. Barbara Schwartz during central office SBTP site visit, June 8, 2009. Dr. Schwartz has recommended that these sessions in fact be broken into 90-minute increments.
[79] *Id.*
[80] See, e.g., multiple Stark and Ventura program service day schedules provided to the special master on April 29-30, 2009. All facilities allot a one-hour treatment period during the school day.
[81] *See* program service day schedules for Stark"s "G" living unit, provided to the special master on April 29-30, 2009.

SBTP units simply fails to provide all required core therapy hours.[82] Stark’s third SBTP unit holds biweekly 90-minute sessions that overlap with youths’ lunch hour.[83] The SBTP unit at SYCRCC also schedules therapy during meal times.[84]

Similar scheduling problems plague the rest of Stark’s living units.[85] Some youth correctional counselors (YCCs) are scheduled to provide small group sessions during school hours.[86] Also scheduled during the school day are large group meetings,[87] sick call,[88] individual treatment and therapy sessions,[89] YCC- and case worker-led small groups,[90] dayroom and outdoor recreational time,[91] pill call,[92] and an activity listed as “Individualized T[reatment] Interventions.”[93]

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[82] *See* program service day schedules for Stark’s “B” living unit, provided to the special master on April 29-30, 2009.

[83] *See* program service day schedules for Stark’s “H” living unit, provided to the special master on April 29-30, 2009. DJJ’s acting SBTP coordinator is reportedly addressing the scheduling problems at Stark’s SBTP units, which were recently consolidated onto two living units. Statements of Heather Bowlds during meeting with Barbara Schwartz and Aubra Fletcher, August 20, 2009; memorandum of Van Kamberian to Donna Brorby, September 1, 2009, p. 2 (providing comments on a draft of this report).

[84] See program service day schedule for SYCRCC’s SBTP unit, provided to Dr. Schwartz and Aubra Fletcher on May 7, 2009.

[85] Stark is highlighted as an example here because DJJ has provided more documentation from Stark than from other facilities. The detailed focus on Stark in this report does not necessarily reflect greater problems there than at other facilities with respect to program service day schedules.

[86] *See* program service day schedules for Stark living units “A,” “C,” “D,” “E,” “F,” “I,” “J,” “K,” “L,” “M,” “N,” “O,” “R,” “W,” and “X,” provided in April 2009.

[87] *See* program service day schedules for Stark living units “C” and “D,” provided in April 2009.

[88] *See* program service day schedules for Stark living units “C,” “D,” “E,” “F,” “I,” “J,” “K,” “L,” “O,” and “R,” provided in April 2009.

[89] *See* program service day schedules for Stark living units “C,” “D,” “E,” “F,” “I,” “J,” “O,” and “R,” provided in April 2009.

[90] *See* program service day schedules for Stark living units “C,” “M,” and “N,” provided in April 2009.

[91] *See* program service day schedules for Stark living units “C,” “D,” “K,” “L,” “I,” “J,” “M,” “N,” “O,” and “R,” provided in April 2009. The April 2009 “O” schedule indicates that youth are simultaneously scheduled to attend class in the dayroom and scheduled for dayroom free time. OSM monitor Aubra Fletcher observed this arrangement in practice during the experts’ January 2009 audit. Two students watched television while their teacher and two other staff sat in the corner of the dayroom. The teacher informed Ms. Fletcher that it was difficult to convene class because “we’re on their turf” when class periods fall within the scheduled free time; he added that the students have the right to refuse to participate in school at any time. The situation was brought to the attention of central office staff and was included in the experts’ informal report. Regardless, the April 2009 “O” unit schedule reinforced the problem.

[92] *See* program service day schedules for Stark living units “W” and “X,” provided in April 2009.

[93] *See id.*

DJJ has acknowledged that in order for the program service day to be successful, "staff in various disciplines[,] including medical and mental health[,] . . . need to be more available to youth during non-school hours," including evenings and weekends.[94] Central office personnel have stated that DJJ cannot require staff to work different hours without renegotiating various bargaining agreements.[95] DJJ negotiated extended working hours for case managers in May 2009; these staff now work until 8:00 p.m. one day each week and one weekend day per week.[96] DJJ is still considering to what extent it will renegotiate work hours for other job classifications.[97] The current staffing plan that DJJ will announce to its bargaining units includes later hours for some mental health staff on sexual behavior treatment program units and intensive treatment program (ITP) units.[98] The plan does not include weekend hours for these staff. It remains unclear why DJJ cannot alter the schedules of mental health clinicians without renegotiating their union contract: one facility has already required its psychologists to lead therapy groups after school from 4:00 p.m. to 5:30 p.m.[99]

Even where educational time does not conflict with other activities, staff adherence to schedules falters. The education experts have discussed with DJJ program monitors the need to require all staff and all facilities to follow the program service day

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[94] *See, e.g.*, memorandum of Van Kamberian to Donna Brorby, September 1, 2009, pp. 1-2 (providing comments on a draft of this report).

[95] *See, e.g.*, statements of Jay Aguas during DJJ Court Compliance Task Force meeting, April 30, 2009.

[96] Statements of Erin Peel during central office SBTP site visit, June 8, 2009. This includes all staff classified as "case managers" and those "case work specialists" who function as case managers. Statements of Jay Aguas during DJJ Court Compliance Task Force meeting, April 30, 2009. The change also appears to include parole agents. Memorandum of Van Kamberian to Donna Brorby, September 1, 2009, p. 1 (providing comments on a draft of this report).

[97] *Id.*

[98] *See* DJJ, Draft Business Rules for Housing Unit Staffing, June 9, 2009; memorandum of Van Kamberian to Donna Brorby, September 1, 2009, p. 1 (providing comments on a draft of this report).

[99] *See* program service day schedule for SYCRCC"s SBTP unit, provided to Dr. Schwartz and Aubra Fletcher on May 7, 2009.

schedule.[100] The medical experts have noted that youth frequently utilize sick call services during the school day for minor complaints that would not result in a similar appointment in the community.[101] The medical experts recommend that DJJ minimize this problem by scheduling appointments for non-acute conditions (*e.g.*, acne, dry skin) after school hours.[102] DJJ leadership has noted and is addressing such problems at O.H. Close in particular.[103]

<u>D. Heman G. Stark</u>

Among the DJJ facilities, Stark has consistently been the least successful in implementing the education remedial plan‟s requirements. DJJ‟s central office adopted a targeted approach to the problem this year, in response to courtroom discussions of education services at Stark. Though DJJ recently announced Stark‟s planned closure, the situation of educational services there bears continued attention for a variety of reasons. Stark still houses youth in need of educational services, and no date is set for its closure. Also, the marginal improvement in education at Stark reflects central office‟s limited capacity to effect major change in its facilities. After seven months of focused attention on education at Stark, absence rates still soared, most youth in restricted settings lacked access to the required 240 minutes of daily instruction, the behavior management

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[100] E-mail of Tom O‟Rourke to Donna Brorby, July 29, 2009.
[101] E-mail of Madeleine LaMarre to Aubra Fletcher, August 3, 2009.
[102] *See id.*
[103] Statements of Joan Loucraft during Case Management Conference, July 9, 2009. A teacher at O.H. Close reported to central office that medical and mental health absences from school have spiked since the implementation of program service day schedules. Statements of O.H. Close teacher during DJJ Court Compliance Task Force meeting, May 21, 2009. According to him, the facility was averaging 300 “treatment absences” per month over a three-month period. He noted that the facility‟s population is only 180 youth. Part of the problem may be in attendance data collection, but the teacher also recounted an example in which a clinician individually called ten youth out of class, a few minutes apart, suggesting that a treatment group was unofficially held during class time.

classroom was still poorly operated, and not all teachers were using lesson plans or adequate syllabi.

1. Response to the Experts‟ January 2009 Stark Report

In February 2009, plaintiff‟s counsel provided the Court with the education experts‟ informal report on H.G. Stark.[104] The report was discussed during the February 20, 2009 Case Management Conference, and thereafter the parties agreed that, *inter alia*, DJJ would prepare a corrective action plan (CAP) in consultation with various court experts, plaintiff‟s counsel, and the special master.[105] The parties also agreed that 45 days later, CDCR‟s Office of Audits and Compliance (OAC) would review the Stark facility‟s progress in implementing the CAP.[106] OAC would then formally audit Stark‟s compliance with the CAP at the 90-day point.[107] DJJ agreed to provide the Court, the experts, and the special master with the OAC audit report by July 20, 2009.[108] DJJ provided the report on August 3, 2009.[109]

The special master, her staff, plaintiff‟s counsel, and the education experts visited Stark after the CAP was approved by the experts and finalized in early April.[110] The

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[104] *See* e-mail of Sara Norman to Department 21, Alameda County Superior Court, et al., February 17, 2009.
[105] Letter of Deputy Attorney General Todd Irby to Department 21, Alameda County Superior Court, February 27, 2009, p. 1. A copy of the corrective action plan is attached to this report as Appendix D.
[106] *Ibid.*
[107] *Ibid.*
[108] *Id.*, pp. 1-2.
[109] *See* CDCR Office of Audits and Compliance, Compliance Review: Heman G. Stark Youth Correctional Facility, June/July 2009 (PoP #474, August 3, 2009) [hereinafter "OAC Compliance Report: Stark CAP"]. As of this writing, DJJ has not filed the report with the Court. The special master does not attach it here due to its length but summarizes its contents below.
[110] *See* Appendix D, Education Audit of Lyle Egan High School Corrective Action Plan. DJJ provided the final CAP to the special master and experts on April 6, 2009, and the plan took effect on April 8, 2009. *See* e-mail of Doug Ugarkovich to Bob Gordon, et al., April 6, 2009. Monitor Aubra Fletcher visited Stark on April 21, 2009 and thereafter provided a memorandum based on her fact-gathering to the relevant experts and parties. *See* memorandum of Aubra Fletcher to Donna Brorby, April 28, 2009; e-mail of Aubra Fletcher to William Kwong, et al., April 28, 2009. The special master gathered further information at Stark on April 30, 2009 and provided a memorandum to the education experts. *See* memorandum of Donna Brorby to education experts, May 11, 2009; e-mail of Donna Brorby to education experts, May 12, 2009.

experts‟ May 18, 2009 visit coincided with the beginning of the OAC‟s 45-day audit. OAC monitors returned to Stark on June 29 through July 2, 2009.[111] Below is a summary of the experts‟ findings and the OAC‟s 90-day report, organized according to the eight key areas identified in the CAP.

a. All students without a diploma or GED will attend school unless the absence is verified for a medical condition or the youth poses an immediate threat to safety.

The experts and OAC found Stark‟s school attendance procedures unsatisfactory.[112] Four hundred school and custody staff remained to be trained on the attendance procedures as of July 2009, and the facility had not yet developed a lesson plan for the training.[113] In the meantime, communication between custody staff and teachers regarding absences was lacking.[114]

Other identified problems included inconsistent attendance counts and failure to provide substitute teachers.[115] As late as July, facility staff were still allowing students who refused to attend school to watch television in living unit dayrooms.[116] The experts have long denounced this practice to central office and facility management, who have failed to take necessary action.[117]

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111 OAC Compliance Report: Stark CAP, p. 1.

112 *See* Tom O‟Rourke and Robert Gordon, Lyle Egan High School Corrective Action Plan Summary, May 18, 2009, p. 1 [hereinafter O‟Rourke/Gordon, Stark CAP Report]; OAC Compliance Report: Stark CAP, p. 1.

113 OAC Compliance Report: Stark CAP, pp. 1, 8.

114 O‟Rourke/Gordon, Stark CAP Report, p. 1; OAC Compliance Report: Stark CAP, p. 1.

115 O‟Rourke/Gordon, Stark CAP Report, pp. 1-2; OAC Compliance Report: Stark CAP, p. 2.

116 OAC Compliance Report: Stark CAP, p. 2.

117 It is clear that living unit staff are not solely responsible. OSM staff took note of a particular comment by Stark management during a March 12, 2009 task force meeting. When asked whether televisions were now turned off during the day, Stark‟s current superintendent replied that the facility was "moving towards that." More than three months later, staff were still leaving the televisions on. OAC attributed this to a lack of adequate staff training regarding school refusers. *See* OAC Compliance Report: Stark CAP, p. 10. OAC‟s report seems to recommend that policy require school refusers to be kept in their rooms during school hours. *See id.* OSM urges DJJ to consult with the education, mental health, and safety and welfare experts before mandating that school refusers remain isolated in their cells for hours at a time.

b. Absence rates of seven percent or more will result in quarterly corrective action plans until the absence rate drops below seven percent.

Stark‟s school principal reported that half of all school-eligible students were absent on April 1, 2009 and almost one-third of school-eligible students were absent on April 30, 2009.[118] However, the principal‟s hand-calculated numbers and electronically available data differed significantly, and in May the experts urged Stark to address this problem immediately.[119]

OAC‟s July audit team did not report on attendance data or address its accuracy. The absence rate appears still to have exceeded seven percent, based on OAC‟s non-compliance finding; the report noted that facility administration is not preparing corrective action plans when the absence rate of seven percent or more.[120]

c. Appropriate criteria for the exclusion of students from school shall be devised. Schools shall maintain a daily document listing all excluded students and the reason for and duration of their exclusion.

The experts and OAC found Stark‟s attendance procedures for off-campus schools unsatisfactory.[121] Many staff were not following the procedures, because of lack of training and because not all staff had even seen the procedures.[122] The system for monitoring staff compliance with the procedures was also unsatisfactory.[123]

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[118] O‟Rourke/Gordon, Stark CAP Report, p. 1. The experts recommended that all facilities use WIN to track education attendance, and DJJ‟s central office has so instructed facility management. E-mail of Tom O‟Rourke to special master, July 29, 2009; statements of Doug McKeever during DJJ Court Compliance Task Force meeting, May 21, 2009.

[119] *Ibid.*

[120] *See* OAC Compliance Report: Stark CAP, p. 1. OAC attributed this to the superintendent and principal‟s inability to coordinate their schedules to meet about a corrective action plan. *See id.*, p. 6.

[121] *See* O‟Rourke/Gordon, Stark CAP Report, p. 2; OAC Compliance Report: Stark CAP, p. 2.

[122] *See* OAC Compliance Report: Stark CAP, pp. 2, 12. Four hundred staff remained to be trained on the attendance procedures, among them staff who are responsible for delivering off-campus school attendance data to the school attendance coordinator. *Id.*, pp. 13-20.

[123] O‟Rourke/Gordon, Stark CAP Report, p. 2; OAC Compliance Report: Stark CAP, p. 2.

d. Improve coordination of schedules in order that students do not miss class for non-educational activities.

As of May 2009, at least two restricted program youth were late to class each day because of their work schedules.[124] On the day of the experts‟ visit, two classes, offered on two different restricted living units, were canceled due to teacher absences.[125] Although a substitute teacher was available, the school did not assign him to either of the cancelled classes.[126] The school also could not verify that the class‟s special education students would receive required compensatory instruction hours.[127] In July, OAC monitors assigned a "partial compliance" rating and observed students being held back from school to attend treatment groups.[128] Scheduling conflicts are discussed in greater detail in this report‟s "Program Service Day" section, above.

e. Instructional teams must develop incentives for increased school attendance.

In May, the experts noted progress in this area.[129] The experts encouraged administrators and staff to increase efforts to encourage students to attend school.[130] OAC did not report on this issue.[131]

f. Operate an alternative behavior management classroom.

The experts and OAC found that Stark was not operating the ABLE classroom according to established procedures.[132] Referring teachers were not assigning students

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[124] *See* O‟Rourke/Gordon, Stark CAP Report, p. 2.
[125] *Ibid.*
[126] *Ibid.*; e-mail of Tom O‟Rourke to Aubra Fletcher, August 28, 2009.
[127] O‟Rourke/Gordon, Stark CAP Report, p. 2.
[128] OAC Compliance Report: Stark CAP, pp. 2, 21.
[129] *See* O‟Rourke/Gordon, Stark CAP Report, p. 2.
[130] *Ibid.*
[131] *See generally* OAC Compliance Report: Stark CAP.
[132] *See id.* p. 2; O‟Rourke/Gordon, Stark CAP Report, p. 2.

appropriate academic work, and the ABLE teacher accepted referred students without assigned work.[133]

g. School administrators and living unit supervisors must use a standardized format for reporting educational progress and data on students in restricted placements and must utilize a standardized checklist to ensure students in restricted programs receive mandated educational services.

The experts and OAC found that significant numbers of students attending school on the restricted living units were not receiving 240 minutes of daily instruction.[134] For example, in July only six of the 40 youths enrolled in school on high-risk living units "S" and "T" were enrolled for 240 minutes.[135] Some of these enrolled youth were not actually attending their assigned classes.[136]

Many of the students deprived of vocational education opportunities are housed on restricted units.[137] Stark offered no vocational or GED classes to the 93 students enrolled in restricted living unit classrooms.[138] Staff assigned to four restricted living units were not completing semi-annual high school graduation plans for each student.[139]

As of July, Stark had no policy indicating how and when students housed in the Correctional Treatment Center are to receive educational services.[140]

h. Use of course syllabi, units of instruction and lesson plans by teachers.

The OAC found that teachers did not have adequate syllabi, units of instruction, or lesson plans.[141] The experts observed that some teachers did not understand what

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[133] O'Rourke/Gordon, Stark CAP Report, pp. 2-3.
[134] *See id.*, p. 3; OAC Compliance Report: Stark CAP, p. 3.
[135] OAC Compliance Report: Stark CAP, p. 3
[136] *Ibid.*
[137] Statements of Tom O'Rourke during Case Management Conference, July 9, 2009. Of the 215 school-eligible students at Stark, only 52 students were enrolled in one of the fifteen vocational courses currently offered at the facility, which the education experts find "unacceptable." *See* O'Rourke/Gordon, Stark CAP Report, p. 3.
[138] *Ibid.*
[139] *Ibid.*
[140] Memorandum of Richard Krupp to Elverta Mock, July 31, 2009 (PoP #475, August 3, 2009).

constitutes a lesson plan.[142] And though one interviewed administrator had conducted the required “walk through observations” of these teachers, he had not documented whether lesson plans were developed or in place in the classrooms.[143]

2. Effects of the Transfer of Adult Prisoners to Stark

In the wake of the August 8-9, 2009 riot at the California Institution for Men (CIM) in Chino, CDCR transferred more than 600 adult prisoners to Stark.[144] All DJJ youth remained inside their living units until the CIM transfers were complete and all adult prisoners were locked down.[145] Youth could not attend classes at Stark‟s main school for a week.[146] School was disrupted for a longer period of time on most of Stark‟s restricted unit satellite schools.[147] Many of Stark‟s high-risk youth in restricted settings currently receive about 15 minutes of instruction per day.[148]

By assigning the CIM prisoners to living units in “building three,” DJJ eliminated access to newly constructed classrooms meant for Stark‟s high-risk, restricted program

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[141] *See* OAC Compliance Report: Stark CAP, p. 3

[142] *See* O‟Rourke/Gordon, Stark CAP Report, p. 3 (“One teacher referred to work sheets placed on the students‟ desks as his „lesson plan.‟ A second teacher presented page numbers written in her grade book as her lesson plans.”).

[143] *Id.*, p. 4.

[144] *See, e.g.*, Hundreds Hurt in California Prison Riot, New York Times, August 9, 2009, *available at* http://www.nytimes.com/2009/08/10/us/10prison.html?_r=1&scp=3&sq=california%20institution%20for%20men&st=cse; statements of Bernard Warner during teleconference, August 11, 2009. Mr. Warner indicated that CDCR planned to transfer a total of more than 700 adult inmates to Stark by the following day. *Id.*

[145] Statements of Bernard Warner during teleconference, August 11, 2009. Youth in need of medical services were escorted to the appropriate building. *Id.*

[146] As of August 11, 2009, teachers were reportedly providing youth homework assignments on their living units. *Id.* At that time, DJJ leadership did not know how many minutes of instruction per day youth were receiving. *Id.* The main school reopened on August 17, 2009. Statements of Doug McKeever during teleconference, August 18, 2009; statements of Michael Brady during *Farrell* experts‟ meeting, August 21, 2009.

[147] The Intensive Treatment Program‟s on-unit school reportedly resumed operation on August 11, 2009, but youth in high-risk restricted settings continued to lack access to full educational programming. *See, e.g.*, document entitled “California Institution for Men Crisis,” undated (provided August 18, 2009).

[148] Statements of Michael Brady during *Farrell* experts‟ meeting, August 21, 2009.

youth.[149] Stark has been unable in the past to provide a full school schedule to restricted units without classrooms.[150] It appears that no youth in high-risk, restricted settings received 240 minutes of instruction per day in the first week following the CIM riot.[151]

School access has improved for some but not all of these youth. DJJ represents that the high-risk youth now housed on "N" have adequate instructional space.[152] Some of the students now housed on "O" and "R" began attending classes in a segregated area of the main school on August 20, 2009.[153] As of that date, five other "O" and "R" students were attending school in their living unit kitchen, reportedly for security reasons. Three others were receiving a "minimum of 15 minutes" of instruction each day on the living unit. The superintendent, principal, and assistant principal could not confirm whether any educational services were being provided to a remaining three "O" and "R" youth.

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[149] Details of the initial transfers are included as Appendix E, document entitled "Heman G. Stark Youth Correctional Facility." In summary, CIM prisoners are housed in units "S" through "Z." DJJ had constructed new classrooms on living units "S," "T," "U," and "V" to improve access to school services for many of the restricted setting youth. Statements of Susan Harrower during Case Management Conference, July 9, 2009. In the initial moves, DJJ consolidated the special management program (SMP), formerly "K" and "L", on "K." Restricted high-risk youth from "S" and "T" were then moved to "L." Restricted high-risk youth from "Y" and "Z" were moved to "N," which had been vacant and is adjacent to the substance abuse program on "M." On about August 19, 2009, DJJ moved 66 youth from "O and R" to "B," which had been vacant (exceeding the *Farrell* limit by 28 youth). *See* Safety and Welfare Remedial Plan, p. 45; e-mail of Michael Brady to Aubra Fletcher, August 31, 2009. DJJ then moved the high risk youth from "L" to "O" and "R" and re-divided the youth on "K" between "K" and "L." *Id.*

[150] *See generally, e.g.*, Tom O'Rourke and Robert Gordon, Site Compliance Report: H.G. Stark, January 2009.

[151] During an August 11, 2009 teleconference, DJJ leadership could not confirm whether youth in restricted settings were receiving educational services as usual. *See* statements of Bernard Warner and Doug McKeever during teleconference, August 11, 2009. As of August 18, 2009, youth in at least some restricted settings (DJJ leadership were uncertain) were "still" unable to attend school because of space limitations. *See* statements of Doug McKeever and Sandra Youngen during teleconference, August 18, 2009.

[152] *See* statements of Michael Brady during teleconference, August 18, 2009; e-mail of Michael Brady to Sara Norman, et al., August 18, 2009.

[153] Statements of Michael Brady during *Farrell* experts' meeting, August 21, 2009. The information contained in the remainder of this paragraph is based on this source.

The twenty non-graduates on “K” and “L” were each receiving a “minimum of 15 minutes” of instruction per day as of August 20, 2009.[154] DJJ reports that it plans to provide 240 minutes of daily instruction to these students by establishing four classroom “areas” in two day rooms. The special master doubts that this plan will be implemented or that it can be successful. First, facility staff do not allow large groups of special management program youth in the dayrooms at the same time.[155] Second, the dayrooms are not large enough for so many classes.[156]

The space limitations in restricted units, while temporary, are indefinite. Chief Deputy Secretary Warner initially informed OSM and plaintiff‟s counsel that CDCR intended to transfer the inmates out of Stark on August 31, 2009 at 2:00 p.m.[157] Mr. Warner stated on August 18 that CDCR‟s plan remained unchanged, according to information provided to him.[158] On August 27, 2009, Mr. Warner announced that the entire Stark facility would be converted to an adult prison, though no time frame had been set.[159] He promised to work closely with the *Farrell* experts during the transition.[160] In the meantime, OSM and the education experts will continue to monitor the status of education services at Stark.

IV. ACCESS FOR YOUTH WITH DISABILITIES

From September 2008 through April 2009, the *Farrell* expert in physical and programmatic access for youth with disabilities, Logan Hopper, conducted his fourth

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[154] Statements of Michael Brady during *Farrell* experts‟ meeting, August 21, 2009. The information contained in the remainder of this paragraph is based on this source, unless otherwise noted.
[155] Statements of facility staff and youth, and observations of OSM monitors, during Stark site visits, January 2009 and April 2009.
[156] *See, e.g.*, statements of “W” and “X” teacher to the special master during Stark site visit, April 30, 2009.
[157] *See* statements of Bernard Warner during teleconference, August 11, 2009 (citing statements of CDCR Secretary Matthew Cate).
[158] *See* statements of Bernard Warner during teleconference, August 18, 2009.
[159] *See* statements of Bernard Warner during teleconference, August 27, 2009.
[160] *See id.*

round of audits. His report on those audits is attached as Appendix F. As in the past, the report begins with a comprehensive overview of findings. At DJJ‟s request, the expert included a new column, headed “recommendations,” in the grid section of the report. Text in this column directs DJJ on how to move toward compliance with specific requirements of the Wards With Disabilities Plan (“the WDP plan” or “remedial plan.”).

Since the expert‟s last report, four of DJJ‟s original disabilities coordinators (“WDP coordinators”) have left their positions.[161] As a result, Stark and SYCRCC both lacked an active WDP coordinator for several months during the past year, Ventura had a succession of three different coordinators, and O.H. Close relied on the central office WDP manager to fulfill the WDP coordinator‟s duties.[162] As of May 2009, DJJ had hired or assigned WDP coordinators at all facilities.[163] DJJ has scheduled training sessions for the coordinators in August 2009 with the disabilities expert and an outside disability advocate.[164] The loss of trained, experienced coordinators impeded progress in this remedial plan during the last year.[165] DJJ needs to train and support the new coordinators and to develop procedures to avoid the lengthy vacancies the program faced last year.[166]

In spite of the coordinator vacancies, every facility increased its percentage of substantial compliance (“SC”) ratings since the previous audit.[167] Central office also increased its percentage of SC ratings. This is notable, given that the percentage of

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[161] Appendix F (Hopper report), pp. 2, 8.
[162] *Ibid.*
[163] *Id.*, p. 8.
[164] Statements of Sandi Becker during Case Management Conference, July 30, 2009.
[165] Statements of Logan Hopper to Zack Schwartz, June 10, 2009. In his report, Mr. Hopper states that “the extent to which the [youth with disabilities] program has progressed at each facility is almost directly proportional to the length of tenure of the WDP facility coordinator.” Appendix F (Hopper report), p. 2. As an example, staff vacancies and turnover made it difficult to monitor the disciplinary and grievance processes for disability issues. *Id.*, p. 38 (item 71).
[166] *Id.*, pp. 8 (item 5), 24 (item 36), 25 (item 39).
[167] Information in this paragraph is based on DJJ Quarterly Report (July 31, 2009). Stark‟s increase in substantial compliance (two percent) was marginal, and the smallest of any facility. *Id.* This was also true in the previous audit. Eighth Report of the Special Master (January 2009), p. 9, n.34.

central office items in substantial compliance had decreased during the prior two audits. The number of central office items in substantial compliance is now comparable to the first audit.[168] The number of central office items in partial compliance has increased since the first audit.[169]

DJJ has shown improvement in several areas designated by the disabilities expert as priorities for the past fiscal year.[170] For example, DJJ improved its system for documenting the mental and physical impairments of youth with disabilities and the accommodations provided to them.[171] The WIN database continues to be upgraded to record disability-specific information, a process that has required collaboration between IT and WDP staff.[172] DJJ is required to study whether a residential program for youth with developmental disabilities is needed; the study is still at a very early stage, but DJJ has convened an interdisciplinary group[173] and has met twice with the disability expert on the topic.[174] DJJ continues to train staff on disability awareness, and recently contracted with an outside disability advocate to review and improve the training, as required by the remedial plan.[175] Intake staff"s identification of impairments has "improved dramatically," although their work is undercut by poor documentation from committing

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[168] Twenty items are in substantial compliance, as compared to 21 during the first audit. *See* DJJ Quarterly Report (July 31, 2009).
[169] Ten items are in partial compliance, as compared to six during the first audit. *Id.*
[170] *See* Ninth Report of the Special Master (June 2009), Appendix A (Experts" Priorities for Fiscal Year 2008-2009). Out of 11 high-priority items, ratings for six improved, either from PC to SC or NC to PC. *See* DJJ Key Indicators Report (July 8, 2009). The ratings on two high-priority items ratings declined, and three showed no change. *See ibid.*
[171] Appendix F (Hopper report), p. 15 (item 14).
[172] *Id.*, p. 54 (item 110).
[173] Statements of Sandi Becker at case management conference, July 30, 2009. This was not true as of September 2008. *See* Eighth Report of the Special Master (January 2009), p. 12.
[174] *Id.*, p. 17 (item 21). The disability expert notes that an initial meeting was "non-productive, and had little follow-up," but states that a later meeting was "productive, and signaled the beginning of what should be a responsible study on the topic." *Id.*
[175] *Id.*, pp. 4-5, 19 (item 25); letter of Todd Irby to Logan Hopper, June 30, 2009; *compare* Appendix F (Hopper report), pp. 4-5, 19 (item 25) *with* Eighth Report of the Special Master (January 2009), p. 9.

courts.[176] In addition – although enough progress had been made on this area by last year that it was not among the disability expert‟s priorities – DJJ has nearly finished the required architectural modifications to ensure physical access for youth with disabilities, and has in fact exceeded the remedial plan‟s requirements for removing architectural barriers.[177]

In other priority areas, progress was limited by a lack of direction from central office, including other program areas that must work with the disabilities program. Facility medical, psychiatric, and education staff use inconsistent methods to identify youth with disabilities, as there are few policies or procedures in this area; guidance to staff over the last year consisted of one memo on identifying asthmatic youth.[178] Central office has not developed policies to prevent placement in restrictive programs based on mental or physical disability, or manifestations of it.[179] Although procedures for self-referrals to the disabilities program have improved, instructions are needed to ensure that forms are used consistently at all sites.[180] Similarly, although there are few indications that youth with disabilities are excluded from special programs (e.g. food service vocational programs) without cause, not all programs have developed procedures to prevent this.[181]

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[176] Appendix F (Hopper report), pp. 21-22 (items 29, 31). Mr. Hopper recommends that DJJ "take more proactive measures to compel the courts to provide sufficient documentation." *Id.*, p. 21 (item 29).
[177] *Id.*, pp. 3, 56-57.
[178] *Id.*, p. 26 (item 41); statements of Logan Hopper to Zack Schwartz, June 10, 2009. The special master‟s previous report on disabilities also observed that "facility medical, psychiatric and education staff are not sufficiently guided by policies and procedures or other central office direction, though they are involved in identifying disabled youth." *See* Eighth Report of the Special Master (January 2009), p. 11.
[179] Appendix F (Hopper report), p. 16 (item 17).
[180] *Id.*, p. 28 (item 46).
[181] *Id.*, p. 50 (item 98).

Progress has also been limited by a lack of coordination between disabilities and other program areas.[182] Facility staff other than high-level supervisors and WDP staff demonstrate "sporadic" understanding of and commitment to the goals of the disabilities remedial plan.[183] Security procedures offer a good example of this disconnect. Since Mr. Hopper‟s last report, DJJ has revised its use of force policy to require accommodations for youth with disabilities.[184] However, these procedures have not been fully implemented at any facility.[185] There is little documentation demonstrating that line staff provide accommodations and seek to de-escalate conflicts.[186] Plaintiff has recently asked the disability expert, along with the mental health and safety and welfare experts, to investigate continuing reports of improper use of force on mentally ill and developmentally disabled youth.[187]

IV. MEDICAL CARE

After the special master filed her ninth report, the medical experts revised their report that was attached as Appendix C to the ninth report. The medical experts‟ revised second report is attached as Appendix G. This version of the experts‟ report supersedes the prior version. The changes were not substantial and do not affect the findings and conclusions of the special master at pages 2-8 of the ninth report.

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[182] *Id.*, pp. 2-3.

[183] *Id.*, p. 3. For example, the disability expert notes that medical and psychiatric staff are not always aware of which youth are in the disabilities program. Statements of Logan Hopper to Zack Schwartz during teleconference, June 10, 2009.

[184] *Compare* Eighth Report of the Special Master (January 2009), p. 10 *with* revised use of force policy (PoP #388, April 20, 2009), pp. 26-28.

[185] Appendix F (Hopper report), pp. 6, 31 (item 53).

[186] *Ibid.*

[187] *See* letter of Sara Norman to the special master, Logan Hopper, Barry Krisberg, Eric Trupin, and Terry Lee, July 24, 2009.

V. CONCLUSION

The special master respectfully submits this report.

Dated: September 3, 2009

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Donna Brorby, Special Master

California Division of Juvenile Justice Summary Education Program Report for School Year 2008-2009

Section I. Introduction

Background

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

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

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

Review Process:

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

The reviewers have conducted site visits during four monitoring cycles, from September 2005 through March 2006, from September 2006 through April 2007, from October 2007 through March 2008 and from October 2008 through May 2009 at the following DJJ operated schools:

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

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

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

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

- In July 2006, July 2007, June 2008, and June 2009, training was provided to Central Office personnel and site-based administrators in order to provide a framework for audit preparation prior to the site reviews.

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

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

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

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

  2) Review of site generated data, including special education records, individual student IEPs, attendance data, school closing data, special management unit documents, class rolls, school schedules, high school graduation plans, psychological evaluations and other educational reports and documents;

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

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

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

Findings

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

A detailed Remedial Plan Site Compliance Report was prepared for each site. These reports were provided by the reviewers to Special Master, Donna Brorby within 30 days of the site visit. Special Master Donna Brorby then submitted copies of the reports to representatives of plaintiffs and defendants.

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

Substantial Compliance (as defined in Consent Decree)-"if any violations of the relevant remedial plan are minor or occasional and are neither systemic nor serious"

Partial Compliance - elements of the remedial plan compliance are evident, but not to a sufficient degree to meet the standard of substantial compliance

Non-compliance-compliance is not evident and/or the level of compliance does not meet minimal requirements of the remedial plan

Not Applicable – item was not monitored at the site because the specific standard did not apply

Not Audited – item was found in substantial compliance system wide for two consecutive audits and was not reviewed in this audit cycle

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

Content of the Summary Education Program Report:

The content of this report is in three parts:

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

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

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

Section II. Summary Reports

The summaries of the reviewers' findings are found in the attached table:

Table: **California Remedial Plan Site Compliance Report**

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

On this table, the name of each site and the date of its review are shown at the top of the column. The items reviewed are listed by each of the six (6) areas and the compliance rating for each item (substantial, partial or non compliance) is shown. Items not audited during this cycle are noted in the far right column.

To further indicate compliance levels, the report is color coded, with items that are noncompliant highlighted in red, items that are partially compliant highlighted in yellow, and items that are substantially compliant or non-applicable left white.

Section III. Major Commendations & Recommendations from 2008-2009 reviews

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

I. Overview, Philosophy & Program Policy

Commendations:

- The DJJ is commended for continuing to have all of its school sites accredited by the Western Association of Colleges and Schools.
- The DJJ core curriculum continues to meet the Content Standards for the California Public Schools.
- The development of High School Graduation plans at 5 of 6 sites indicates that progress is being made in planning for students to meet graduation requirements.
- All students are screened and provided English language services. All teachers are now SDAIE or CLAD certified.

Recommendations:

- The DJJ must appoint a permanent Superintendent of Education to provide the leadership necessary to attain full compliance with consent decree requirements.
- The DJJ must fill the vacant central office education positions or update the Educational Central Office Organizational Chart. The use of term limited positions greatly inhibits the DJJ in recruiting qualified staff to fill vacant positions.
- Community feedback is needed to evaluate the success or failure of the DJJ educational programs. A feedback system must be developed to determine whether students released from the DJJ are enrolled in school, employed or recidivated.
- All students must be prepared for transition to the community. The transition services provided to students 90 days prior to release from the facility should be standardized. Inconsistency in transition services was evident at all sites audited.

II. Staffing

Commendations:

- Progress is being made in hiring teachers that hold valid California teaching credentials. Highly qualified teachers in the appropriate fields are being provided at all facilities, with the exception of the Lyle Egan High School.
- A competitive salary schedule has been adopted and continues to be reviewed annually to enable the DJJ to attract qualified teachers to the system.
- Each high school with a restricted program has a minimum of 2 school psychologists.
- In special education testing, the length of time from referral to report completion has improved significantly.

Recommendations:

- Staffing patterns and allocations for general and special education teachers must be examined and brought into compliance with remedial plan requirements.
- Fire Camps should be required to comply with mandates of the Remedial Plan in order to meet IDEA, California Department of Education and Remedial Plan requirements.
- Additional substitute teachers are needed at the Egan site to prevent class cancellations due to teacher absences.
- Immediate steps must be taken by the DJJ Central Office to reduce the time required to fill vacancies.

III. Student Access and Attendance

Commendations:

- All sites have provided in-service training on SCT policy and procedures and documentation of the development of a SCT tracking system.
- All schools have documented that the SCT identifies, refers and assesses students not previously identified as eligible for special education services, including those students in restricted settings.
- The DJJ is commended for the development of Cooperative Agreements between custody, education and treatment to ensure access to education programs.
- The DJJ is commended for their efforts to implement the "Program Service Day".

Recommendations:

- Written policy and procedures require that students who fail to make adequate progress toward high school graduation must be referred to the School Consultation Team (SCT). All sites must follow procedures and use the standardized SCT forms.
- Teachers must be provided daily feedback as to the location of absent students and the reasons for their absences. DJJ Central Office staff must develop standardized attendance reporting procedures to be followed system wide.
- Teachers assigned to the Alternative Behavior Learning Environment (ABLE) classrooms must follow established guidelines. DJJ must develop a monitoring system to ensure consistent implementation of the ABLE behavior management system at each site.
- Student attendance fails to meet remedial plan requirements.
- Instructional programs for both regular and special education students in the restricted settings are inadequate. Student access, staff and adequate instructional space must be provided in order to ensure equal educational opportunities for these students.
- Schools must provide a full range of alternatives for students to complete their education, including students on the restricted units. The 240 minute school day, with full access to vocational, special education and GED programming, must be provided. Access to the GED program must be expanded; current policies restrict students from GED program enrollment.
- Student enrollment in vocational classes continues to be very low. These vocational resources must be fully utilized to ensure that students receive employment skills necessary to prepare them to re-enter the community.

IV. Curriculum

Commendations:

- DJJ staff is commended for maintaining compliance with items 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.13, 4.14 and 4.23 for two consecutive years.
- All schools are commended for demonstrating compliance in using educational technology, including distance learning and global classroom courses.
- The 5 year strategic plan and reading initiative continue to be implemented by all schools.
- The DJJ continues to meet all California Department of Education and Western Association of Schools and Colleges (WASC) standards for textbooks, library books and educational supplies.
- Technical job studies and surveys for vocational course planning have been instituted statewide.
- Significant improvements are noted in the efforts of site-based administrators to conduct quarterly teacher observations that document evidence of instructional planning, use of course syllabi and delivery of the state approved curriculum.

Recommendations:

- Administrators must consistently document their review of evidence of the use of course syllabi, units of instruction and lesson plans.
- Updated educational policies must be made available electronically at all facilities.
- A schedule for policy reviews must be established and published to ensure that all policies are being reviewed in a timely manner.
- Administrators must provide leadership in monitoring the mini-libraries on the living units. Librarians need to take more responsibility in maintaining inventory and selecting books.
- The automated library system must be fully implemented at all sites.
- Distance learning technology must be provided to students on the restricted units. Technology must be used to increase educational service hours without compromising security for students segregated from the general population.
- Yearly progress on the 5-year Strategic Plan must be formally documented by DJJ Central Office staff.

V. Special Education

Commendations:

- DJJ educational staff is commended for maintaining satisfactory compliance ratings for all schools on the following audit items during the 2008-2009 monitoring cycle:
    - 5.10 Sites have been able to consistently document that all revised assessment procedures and standards have been met.
    - 5.11 Sites have been able to consistently document on-going training of staff in revised assessment procedures including county intake processes.
    - 5.17 Programs have been able to document that special education eligibility determinations are being made prior to the actual IEP meeting.
    - 5.23 Sites have documented that Education Stakeholders' meetings continue to be held on a quarterly basis.

Recommendations:

- There has been a decrease in the efforts by DJJ staff to monitor compliance with Education Remedial Plan requirements for IEP development and implementation. Review of the most current central office organization chart indicates that one of the two Regional Services Specialists has been reassigned. This reassignment has reduced internal on-site review and correction of non-compliance issues in special education IEP development and implementation. The Educational Services Remedial Plan states, *"To address on-going monitoring efforts, the Regional Program Specialists will conduct at least quarterly reviews of schools on a rotating basis as part of the CYA Master Calendar schedule. More frequent site reviews will be necessary to establish compliance and can be reduced to quarterly as maintenance efforts are assured*." (Page 42) The continuation of an effective internal compliance monitoring system is necessary to ensure that DJJ will satisfactorily maintain the following special education IEP requirements:

    1. Alignment of goals/objectives
    2. Periodic progress or benchmark reviews
    3. Consideration of the least restrictive environment
    4. Transition services
    5. Compensatory services
    6. Accommodations and modifications in general education classrooms
    7. Accommodations and modifications in living unit and treatment settings

    (Education Services Remedial Plan, pages 40-41).

    The 2008-2009 Education Audit indicates that, after three years of monitoring, the DJJ has failed to achieve satisfactory ratings in the provision of a full continuum of services. School programs failed to provide all segments and services listed in IEPs. Schools failed to document consideration of related services/transition planning and have not implemented a system for documenting IEP progress reviews. Five (5) of the six (6) schools failed to meet remedial plan requirements for the provision of compensatory services. DJJ must maintain an internal monitoring system to identify and remediate special education compliance issues before problematic issues become systemic. This self-monitoring process is key to the provision of meaningful special education services that meet Educational Services Remedial Plan requirements. The reduction in the number of staff assigned to monitor special education IEP development and implementation and the resulting failure of DJJ to correct procedural and IEP related issues will continue to result in non-compliant ratings. Steps must be taken to comply with IDEA 2004 and IEP related requirements as stated in the Educational Services Remedial Plan.

- DJJ Central Office staff must update the current Special Education Manual to include changes mandated by IDEA revisions and No Child Left Behind legislation. The 2004 reauthorization to IDEA required major updates to the DJJ Special Education Policy Manual. The policy updates and changes were sent to the CDCR-Division of Juvenile Justice Policy, Procedures, Programs, & Regulations Unit during the fall of 2008. The manual has been in the vetting process since that time and the DJJ Supervisor of Correctional Education/Special Education reported that the document is in the final stages of review. As of June 3, 2009, the policy changes had not been signed or authorized by DJJ staff. This failure to fully comply with educational audit compliance item 5.1 must be addressed and corrected immediately.

- All special education students must be provided with a full continuum of placement options to include all segments and services listed in the student's IEP, including access to GED and vocational programming when such services are identified as service needs by the IEP team. All sites must provide general education classes and ensure that time; frequency and duration of all service requirements indicated in IEPs are met.

- All students on the special management units, including special education students, must be offered a full continuum of services to include access to a 240 minute instructional day.

- All DJJ facilities must develop and maintain a standardized system for tracking compensatory obligations (to special education students) created by school removals or denial of access to educational programming. Documentation of compensatory obligations and the provision of those services must be maintained by the school principal and monitored for compliance by DJJ Central Office staff.

VI. California High School Exit Exam

Commendations:

- Documentation of adherence to the statewide testing schedule has been established. DJJ is commended for maintaining substantial compliance in this area at all sites.
- All schools have successfully demonstrated that students taking state mandated exams receive appropriate accommodations, modifications or variations as a part of testing procedures in accord with DJJ guidelines.
- For two consecutive monitoring cycles, all schools have demonstrated the ability to provide the students failing at least one part of the CAHSEE exam with remediation related to test items.

Recommendations:

- Schools must provide a full range of alternatives for students to complete their education, including students on the restricted units. The 240 minute school day, with full access to vocational, special education and GED programming must be made available to all students.
- Student access to GED programs should be expanded; current policies restrict students from getting into the GED program.
- Site-based administrators must be held accountable for providing a full range of alternatives to students unable to obtain a high school diploma.

Additional comments:

Policies and Procedures

The Education Services Manual, which contains more than 100 pages, is divided into four chapters. These chapters include policies in the areas of Administration, Personnel, Operations, and Curriculum, Instruction and Assessment. Each chapter is subdivided into policy sections which more than adequately address operational requirements for the schools and school system. The policies provide the direction and support needed for the Superintendent of Education to manage and operate the Education Services Branch of the Department of Juvenile Justice.

The 116 page California Education Authority Special Education Manual was revised by Department of Juvenile Justice staff in October 2006 to conform to the Individuals with Disabilities Education Improvement Act (IDEA) of 2004, California Education Code Section 5600 and Farrell-v-W. Allen III RG03079344. The manual is divided into individual sections that include policy statements and implementation directions.

The format in both manuals includes a general policy statement with staff procedures to be followed to meet the specific standard. It is very clear what the expectations are for the system and who is responsible to see that they are carried out. The policies, as written in both manuals, enable the Education Services Branch of the DJJ to operate as a local education agency as established in statute. (W&I Code 1120.2).

The concerns of the reviewers are the following:

- All education policies should be accessible on line.
- Numerous educational policies are being ignored or selectively implemented. These findings are noted in each of the audit reports.
- A significant number of Temporary Departmental Orders are currently in place. These orders are in effect until the development of policies and regulations is completed. It is imperative that these orders be converted to policy.
- The Special Education Manual should be reviewed and updated as DJJ staff implement specific IDEA 2004 implementation requirements in the areas of student eligibility, assessment, and IEP and Transition plan development.

The Education Services Branch of the Department of Juvenile Justice has a full complement of policies available to administer and provide oversight of the educational program. Adherence to these policies will enable the DJJ to meet the mandates of the education section of the Consent Decree Remediation Plan.

Conclusion

In summary, five of the six Department of Juvenile Justice school programs have made meaningful progress towards meeting the mandates of the remedial plan as noted in the California Remedial Plan Site Compliance Reports October, 2008 –May, 2009. The DJJ continues to have all sites accredited by the Western Association of Colleges and schools and have a core curriculum in place that meets the content standards for the California Public Schools. The schools continue to make progress in planning for students to meet graduation requirements and provide English language services to all eligible students. The competitive salary schedule has enabled the DJJ to attract and retain a qualified teaching staff. Student Consultation Teams have become more proactive in identifying student's needs as well as providing services to students not previously identified for special education programming. The DJJ is commended for developing cooperative agreements between custody, education and treatment to assist and remove barriers to the 240 minute school day. The addition of a 5 period school day and the case

conference day supports student's full access to the educational program. As noted earlier in the report schools are making progress in special education documentation.

Continued progress is expected to occur when the DJJ identifies and appoints a full time Educational Superintendent and fills all vacant central office positions noted in the current organizational chart. This should provide consistent leadership, direction and supervision of the educational program. The DJJ must take all necessary steps to provide a safe and secure school environment for students and teachers in all schools before the mandates of the remedial plan can be fully met.

California Remedial Plan Site Compliance Report							
Area : EDUCATION	Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon				From October 2008 through May 2009		
Ratings: SC = Substantial Compliance	PC = Partial Compliance			NC = Non-Compliance			
SC or N/A-no highlight	PC- yellow highlight			NC- red highlight			
Site	Chaderjian	Boss	Egan	Wieden	Perry	Clark	ALL SITES
Date of Review	10/22/08	10/24/08	01/14/09	02/11/09	05/13/09	05/15/09	2008-2009
Items Reviewed							
I. Overview							
1.1 Schools meet WASC accreditation standards							**Not Audited**
1.2 Curriculum meets CA state standards							**Not Audited**
1.3 High School Graduation Plans in records	SC	SC	NC	SC	SC	SC	
1.4 Semi-annual reviews of High School Graduation Plans	SC	PC	NC	NC	PC	SC	
1.6 Progress being made toward high school diplomas	NC	PC	NC	NC	PC	SC	
1.7 English Language Learner screening & services	SC	SC	PC	SC	SC	SC	
1.8 Transition planning (90 days prior to release)	SC	SC	NC	SC	PC	SC	
II. Staffing							
2.1 Teachers hold valid CA credentials and teach in-field	SC	SC	NC	SC	SC	SC	
2.2 Adequate credentialed staff in content areas for graduation	SC	SC	NC	SC	PC	SC	
2.3 Recruitment plan for education staff and 2 recruiters	PC	PC	NC	PC	SC	SC	
2.4 Time between education vacancy and hiring	PC	SC	NC	PC	NC	SC	
2.5 Pool of substitute teachers = 15% of teaching staff	SC	SC	NC	SC	SC	SC	
2.6 Class not cancelled due to teacher absence/lack of substitutes	NC	SC	NC	SC	SC	SC	
2.7 In-field teacher used for teacher vacancy of 45 days	SC	SC	NC	PC	SC	SC	
2.8 Psychologist and related service providers available for input	PC	SC	SC	SC	PC	SC	
2.9 Time from referral for testing and report completed	SC	SC	SC	SC	PC	SC	
2.10 Time from referral for related services to service delivery	SC	SC	SC	SC	SC	SC	
2.11 2 school psychologists for each restricted program							**Not Audited**

	Site	Chaderjian	Boss	Egan	Wieden	Perry	Clark	ALL SITES
III. Student Access & Attendance								
3.1	Standardized Academic Calendar meets CA requirements							**Not Audited**
3.2	Standardized Academic Calendar-basis of student services	SC	SC	NC	SC	SC	SC	
3.3	Policy & practice-all students enrolled within 4 days	SC	SC	NC	SC	SC	SC	
3.4	Registrars request records on new students within 4 days	SC	SC	SC	SC	PC	SC	
3.5	Students meeting GED criteria have GED opportunity	PC	SC	PC	SC	NC	SC	
3.6	SCT services for students with academic/ behavioral problems	SC	SC	PC	SC	PC	PC	
3.7	SCT records of interventions and referrals	SC	SC	SC	SC	PC	SC	
3.8	Students not making academic progress referred to SCT	PC	SC	SC	SC	NC	SC	
3.9	Development of SCT tracking system	SC	SC	SC	SC	SC	SC	
3.10	Documentation of progress reviews of SCT plans	SC	SC	SC	SC	PC	SC	
3.11	SCT logs show follow-through on eligibility testing	SC	SC	SC	SC	SC	SC	
3.12	Students referred from SCT receive special education testing	SC	SC	SC	NA	SC	SC	
3.13	SCT training (procedures, roles & responsibilities, forms)	SC	SC	SC	SC	SC	SC	
3.14	Teachers informed of missing student's whereabouts	SC	NC	NC	SC	SC	SC	
3.15	Document school attendance for previous 30 days	NC	NC	NC	SC	NC	NC	
3.16	Cooperative Agreements to ensure students' attendance	SC	NC	PC	SC	SC	SC	
3.17	Quarterly reviews of school attendance by Executive Team	SC	NC	NC	SC	SC	SC	
3.18	Plans (due 4/05) to remediate deficient attendance	SC	NC	PC	SC	SC	SC	
3.19	Quarterly corrective action plans for high absence rates	PC	NC	PC	SC	SC	SC	
3.20	Policy & procedure to eliminate class cancellations	NC	SC	NC	SC	SC	SC	
3.21	Teacher records indicate whereabouts of missing students	SC	NC	PC	SC	PC	SC	
3.22	Exclusion from school forms have complete data	SC	SC	SC	SC	SC	SC	
3.23	Observation of students not being sent to school	PC	NC	NC	PC	PC	SC	
3.24	Accurate attendance data in WIN database	PC	NC	SC	SC	SC	SC	
3.25	Mgmt team monthly review of attendance data	SC	NC	NC	SC	SC	SC	
3.26	Performance expectations on attendance (due 7/05)	SC	SC	PC	SC	SC	SC	
3.27	Training on attendance expectations	SC	SC	SC	SC	SC	SC	
3.28	Implementation of attendance policy & procedures (due 12/05)	SC	NC	NC	SC	SC	SC	
3.29	Incentives developed for increased school attendance	SC	SC	PC	SC	SC	SC	
3.30	Annual state school calendar implemented							**Not Audited**
3.31	Yearly calendar w/44 student advising/case conference days							**Not Audited**
3.32	Adequate instructional space	SC	SC	NC	SC	SC	SC	
3.33	Structured classroom behavior management system	SC	SC	SC	SC	SC	PC	
3.34	Alternative behavior management classroom at each site	SC	SC	NC	SC	SC	SC	
3.35	Staff training on behavior management system	SC	SC	SC	SC	SC	SC	
3.36	Behavioral goals for spec. ed. students-restricted programs	PC	NA	PC	SC	NA	NA	
3.37	Use of small classrooms (adequate size) in restricted settings	PC	NA	NC	PC	NA	NA	
3.38	Staff ratio & credentialed teachers in restricted settings	NC	NA	NC	PC	NA	NA	
3.39	Instructional program in restricted placements	NC	NA	NC	SC	NA	NA	
3.40	Training provided to staff in restricted settings	SC	NA	SC	SC	NA	NA	

	Site	Chaderjian	Boss	Egan	Wieden	Perry	Clark	ALL SITES
IV. Curriculum								
4.1	Curriculum Guides & policies aligned with CA Education code							**Not Audited**
4.2	Process to develop and revise curriculum on cyclical basis							**Not Audited**
4.3	Curriculum guides for all core & vocational classes							**Not Audited**
4.4	Core Curriculum Guides available in electronic form (due 12/05)							**Not Audited**
4.5	Schools meet CA & WASC standards for books & materials							**Not Audited**
4.6	Annual inventory & needs assessment of books & equipment							**Not Audited**
4.7	Textbooks & library books available in classrooms	SC	SC	SC	SC	SC	SC	
4.8	Books available in mini-libraries on living units	SC	SC	PC	SC	PC	SC	
4.9	Professional development for school leadership personnel	SC	SC	SC	SC	SC	SC	
4.10	Training schedule on new procedures-educ & custody staff	SC	SC	SC	SC	SC	SC	
4.11	Training attendance-new procedures-educ & custody staff	SC	SC	SC	SC	SC	SC	
4.12	Formation of Trade Advisory Committees & quarterly meetings	SC	NC	PC	SC	SC	SC	
4.13	Annual surveys for vocational course planning (due 7/05)							**Not Audited**
4.14	Annual Career Technical job studies to evaluate CTE program							**Not Audited**
4.15	Use of technology at each site (due 6/05)	SC	SC	SC	SC	SC	SC	
4.16	Distance learning courses meet CA Content Standards	SC	SC	SC	SC	SC	SC	
4.17	Use of Global Classrooms distance learning (due 6/06)	SC	SC	SC	SC	SC	SC	
4.18	Distance learning provided in restricted units	SC	NA	NC	SC	NA	NA	
4.19	Automated library system at each HS (due 6/06)	SC	SC	SC	SC	NC	SC	
4.20	Teachers use course syllabi & lesson plans	SC	SC	PC	SC	SC	SC	
4.21	Quarterly teacher observations using revised rubric	SC	SC	PC	SC	SC	SC	
4.22	5 year strategic plan & reading initiative implemented	SC	SC	SC	SC	SC	SC	
4.23	Policies revised to reflect operational changes							**Not Audited**
4.24	Education policies available electronically (due 6/06)	NC	NC	SC	SC	SC	SC	

	Site	Chaderjian	Boss	Egan	Wieden	Perry	Clark	ALL SITES
V. Special Education								
5.1	Special Education Policy Manual revised & available (due 9/05)							**Not Audited**
5.2	Files transferred & services implemented in 4 days	SC	SC	NC	SC	SC	SC	
5.3	Screening provided and referrals for psychological testing	SC	SC	SC	NC	PC	SC	
5.4	Teachers identify special ed students in classrooms	SC	SC	SC	SC	SC	SC	
5.5	Referral for testing-update eligibility; reports complete & timely	SC	SC	SC	SC	PC	SC	
5.6	Site has full continuum of placement options	NC	NC	NC	PC	PC	PC	
5.7	Continuum of services available in restricted settings	NC	NC	NC	PC	PC	PC	
5.8	Segments & services listed in IEPs are provided	NC	NC	NC	PC	PC	PC	
5.9	Accuracy & completeness of special education data system	SC	SC	PC	PC	SC	SC	
5.10	Assessment procedures updated & standardized	SC	SC	SC	SC	SC	SC	
5.11	Training and reports of assessment completion rates	SC	SC	SC	SC	SC	SC	
5.12	Procedures standardized, including county intake (due12/05)	NC	PC	PC	SC	SC	PC	
5.13	Clinics-agreements with Intake & CS on providing IEPs	PC	SC	SC	SC	SC	SC	
5.14	Procedures for Intake & CS on providing IEPs	NC	NC	NC	SC	SC	SC	
5.15	Pre-existing valid IEPs implemented	PC	PC	SC	SC	SC	SC	
5.16	Changes in IEPs documented w/rationale	PC	PC	SC	SC	SC	SC	
5.17	Eligibility determined prior to IEP meeting	SC	SC	SC	SC	SC	SC	
5.18	IEP eligibility meetings held timely & with notices, participation	PC	SC	SC	SC	SC	SC	
5.19	IEPs include consideration of related svc/transition planning	PC	PC	NC	SC	PC	SC	
5.20	Training on specific topics for special ed teachers							**Not Audited**
5.21	System of IEP progress reviews implemented	NC	SC	NC	SC	PC	NC	
5.22	Compensatory special education svc provided when needed	PC	SC	NC	PC	NC	PC	
5.23	Education Stakeholders' Committee w/quarterly meetings	SC	SC	SC	SC	SC	SC	
5.24	Training to education and custody staff on Spec Educ Manual							**Not Audited**
5.25	Regional Prog Specialist site reviews of spec ed compliance							**Not Audited**
VI. California High School Exit Exam								
6.1	CA assessment program provided to eligible students							**Not Audited**
6.2	CYA curriculum in LA & math related to Graduation Test							**Not Audited**
6.3	Students have multiple opportunities to pass state exam							**Not Audited**
6.4	Students have appropriate test accommodations /modifications	SC	SC	SC	SC	SC	SC	
6.5	Students with equivalent passing scores- waivers requested							**Not Audited**
6.6	Students failing test receive remediation	SC	SC	SC	SC	SC	SC	
6.7	Test data is monitored & basis of school improvement plans	SC	SC	SC	SC	SC	SC	
6.8	Students have range of alternatives to complete education	PC	SC	NC	SC	PC	SC	

Log Entry # 376
Completed by Litigation Coordinator

California Department of Corrections & Rehabilitation
Division of Juvenile Justice

Proof of Practice

Document Submission

Date: 04/06/2009

The following information is being provided to the Expert(s), the Special Master, and/or other Stakeholders for the following reason(s):

☒ Informational Purposes Only

☐ Informational Purposes and ***Feedback Requested***. Due Date for Requested Feedback: ____________

☐ ***Approval from Experts Required***. Due Date for Requested Feedback: ____________
See the ____________ Remedial Plan, page number ___.

☐ Special Request from ____________

	Name	Section #	Item #	Due Date	Description
Remedial Plan	Safety & Welfare	6	2a	10/01/06	"Statewide standards for Program Service Day"
			2c	Various	"Program Service Day schedule for core program"
			6	Various	"Program Service Day schedule for BTPs"
	Mental Health	5	18	--	"Develop Program Service Day Schedule for MH living units"

Name and Description of Submitted Document(s)	**1** – Policy Bulletin Number 08-03 for Program Service Day (1 page); **2** – Program Service Day policy (6 pages). TOTAL NUMBER OF PAGES: 7
Justification for Providing Document(s)	These documents constitute updates to the Program Service Day policy and are being provided to the Safety & Welfare and Mental Health Experts for informational purposes.

Document(s) Submitted to:	Terry Lee	Title	Mental Health Experts
	Eric Trupin	Title	Mental Health Experts
	Barry Krisberg	Title	Safety & Welfare Expert
	Donna Brorby	Title	Special Master

Area Manager	**Brigid Hanson**	Title	**Director, Administration and Operations**

Signature: [signature] 4/7/09
Date

Area Manager	**Juan Carlos Arguello**	Title	**Mental Health Team Supervisor**

Signature: [signature] 4/6/09
Date

Area Manager	**Tammy McGuire**	Title	**Safety & Welfare Team Leader**

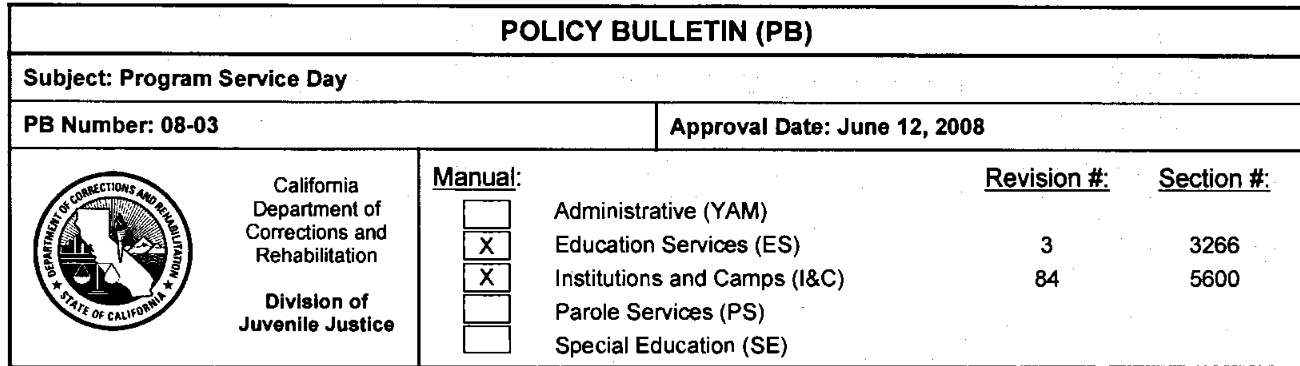
Signature: [signature] for 4/10/09
Date

DJJ Litigation Rep.	**Doug Ugarkovich**	Title	**Farrell Litigation Coordinator**

Signature: [signature] 4/6/09
Date

STATE OF CALIFORNIA
DIVISION OF JUVENILE JUSTICE
Policy Bulletin
DJJ 6.210 (Rev 06/08) Page 1 of 1

DEPARTMENT OF CORRECTIONS AND REHABILITATION



POLICY BULLETIN (PB)				
Subject: Program Service Day				
PB Number: 08-03		**Approval Date: June 12, 2008**		
California Department of Corrections and Rehabilitation **Division of Juvenile Justice**	Manual:		Revision #:	Section #:
	[ ]	Administrative (YAM)		
	[X]	Education Services (ES)	3	3266
	[X]	Institutions and Camps (I&C)	84	5600
	[ ]	Parole Services (PS)		
	[ ]	Special Education (SE)		

The purpose of this Policy Bulletin (PB) is to provide all Division of Juvenile Justice (DJJ) Institutions and Camps (I&C) and Education Services (ES) Branch Manual holders with information regarding the attached new DJJ policy for Program Service Day, I&C Manual Section 5600 and ES Manual Section 3266.

The Program Service Day is referenced in three of the six *Farrell* remedial plans – the Safety and Welfare Remedial Plan, the Mental Health Remedial Plan, and the Education Remedial Plan. The Program Service Day is a coordinated schedule of each of the facilities and the programs and services that each facility provides. The intent of the day is to provide flexibility and minimize scheduling conflicts while scheduling youth into school, individual counseling, groups, case conferences, and related activities during the hours when program staff are on duty.

The Programs Work Group – one of three work groups created in response to reform needs and the *Farrell* litigation – submitted a Program Service Day proposal to the Executive Team on January 30, 2008, and the proposal was accepted. At the request of the Chief Deputy Secretary, the Programs Work Group developed an implementation plan, which includes the formulation of a policy.

This PB contains changes to the above reference manuals. To update your manuals, please follow the directions below step by step.

1. Locate the correct manual(s), as marked above.

2.

Remove	Insert	Special Instructions
N/A	• Program Service Day, Institutions and Camps (I&C) Manual, Section 5600 • Program Service Day, Education Services (ES) Manual, Section 3266	

3. Update the Revision Record Log (first page of the manual) using the revision number reference above.

This cover sheet does not need to be archived in the manual, only the attached items.

Please distribute to interested parties and make additional copies if necessary. Please direct any inquiries to Dolores Slaton, Policy, Procedures, Programs, and Regulations (PPP&R) Unit Manager, at (916) 262-1431.

BRIGID HANSON
Director
Administration and Operations

Policy Title: PROGRAM SERVICE DAY

California Department of Corrections and Rehabilitation

Division of Juvenile Justice

Manual:		Revision #:	Section #:
[ ]	Administrative (YAM)		
[X]	Education Services (ES)	3	3266
[X]	Institutions and Camps (I&C)	84	5600
[ ]	Parole Services (PS)		
[ ]	Special Education (SE)		

Chief Deputy Secretary (CDS):	***Effective Date:***	***Revision Date(s):***	***Section(s):***
Bernard E. Warner	03/31/09	N/A	• Education Manual Section 3266 • Institutions & Camps (I&C) Branch Manual Section 5600 ***Replaces:*** N/A

Subject:

Program Service Day

Authority:	***Attachments***	
	Forms:	***Local Procedures:***
Welfare and Institutions Code: • Section 1712 • Section 1120	None	Local procedures will be submitted to the PPP&R Unit within 90 days of the Chief Deputy Secretary's approval of the DJJ Program Service Day policy. Local procedures will be needed for all Youth Correctional Facilities that are in operation at the time the policy is implemented.

Policy Statement:	This policy establishes the Program Service Day, which is a coordinated schedule for each facility and the programs and services it provides. The schedule shall provide the structure to ensure all services are accomplished in an efficient manner. It is intended to minimize scheduling conflicts while ensuring that each youth receives necessary treatment/rehabilitative services and is constructively active during the majority of his or her waking hours.
Scope:	This policy will affect each Division of Juvenile Justice (DJJ) employee, volunteer, and youth within a Youth Correctional Facility, and each external stakeholder who interacts with youth at DJJ facilities.
Goal(s) & Outcome Measure(s):	Each youth will receive the required services.
Related References:	• Education Remedial Plan, as filed on March 1, 2005 • Mental Health Remedial Plan, as filed on August 24, 2006 • Safety and Welfare Remedial Plan, as filed on July 10, 2006 • TDO #07-76, School Day Schedule and Annual Academic Calendar, Sections 3220-3224, ES Manual

Policy Title: PROGRAM SERVICE DAY

California Department of Corrections and Rehabilitation **Division of Juvenile Justice**	Manual:		Revision #:	Section #:
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	[ ]	Parole Services (PS)		
	[ ]	Special Education (SE)		

Requirements:			
	This policy has a training requirement:	☒ Yes	☐ No
	This policy has an audit requirement:	☒ Yes	☐ No
	This policy has restricted distribution:	☐ Yes	☒ No
	This policy requires annual review:	☒ Yes	☐ No
	This policy requires a local procedure:	☒ Yes	☐ No

DEFINITIONS

Dynamic Factors – Those aspects in a youth's life that can be changed, such as: attitudes, social cognitive skills, education, employment, etc.

Interdisciplinary Treatment Team – The group responsible for identifying the case management plan with a youth. At minimum, it consists of the youth, case manager, youth correctional counselor, education representative, health care professional, and re-entry specialist.

Intervention – A practice that targets dynamic risk factors and/or responsivity factors.

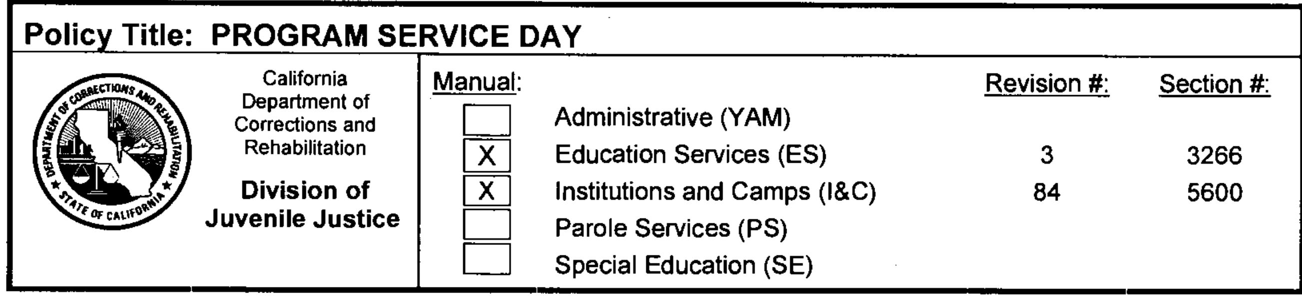
Program – A self-contained service delivery system, including:

- Entrance and exit criteria tied to screening and assessment
- Case planning and management
- Delivery of services inclusive of treatment/rehabilitation and transition/community planning
- Assessment of progress

Responsivity – The ability to deliver interventions in a style and mode that is consistent with the ability and learning style of the youth.

Service – A method, system, or organization for delivering programs to youth in DJJ. Services would include:

- Behavior Management
- Treatment/Rehabilitative Interventions
  - Substance Abuse
  - Mental Health
  - Behavioral Health Interventions
  - Education
  - Vocation
- Activities
- Case Management
- Transition/Community Planning



Policy Title: PROGRAM SERVICE DAY

California Department of Corrections and Rehabilitation

Division of Juvenile Justice

	Manual:	Revision #:	Section #:
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[ ]	Parole Services (PS)		
[ ]	Special Education (SE)		

GENERAL POLICY STATEMENT

The Program Service Day is a coordinated schedule for each DJJ facility and the programs and services it provides. The schedule shall provide the structure to ensure all services are accomplished in an efficient manner. It is intended to minimize scheduling conflicts while ensuring that each youth receives necessary treatment/rehabilitative services and is constructively active during the majority of his or her waking hours.

RESPONSIBILITIES AND DUTIES

The DJJ Executive Management Team shall:

- Approve all Program Service Day standards prior to dissemination to the field
- Approve the Program Service Day schedule developed at each facility prior to its incorporation into the local operating procedures
- Approve all local operating procedures related to the Program Service Day prior to implementation at each facility
- Ensure that an interdisciplinary team provides training to facility staff on the Program Service Day policy within 60 days of implementation

The Director of Juvenile Programs shall ensure that:

- The standards for implementation of the Program Service Day are developed and submitted for approval
- Execution of the standards and service requirements are monitored monthly following the implementation of the Program Service Day schedule at each facility

The Superintendent, High School Principal, Chief Medical Officer (CMO), and/or designee shall ensure that:

- Local operating procedures are developed within 90 days of the Program Service Day implementation based on the approved standards
- Interdisciplinary Treatment Teams are developed
- Outcomes are being monitored

The Superintendent, High School Principal, and CMO, and/or their designees, will work collaboratively to ensure that the responsibilities and duties regarding the Program Service Day policy and any related procedures are met.

Policy Title: PROGRAM SERVICE DAY					
	California Department of Corrections and Rehabilitation **Division of Juvenile Justice**	Manual:		Revision #:	Section #:
		[ ]	Administrative (YAM)		
		[X]	Education Services (ES)	3	3266
		[X]	Institutions and Camps (I&C)	84	5600
		[ ]	Parole Services (PS)		
		[ ]	Special Education (SE)		

TRAINING

Employee

1. Each employee with direct contact, care, and/or service for a youth at each Youth Correctional Facility shall receive training on the Program Service Day policy within 60 days of implementation of the policy at the facility.

2. Each new employee at each Youth Correctional Facility shall receive an overview of the Program Service Day policy during New Employee Orientation. Any employee with direct contact, care, and/or service for a youth at each Youth Correctional Facility will be trained on the policy within 30 days of arrival at the facility.

3. Any employee, upon discretion of the Superintendent, High School Principal, and/or Chief Medical Officer (CMO), will receive refresher training as needed.

QUALITY ASSURANCE

The Superintendent, High School Principal, CMO, and/or their designees will collaboratively be responsible for quality assurance as it relates to the Program Service Day policy. The Superintendent, High School Principal, CMO, and/or their designees shall monitor compliance with mandates and report monthly to the Director of Juvenile Facilities and the Director of Juvenile Programs.

Superintendent, High School Principal, Chief Medical Officer (CMO), and/or designee

1. Ensures and reports compliance with education mandates for student enrollment, minimum instructional time, attendance, and access to required curriculum and supplementary services

2. Ensures and reports compliance with treatment mandates for minimal service time, access to required treatment groups, and strategies

BERNARD E. WARNER
Chief Deputy Secretary

Policy Title: PROGRAM SERVICE DAY				
California Department of Corrections and Rehabilitation **Division of Juvenile Justice**	Manual:		Revision #:	Section #:
	[ ]	Administrative (YAM)		
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	[ ]	Parole Services (PS)		
	[ ]	Special Education (SE)		

PROCEDURES

Each facility, under the leadership of the Superintendent, High School Principal, Chief Medical Officer (CMO), and/or their designees, shall develop a Program Service Day schedule for each youth that allows for minimum treatment requirements to be met.

To preserve the integrity of the school day schedule and ensure minimum education minutes are provided to all non-graduates, the start and end times of the school schedule, as established and approved by the California Education Authority (CEA) Superintendent of Education, must be maintained. The Program Service Day schedule also provides flexibility in meeting the needs of any youth who has attained high school graduate or equivalent status.

Local operating procedures shall be developed at each facility within 90 days of implementing the policy. Procedures shall include any processes used to implement the Program Service Day Schedule facility-wide and will indicate 1) who on site will review reports regarding services being met and 2) who is responsible to develop and implement strategies for improvement, if standards are not met. Procedures shall define how the following will be developed and who will be responsible:

- A living unit/facility schedule that depicts structured activities for all waking hours for youth before, during, after school and in the evening
- A schedule that defines the treatment/rehabilitation interventions needed for each youth
- A school enrollment schedule depicting courses needed by each youth to meet education requirements including courses needed to graduate or obtain a GED
- A schedule depicting treatment/rehabilitation interventions that will be offered during the school day. This schedule will be provided to the School Scheduler so that each youth can be scheduled into the requested treatment/rehabilitation intervention periods
- A facility schedule depicting staff assignments for treatment/rehabilitation interventions from all areas to include a list of "back-up staff" to cover the intervention periods scheduled during the school day (similar to substitute teachers)

Log Entry # 402
Completed by Litigation Coordinator

California Department of Corrections & Rehabilitation
Division of Juvenile Justice

Proof of Practice

Document Submission

Date: 05/15/2009

The following information is being provided to the Expert(s), the Special Master, and/or other Stakeholders for the following reason(s):

☒ Informational Purposes Only

☐ Informational Purposes and ***Feedback Requested***. Due Date for Requested Feedback: ____________

☐ ***Approval from Experts Required***. Due Date for Requested Feedback: ____________
See the ____________ Remedial Plan, page number ___.

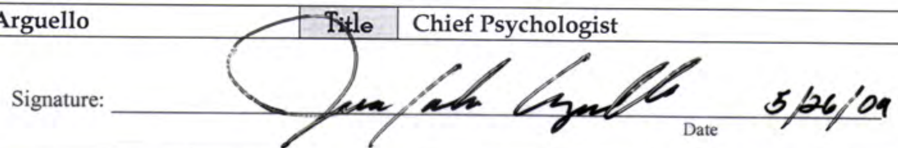
	Name	Section #	Item #	Due Date	Description
Remedial Plan	Mental Health	5	18	--	"Develop Program Service Day schedule for MH living units"
	Safety & Welfare	6	2a	10/01/06	"Statewide standards for Program Service Day"
			2b	11/01/06	"Program Service Day schedule for Chaderjian"
			2c	Various	"Program Service Day schedule for core program"
			6	Various	"Program Service Day schedule for BTPs"

Name and Description of Submitted Document(s)	1 – Program Service Day Standards (2 pages). TOTAL NUMBER OF PAGES: 2

Justification for Providing Document(s)	This document is being submitted to the Safety & Welfare and Mental Health Experts to provide them with a list of the Standards that are to govern the execution of Program Service Day throughout all DJJ facilities.

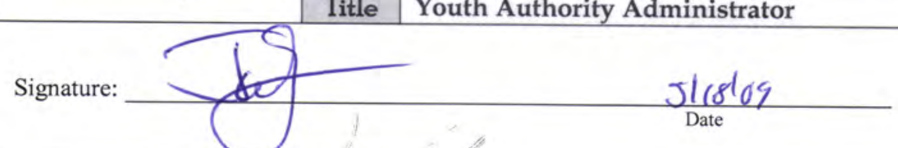
Document(s) Submitted to:	Name		Title
	Terry Lee	Title	Mental Health Expert
	Eric Trupin	Title	Mental Health Expert
	Barry Krisberg	Title	Safety & Welfare Expert
	Donna Brorby	Title	Special Master

Area Manager	Juan Carlos Arguello	Title	Chief Psychologist



Signature: ____________ Date 5/26/09

Area Manager	Jay Aguas	Title	Youth Authority Administrator

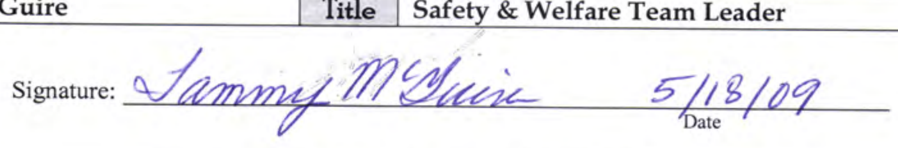


Signature: ____________ Date 5/18/09

Area Manager	Eric Umeda	Title	

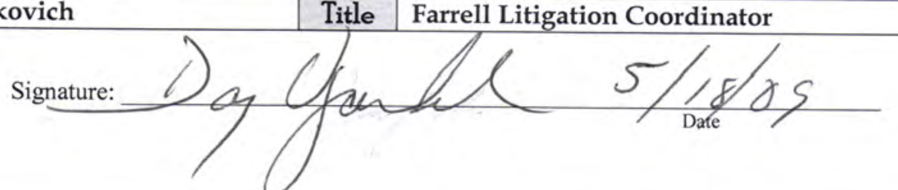
Signature: ____________ Date 5/21/09

Area Manager	Tammy McGuire	Title	Safety & Welfare Team Leader



Signature: Tammy McGuire Date 5/18/09

DJJ Litigation Rep.	Doug Ugarkovich	Title	Farrell Litigation Coordinator



Signature: ____________ Date 5/18/09

DIVISION OF JUVENILE JUSTICE
PROGRAM SERVICE DAY STANDARDS

Standards:

Standard 1 A Program Service Day Schedule will be developed to maximize out of room time and to ensure structured activities based on evidence based principles for 40 to 70 percent of waking hours.

Standard 2 The Program Service Day schedule will ensure that youth will be actively engaged in developmentally appropriate and rehabilitative activities with the expectation that they will spend minimal time in their rooms during normal waking hours.

Standard 3 Each facility shall have the Program Service Day Schedule posted in the school and on the living units.

Standard 4 The "regular" school day for each non-graduate and non-work assigned graduate to include a minimum of 300 instructional (education) minutes and 60 "therapeutic intervention" minutes (treatment) for four days each week (176 school days each year).

Standard 5 Teacher instructional preparation time will be concurrent with one of the four 60-minute treatment periods four days each week (176 school days each year).

Standard 6 One day each week will be scheduled as a "case conference" day with three instructional periods offered am or pm (as per the current Program Service Day schedule).

Standard 7 A joint committee at each correctional facility composed of the High School Principal, Chief of Security and Mental Health/Program Administrators will select the spaces to be used for the "treatment period" based on safety, security, logistics, staffing and efficacy.

Standard 8 The Senior Psychologist and Treatment Team Supervisor/Supervising Casework Specialist is responsible to assign treatment staff to each designated treatment space each treatment period and to inform all appropriate staff (living unit, school, facility security, etc.) of the assignments at least five days in advance of assignment.

Standard 9 The Psychologist and the youth's assigned Parole Agent, Case Manager or Casework Specialist is responsible to provide the Class Scheduler the prioritized list of required intervention groups for each youth who are to be assigned to a "treatment period".

Standard 10 The Class Scheduler is responsible to assign youth by the following priority:

- Non-graduate regular education students first by core graduation required courses, then by treatment plan, then by other education assignments.
- Non-graduate special needs students first by Individual Education Plan (IEP) or Language Assessment Team (LAT) plan required courses, then by treatment plan, then by other education assignments.
- Graduates first by treatment plan then other education assignments.

Standard 11 School Administration (including the school scheduler and attendance coordinator) shall access the daily list of Medical Appointments to

effectively document non-emergency medical/dental/vision/mental health appointments.

Standard 12 The regular removal of youth from the same class should not occur. Attendance information will be shared monthly with all facility managers for appropriate follow up and action.

Standard 13 Scheduling staff will be expected to communicate to resolve any youth scheduling conflicts.

Standard 14 Safe, secure and clean treatment areas will be designated and maintained.

Standard 15 Education staff will assume no formal student supervision responsibility during concurrent treatment/preparation period and during lunch time.

Standard 16 Students will not be scheduled for non-educational activities during any instructional period.

Standard 17 Students will not be removed from school during scheduled/calendared testing days (CA High School Exit Exam, CASAS, etc.).

Standard 18 Hour of Sleep (HS) pill call shall not occur until program activity is completed and shall not begin before 2000 hours and preferably at 2100 hours. HS meds must be administered after program activity has stopped in order to avoid having youth who received sedating medications engaging in program activities.

Standard 19 Each posted living unit schedule will have the names and titles of the staff assigned to facilitate and/or co-facilitate the treatment group. This includes but is not limited to assigned Psychologists, SYCC's, YCC's, Casework Specialists, Parole Agents, Case Managers, Psychiatrists, Nurses, Psychiatric Technicians, etc.

Standard 20 The Superintendent, Principal and Chief Medical Officer will work collaboratively to develop and ensure minimum mandates are met and identify improvements made in the following areas:

- student enrollment
- minimum instructional time
- attendance and access to required curriculum
- supplementary services
- minimal treatment service time
- access to required treatment groups
- daily large muscle exercise

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE

EDUCATION AUDIT OF LYLE EGAN HIGH SCHOOL CORRECTIVE ACTION PLAN

January 12, 2009 through January 14, 2009

Item	Item/ Description	Action Required By Whom	Proposed Action Plan	Date To Be Completed	Current Status	Comments/POP *	Follow-up Review (To be completed by CPRB)
3.14	Written policy, procedure, and practice document that all students who do not possess a high school diploma or GED will attend school each scheduled school day except for verified medical conditions or when the student is an immediate threat to the safety of self or others.	Superintendent and Principal	1. Finalize Security/School Attendance Procedure	03/11/09	Complete	Procedure in Facility Operations Manual	
		Assistant Principal	2. Provide necessary refresher training to Education, School Security, and Living Unit Staff on Security/School Attendance Procedure	03/15/09	Complete	Training sign-in sheets and/or R&I document	
			3. Implement Security/School Attendance Procedure	03/15/09	Complete	Student Movement Accountability YA7.115 & Student Absent Lists YA7.105	
			4. Develop monitoring system to ensure compliance with Security/School Attendance Procedure	03/30/09	Complete	Attendance Tracking Reports Weekly Attendance meeting minutes	
		School Security	A. School Security will cross check teacher check list from classrooms against the student roster list	N/A	On-going	School Area Attendance Form YA 7.403	
		Assistant Principal	B. Review Attendance Coordinator's teacher check off list weekly	N/A	On-going	Attendance Coordinator uses check off list for each teacher	
		Assistant Principal/School Attendance Coordinator	C. Schedule refresher training for Attendance Coordinator on data entry and query reports cited below	04/30/09	Incomplete	Preparation of noted reports, training documents	
		Treatment Team Supervisor/ Program Administrator	D. Review WIN 3-day Absence Report, NIS Report, and Students Absent Due to Work Report to TTS/Program Administrator to monitor and reduce absences	N/A	On-going	Attendance tracking report. End of month absence rate	
		Attendance Coordinator/ Asst. Principal	5. Adhere to WIN Education Attendance Tracking Procedures	N/A	On-going	WIN Attendance Tracking reports	

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE

EDUCATION AUDIT OF LYLE EGAN HIGH SCHOOL CORRECTIVE ACTION PLAN

January 12, 2009 through January 14, 2009

Item	Item/ Description	Action Required By Whom	Proposed Action Plan	Date To Be Completed	Current Status	Comments/POP *	Follow-up Review (To be completed by CPRB)
3.19	On a quarterly basis, schools with absence rates of 7% or more will continue to make corrective action plans until absence rate is below 7%.	Superintendent and Principal	1. Revise Corrective Action Plan to include new procedures	03/30/09	On-going	Monthly Superintendent/ Principal attendance meeting minutes Revised Corrective Action Plan	
			2. Update CAP as needed to address absentee rate	06/30/09	On-going	Updated CAP Meeting minutes	
3.21	The CYA shall devise appropriate criteria for the exclusion of students from school and maintain a daily document that lists the number and names of all students who were excluded from school. The record includes the name of the youth excluded, the name of the person who authorized his/her exclusion, the reason for his or her exclusion, and duration of the exclusion.	Superintendent and Principal	1. Modify Security/School Attendance Procedure for off-campus schools. (SMP or BTP/CTC/ITP/IBTP)	04/13/09	Incomplete	Security/School attendance procedure. Restricted programs	
			2. Provide necessary refresher training to Treatment and Education Staff on Security/School Attendance Procedure for off-campus schools	04/13/09	Incomplete	Training sign-in sheets/R&I rosters Education and TTS meeting minutes	
			3. Implement Security/School Attendance Procedure for off-campus schools	04/13/09	Incomplete	Student Movement Accountability YA7.115 & Student Absent Lists YA7.105	
		Assistant Principal	4. Develop monitoring system to ensure compliance	04/13/09	Incomplete	WIN Attendance Tracking Reports. Weekly Attendance meeting minutes	
			5. Discuss attendance issues at Facility/Education meetings	N/A	On-going	WIN Attendance Tracking reports. Weekly Attendance Meeting minutes	

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE

EDUCATION AUDIT OF LYLE EGAN HIGH SCHOOL CORRECTIVE ACTION PLAN

January 12, 2009 through January 14, 2009

Item	Item/ Description	Action Required By Whom	Proposed Action Plan	Date To Be Completed	Current Status	Comments/POP *	Follow-up Review (To be completed by CPRB)
3.23	Observe any students being pulled from class, held back on housing unit, or held over after meals to perform work details.	Living Unit Staff	1. Follow DDMS policy for school refusal	03/03/09	On-going	WIN generated DDMS reports	
			2. Counseling: Youth Correctional Counselor(YCC) Crisis Response Team(CRT)	N/A	On-going	WIN Chronos	
		Assistant Principal	SCT Referral (if necessary)	N/A	On-going	WIN SCT Reports	
		SYCCs/ Principal	A. Interview & mediate issues for youth with personal safety concerns	N/A	On-going	Email summaries to Assistant Superintendant Notes from group session	
		Attendance Coordinator	1. Prepare and distribute to TTS/Program Administrator 3-day Absence Report, NIS Report, Students Absent Due to Work Report	04/30/09	Pending	WIN Attendance Tracking Completed reports	
		Treatment Team Supervisors/ Program Administrator	1. Review WIN 3-day Absence Report, NIS Report, and Students Absent Due to Work Report to TTS/Program Administrator to monitor and reduce absences	N/A	On-going	Documentation of meetings with Staff as required	
3.29	Instructional teams will be required to develop incentives for increased school attendance.	Principal	1. Implement Incentive Programs	04/03/09	On-going	List of incentives Copies of certificates	
3.34	An alternative behavior management classroom will be provided at each school.	Principal	Ensure ABLE is functioning and teachers are using it according to the ABLE procedure	01/15/09	Complete	Printed File Maker Pro screens documenting use of the ABLE classroom	

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE

EDUCATION AUDIT OF LYLE EGAN HIGH SCHOOL CORRECTIVE ACTION PLAN

January 12, 2009 through January 14, 2009

Item	Item/ Description	Action Required By Whom	Proposed Action Plan	Date To Be Completed	Current Status	Comments/POP *	Follow-up Review (To be completed by CPRB)
3.39	Written policy, procedure, and practice require high school administrators, together with their living unit counterparts, to be responsible for the following in supervising staff assigned to restricted placement: 1) Use of a Standardized format for reporting educational progress and data on students in restricted placements. 2) Use of a standardized checklist by school administrators to ensure students in restricted programs are receiving their full complement of mandated educational services.	Assistant Principal	1. Establish a five period school schedule per High Graduation Plan needs of youth for off-campus schools (SMP or BTP/CTC/ITP/IBTP) 2. Complete scheduled progress reports for students on restricted program (2 times per academic year as required in plan)	04/30/09 04/15/09	Incomplete On-going	Student schedules Progress Reports per Academic Calendar/ High School Grad Plan Progress Report every 6 months	
4.20	Written policy, procedures, and practice require the use of course syllabi, units of instruction and lesson plans by teachers.	Principal/ Assistant Principal	1. Implement random "Walk-through" practice 2. Implement Quarterly Teacher Observation process 3. Enforce preparation of lesson plans for all classes	04/13/09 N/A 04/30/09	Incomplete On-going On-going	Copies of "Walk-through" comment sheets Copies of "Quarterly Observation Document" Copies of teachers lesson plans	

California Department of Corrections and Rehabilitation
Division of Juvenile Justice

Heman G. Stark Youth Correctional Facility

Living Unit	Previous Program As of August 5, 2009	Current Program As of August 12, 2009
A	Special Counseling Program 23	Special Counseling Program 23
B	Closed---Habitable	Closed ---Habitable
C	Intensive Treatment Program 19	Intensive Treatment Program 19
D	Intensive Behavior TX Program 19	Intensive Behavior TX Program 19
E&F	Closed ---Under renovation; uninhabitable	Closed ---Under renovation; uninhabitable
G	Sex Behavior Treatment Program 33	Sex Behavior Treatment Program 33
H	Sex Behavior Treatment Program 30	Sex Behavior Treatment Program 31
I	Low Risk Core Treatment Program 32	Low Risk Core Treatment Program 32
J	Low Risk Core Treatment Program 34	Low Risk Core Treatment Program 34
K	Special Management Program 18	Special Management Program 40
L	Special Management Program 18	Behavior Treatment Program 40
M	Substance Abuse Treatment Program 31	Substance Abuse Treatment Program29
N	Substance Abuse Treatment Program 0	High Risk Core Treatment Program 24
O	Low Risk Core TX Program/PVP 39	Low Risk Core TX Program/PVP 38
R	Morrisey/ Parole Violator Program 24	Morrisey/ Parole Violator Program 28
S	Behavior Treatment Program 22	California Institution for Men
T	Behavior Treatment Program 17	California Institution for Men
U	Closed	California Institution for Men
V	Closed	California Institution for Men
W	Closed	California Institution for Men
X	Closed	California Institution for Men
Y	High Risk Core Treatment Program 18	California Institution for Men
Z	High Risk Core Treatment Program 9	California Institution for Men

Note:

All treatment programs meet Farrell Remedial plan population requirements with the exception of Living Units K&L. A plan will be developed by August 17, 2009, to address the population on Living Units K&L. This plan will include the identification of a program that can be relocated to Living Unit B thereby freeing a unit for reducing the population on Living Units K & L. Living Unit B cannot be used to house K & L youth as it is located among the facility's mental health units.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION - DIVISION OF JUVENILE JUSTICE
Wards with Disabilities Program Remedial Plan
Auditor's Annual Report for the 2008-09 Fiscal Year

Auditing Activities for the 2008-09 Fiscal Year

This report represents the fourth auditing report by the Disabilities Expert and Auditor, Logan Hopper, in response to the Consent Decree entered in the matter of *Farrell v. Cate.* The Consent Decree requires that the Disabilities Expert visit each DJJ correctional facility and Headquarters during each fiscal year and report on the progress DJJ is making in implementing the Wards with Disabilities Program (WDP) Remedial Plan, filed with the Court on May 31, 2005. From September, 2008, through April, 2009, the Disabilities Auditor visited the following facilities:

Ventura Youth Correctional Facility
Heman G. Stark Youth Correctional Facility
N. A. Chaderjian Youth Correctional Facility
Southern Youth Correctional Reception Center and Clinic
O.H. Close Youth Correctional Facility
Preston Youth Correctional Facility
Division of Juvenile Justice Headquarters

For the fiscal year 2008-09, the Disabilities Auditor scheduled two one-day site visits to each correctional facility. The first audit date involved a general review of all items contained in the WDP Audit Instrument, dated May 31, 2005. The second audit date focused on follow-ups and a more detailed analysis of items not resolved during the first audit date, as well as interviews and final coordination with facility staff. At the end of the first facility visit, a summary report describing the basic activities of the audit and general findings was submitted to the parties. One of the purposes of the first site visit was to monitor the progress of partially compliant and non-compliant items since the last report and to provide guidance to the facility WDP coordinator and other staff on ways to gain compliance by the end of the 2008-09 auditing cycle. At the end of the second site visit, the Disabilities Auditor completed an evaluation of the facility's compliance using the approved Audit Instrument, and prepared a detailed draft report for the facility, providing the compliance rating and a commentary on the implementation progress for each item.

Executive Summary

As the most basic summary of the year's activities and the current status, DJJ and the Wards with Disabilities Program have made progress and reached substantial compliance in a number of areas. However, there still are areas where compliance has not been reached, and further efforts are needed to effectively provide wards with disabilities equal access to programs and services. Many of these areas require consistency and coordination among the various facilities and further policy development and direction from Headquarters. The main purpose of this report is to provide guidance as to where DJJ should continue with established procedures, and where further development is needed to achieve substantial compliance with the WDP Remedial Plan.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION - DIVISION OF JUVENILE JUSTICE
Wards with Disabilities Program Remedial Plan
Auditor's Annual Report for the 2008-09 Fiscal Year

During the fiscal year, the Wards with Disabilities Program was impacted significantly by the departure of four of the original facility WDP coordinators. At Preston YCF and at N. A. Chaderjian YCF, the two original WDP coordinators, Sherri Lowe and Velia Quesada, still remain, and their dedication and effectiveness have been a major factor in the advancement and consistency of the WDP program at those facilities. At O. H. Close YCF, the departmental WDP manager, Sandi Becker, filled in as the facility coordinator as time permitted, and her involvement and the assistance with various other staff helped greatly, although the facility was without a full-time coordinator for most of the fiscal year. At Ventura YCF, the facility moved quickly to fill the vacant position; however, three separate individuals held the position. At SYCRCC and Heman G. Stark YCF, the facilities were without a full-time coordinator for much of the fiscal year. Therefore, the programs at four facilities obviously experienced some degree of delay during the period when there was no permanent coordinator. The extent to which the program has progressed at each facility is almost directly proportional to the length of tenure of the WDP facility coordinator. As for the departmental WDP coordinator role, Ms. Becker has worked diligently to perform the leadership duties, and she is believed to be gaining cooperation from other Headquarters staff and reaching an understanding of the program and her duties. She brings a new perspective to the position and is very capable and dedicated to the task. It should also be noted that WDP staff has been receptive to specific recommendations from the Disabilities Expert for improving reports and activities, and this cooperation has been appreciated. Despite the varying degrees of experience among the current group of coordinators, the actions of all of the WDP coordinators continue to represent one of the strongest aspects of the Wards with Disabilities Program.

As a result of the combined efforts of these coordinators, the WDP program has progressed as an entity at all facilities. The execution of basic WDP tasks by these coordinators, such as overseeing the Staff Assistant teams, providing individualized assistance to wards with disabilities, and monitoring the disciplinary and grievance systems, continues to meet basic goals established by the plan. One issue that is of concern is the possibility that in the future, these coordinators may not be available full-time to execute the duties required of them, and it must be emphasized that the WDP Remedial Plan requires that these be full-time positions, and experience has shown that such a commitment will be necessary to achieve the compliance goals. Documentation of compliance efforts and activities as required by the remedial plan continues to progress, although it is clear that greater standardization and coordination among the facilities and Headquarters is still needed.

The annual auditor's report for last year cited a need for better coordination of required WDP Remedial Plan elements into the day-to-day operations by facility staff, particularly those in supervisory positions, as well as more meaningful acceptance and understanding of the program's goals by all correctional staff. The WDP Remedial Plan is a complex and comprehensive document that touches upon all operations of DJJ 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. Generally, Superintendents continue to be cooperative with respect to the goals of the remedial plan. High-ranking supervisors at all facilities, usually Program Administrators or Treatment Team Supervisors, also continue to provide assistance to the facility WDP coordinators in procedural and operational matters, and many of these staff should be commended for their commitment toward making the implementation of the

plan filter into the various disciplines and departments. Staff Assistants that have been properly trained, which usually includes about 20 to 30 staff per facility, help to reinforce the goals of the remedial plan to other staff. However, beyond these staff members, the level of understanding and commitment to WDP Remedial Plan goals and objectives is still sporadic, and full cooperation from all facility staff is needed for significant progress. Unfortunately, some DJJ staff are still not knowledgeable or supportive as to how the WDP Remedial Plan requirements relate to their activities.

The sections that follow summarize the successful implementation actions taken by the DJJ in some areas, as well as document some areas where little meaningful progress has been made and where more focus is needed to meet the remedial plan's requirements.

Physical Accessibility Modifications

The facility management departments at all locations should be commended for the numerous architectural modifications undertaken during the past year to increase accessibility for wards with mobility impairments. It should be noted that the WDP Remedial Plan requires only a basic architectural barrier removal component, and the facility management department has actually gone beyond the specific barrier removal items included in the plan. In addition, there are many areas that are exemplary in their design and in the appropriate incorporation of accessibility elements into the construction. At this point in time, the architectural modifications required by Appendices B and C of the WDP Remedial Plan have been completed at four facilities. DJJ recently petitioned the Court, and the Court approved extending the deadline for all modifications until December 31, 2009, so modifications still required are not past the new due date. Refer to item 121 in the detailed charts that follow for the remaining barrier removal items.

Wards with Disabilities Identification and Accommodation

During the fourth round of visits, procedures for referring and identifying wards with disabilities, both at the reception centers and at the permanent facilities, undertook a renewed emphasis, in an attempt to have all current wards identified appropriately. The campaign was largely successful, although there were some areas of confusion at a few facilities, particularly in the area of mental health assessments. Facilities still used different methods and achieved differing results in attempts to identify, classify, and assign appropriate accommodations to wards with disabilities, pointing to the fact that clarifications from Health Care and Mental Health are still needed. New clarifications as included in the ADA Amendments Act of 2008 also need to be incorporated into identification procedures; these should be reviewed by the Disabilities Expert prior to implementation. Criteria for educational assessments and identifications made via Special Education / I.D.E.A / Section 504 appear to be understood very well, but the procedure of using the School Consultation Teams (SCT's) to facilitate these identifications, as required by the WDP Remedial Plan, still needs improvements and guidance on the proper forms and procedures to be utilized. The WIN computerized identification system, close to full implementation at the facilities, assists in these identifications and assessments, but there is still confusion regarding the extent to which the WIN system should be used,

versus written forms (see separate discussion of WIN below). During this fiscal year, there was still a lack of clear direction from Headquarters on these processes, although WDP staff at all facilities used their best efforts to prepare appropriate documentation of wards with disabilities and their reasonable accommodations.

Self and Staff Referrals for Wards with Disabilities

These referrals are still transitioning from the previous Request for Sick Call (YA 8.229) form to the new "Disability Referral / Evaluation Form" (DJJ 8.288), and usage of the new form is increasing. However, in general, it was not common that forms YA 7.464, YA 8.229, or DJJ 8.288 were being used by wards for self-referrals. It is recommended that these forms remain in use with no revisions throughout the next fiscal year, so that their proper usage and effectiveness can be further monitored and evaluated by the Disabilities Auditor and WDP staff.

WIN Information Systems

DJJ has worked steadily to upgrade its computerized ward informational and record-keeping system, referred to as the WIN system. At the present time, the WIN system has been upgraded and installed at all six facilities. The original facility WDP coordinators received extensive training on use of the system, but it is unknown to what extent the four new facility coordinators and other staff members have been trained. It has not been possible to provide a complete evaluation of the veracity and effectiveness of information entered by staff into the system, since this is an on-going process subject to refinement. Nevertheless, it is felt that DJJ has performed admirably in bringing about changes to the WIN system, and the efforts of the IT staff involved in the WIN system upgrades should be commended for their willingness to work with the WDP coordinators and include WDP-specific data in the system. The WDP 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, and it appears that DJJ has made significant progress in this area. Refer to item 110 in the detailed charts for more information.

ADA Staff Training

One of the most important activities required by the WDP Remedial Plan is the provision for initial and on-going staff training in the areas of (1) disability sensitivity training and (2) WDP policies and procedures. The WDP Remedial Plan originally required that initial staff training be completed by the end of May, 2006 (within 12 months of adoption of the WDP Plan), but this deadline was extended by the Court until December 31, 2009. The remedial plan also requires that annual training be provided to all staff, as well as to all new hires as part of the Training Center activities. Training activities for current staff have increased during the fiscal year, and the Disabilities Auditor has been provided with numerous training attendance lists for most facilities. Since the lists provide only the names of attendees and do not correlate these to the total number of staff and the exact positions these staff hold, it has been impossible to gauge exactly what percentage of current staff have been trained (and exact figures

have not been provided by DJJ). A rough accounting would estimate that approximately 80% of all current staff have received the initial sensitivity training, as well as training on the WDP policy (which could be consider follow-up annual training. The WDP Remedial Plan requires that an outside (non-State) disability advocacy consultant be utilized to assist in developing the final curriculum for all training modules. It is our understanding that such a consultant is completing the contractual process, and should begin work soon. See item 25 in the detailed charts that relate to staff training.

Due to the turnover of facility WDP coordinators during the year, coupled with budgetary constraints that restricted travel and outside coursework or seminars, training for new WDP coordinators has been lacking and is a major issue at this time. While the departmental WDP Manager provided a general degree of orientation and WDP Remedial Plan training to the four new facility coordinators, the type of independent training required by the WDP Remedial Plan has not been provided to them. All facility WDP coordinators should be provided with the additional training designed by the new consultant, or new coordinators could alternately attend independent disability trainings. See item 39 in the detailed charts that follow.

The WDP Remedial Plan also requires general ADA and specific WDP training for all new hires at the departmental training facility. Since this venue is not on the audit visit list, the Auditor has no personal knowledge or opinions about whether this training is being provided and the nature and quality of such training, and no specific information or documentation on this training has been provided by DJJ.

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. Training for these SA’s has been completed at all facilities, and these training sessions have helped to increase staff awareness of the requirements of the WDP Remedial Plan. These SA teams are active at all facilities, with some teams having greater participation than others. The intent of the WDP Remedial Plan is that these SA teams become increasingly active in assisting wards with disabilities, with less direct involvement from the facility WDP coordinator, and this appears to be evolving. While the facilities are doing a good job in assuring the presence of Staff Assistants at hearings and other functions, it should be realized that other accommodations may be necessary for certain disabilities, to allow wards with these disabilities to represent themselves independently.

Coordination with Special Study Groups

The WDP Remedial Plan contains a number of activities that require specific studies and/or the preparation or revision of various policies and procedures. Most of these activities carry no specific schedule for implementation in the remedial plan. These studies and activities include:

(1) *a special working group to study and provide recommendations for establishing residential programs for wards with developmental disabilities*. This item has been slow in implementation and has gone through several preliminary meetings over the past two years with no significant action. However, due to renewed efforts from Mike Brady and Jay Aguas, a meeting held in April, 2009, and attended by a number of key DJJ mental health staff, showed great promise toward achieving reasonable results in this area, with the goal being to complete the study by October, 2009. See item 21 in the detailed charts that follow.

(2) *the formulation of specific policies related to medical issues concerning wards with disabilities, including a revision of the eyeglasses prescription policy, and an action plan for the integration of wards with disabilities into the general population after release from an OHU.* These were actually handled somewhat separately during the fiscal year. The eyeglasses and vision testing policy went through several drafts and revisions, and a very effective policy and implementation program, approved by the Disabilities Expert, was issued. The action plan for the integration of wards with disabilities relating to OHU's was drafted and revised to bring about an effective statement of the goals relating to these issues. However, it was not evident that any particular action was being taken or that any permanent policy was affected due to the written statement; see item 8 in the charts that follow for more detailed information.

(3) *a special working group and study on the effects of and tracking policies for the prescription of certain psychotropic drugs.* A psychopharmacological policy was drafted and adopted by DJJ during the fiscal year. While it contains many improvements, it is not clear that recommendations of the Disabilities or Mental Health Experts were fully taken into account during the policy's issuance, since the WDP Remedial Plan is clear that the process is supposed to be a collaborative one. In addition, the policy even as issued was not implemented at the time of site audits during the fiscal year. See item 9 in the charts that follow for more detailed information.

(4) *coordination with safety and welfare issues for wards with disabilities, as they would be included in the safety and welfare remedial plan.* While it is believed that strides have been made to implement the polices and procedures described on pages 40-44 of the WDP Remedial Plan, documentation of these practices and the reduction of use of force on wards with disabilities was problematic at most facilities. Recommendations for implementing and documenting the procedures were discussed with security staff at all facilities during the audits. A meeting to further discuss these issues with Headquarters has been set for June, 2009. See item 53 in the charts that follow for more details.

Report respectfully submitted,

Logan Hopper, Disabilities Expert and Auditor

Facility Compliance Chart

This chart represents the combined auditing report for the third round of site visits during the 2008-2009 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:

- Ve Ventura Youth Correctional Facility
- HS Heman G. Stark Youth Correctional Facility
- Ch 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 report attempts to determine a general level of compliance for all applicable items from the Wards with Disabilities (WDP) Remedial Plan and the Disabilities Audit Instrument, using the following codes:

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

SC* = New or previous second consecutive "Substantial Compliance" rating; the Auditor recommends no further independent auditing, but rather continuing auditing by the Departmental WDP Coordinator.

+ or - = Even though it has not been done in the past, a "+" or a "-" has been given occasionally (typically for a "PC" rating) as a way of acknowledging either an improvement or a decline from a past rating. If a reader has an objection to this addition, the symbols may be disregarded. It is the Auditor's intent that these "+" or "-" symbols should not be used in any statistics generated, but used only to gauge an improvement or decline.

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

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	A. Headquarters										
	I. Directorate										
1	Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director’s office.	Verify current copy is retained.	NA	NA	NA	NA	NA	NA	SC*	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND AS OF THIS REPORT, IS BEING BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	B. Departmental Ward Disability Coordinator & Functions										
2	By October 2005, establish and maintain a full-time Departmental Wards with Disabilities Program (WDP) Coordinator and analytical staff to develop, support, lead and manage a quality program.	Verify positions are in place and filled.	NA	NA	NA	NA	NA	NA	SC	Sandi Becker is the full-time Departmental WDP Coordinator. Maria Correa was the full-time WDP Assistant until December 31, 2008, at which time other staff have been made available as needed.	While it has been reported that other staff at Head-quarters are available to assist with clerical and analytical tasks, it is felt that an assistant (not necessarily full-time) dedicated to and knowledgeable about the program is needed to carry out the variety of tasks.
3	Ensure duty statement encompasses all Departmental WDP Coordinator duties defined in the WDP Remedial Plan.	Review duty statement.	NA	NA	NA	NA	NA	NA	SC	A signed duty statement for the Departmental WDP Coordinator was presented at the latest Headquarters audit.	
4	The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the Departmental WDP Coordinator.	NA	NA	NA	NA	NA	NA	SC	Sandi Becker is believed to be performing the required oversight functions.	
5	Establish and maintain full-time WDP Coordinators at each facility by Feb., 2006.	Verify positions are in place and filled.	NA	NA	NA	NA	NA	NA	SC-	Each facility currently has an active WDP Coordinator in place, although four facilities were without a coordinator for parts of the fiscal year.	Headquarters and Personnel should develop improved procedures for the interviewing and hiring process for new coordinators when needed.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
6	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.	NA	NA	NA	NA	NA	NA	PC	An emergency announcement protocol, TDO #07-94 dated Nov. 27, 2007, has been previously provided to the Auditor. The Auditor made a preliminary review of a draft document during last fiscal year, with recommendations to include more specificity on the assistance necessary for wards with physical and psychiatric disabilities; however, the final approved TDO appears to be different in several ways. First, the requirement for the flickering of lights described by the remedial plan is only listed as an option in the protocol, without clear guidance on other equally effective methods. Second, the protocol lacks specificity, and falls short of industry standards, such as NFPA emergency guidelines. Third, the Auditor has not been able to verify proper training or the readiness for usage at the facilities.	Since the current TDO expires on November 27, 2009 (in five months), it is strongly suggested that DJJ consult with the Disabilities Expert on ways to improve and clarify the items discussed in the previous column prior to re-issuance.
7	The Departmental WDP Coordinator shall ensure that a WDP report is completed monthly, quarterly and annually for each site.	Review monthly, quarterly and annual reports for completeness.	NA	NA	NA	NA	NA	NA	PC	Due to facility WDP coordinator turnover during the last fiscal year, monthly reports were sporadically prepared at half of the facilities within the last twelve months. Facilities generally use the basic "population" report, as well as charts on wards' with disabilities grievances, disciplinary actions, and placements into restrictive settings. An annual report for the department as a whole and each facility was prepared for the first time.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
8	In conjunction with the Health Care Transition Team, Medical Experts and Disabilities Expert, prepare an "action plan" for wards with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining the most physically accessible locations available and making the barrier removal improvements required on a timely basis.	Audit to determine implementation and review documentation to ensure compliance.	NA	NA	NA	NA	NA	NA	PC	An "action plan" statement was sent to the Disabilities Expert during the fiscal year, and after several consultations and revisions, it was indeed approved by the Disabilities Expert . This document was well-prepared and represents a commendable effort on the part of the departmental WDP Manager to complete this part of the task. However, the audit item requires not just the preparation of a document, but specific "action" on the part of DJJ. There might be some differences of opinion as to what is meant by an "action plan" as used in the WDP Remedial Plan, but in the Auditor's opinion, this requires specific action and goes beyond mere policy. It is discomforting to see that the new OHU Policy (Section 6246.5 of the I&C Manual, effective 1/26/09 and sent to the Disabilities Expert as PoP #394 on 5/5/09) contains no reference whatsoever to the issues described in the "action plan" statement. During the facility audits, the OHU's were visited, and there were no indications that staff were familiar with such an "action plan". The audit "method" stated in the previous column requires "implementation" & "documentation" of such, not merely the presence of a written statement for which distribution and implementation has been unsubstantiated.	Include the OHU action plan statement in the new OHU Policy (Section 6246.5 of the I&C Manual), or provide other documentation that the OHU's are aware of and are implementing its policies and procedures.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
9	In conjunction with the Health Care Transition Team, the Mental Health and Medical Experts, and Disabilities Expert, ensure systems are in place to monitor the use of psychotropic prescriptions and medications including SSRI's for wards under the age of 20.	Audit to determine implementation and review documentation to ensure compliance.	NA	NA	NA	NA	NA	NA	PC	The are two issues involved in the compliance rating given. First, early in the fiscal year, DJJ prepared draft psychopharmacology guidelines. These were sent to the Disabilities Expert as PoP #206 on 8/8/08. In addition, it is known that DJJ sent several drafts to the Mental Health Experts before and after that date. The Disabilities Expert sent comments and suggested revisions to the first draft on 10/3/08. It is known that the Mental Health Expert also sent comments and suggested revisions in a document titled "Draft 18". It is unknown if that document was solely or jointly drafted by either the Mental Health Expert or DJJ, but it contained numerous positive revisions. These communications were the last received from DJJ before the "final" policy was approved by Bernard Warner on 1/20/09. A detailed review of the policy that was approved and submitted to the Disabilities Auditor during the Headquarters Audit shows that it is virtually identical to the policy originally submitted for Expert review, with none of the issues raised in the Disabilities Expert's review or in "Draft 18" being taken into consideration. This procedure hardly qualifies as a cooperative process undertaken "in conjunction" with the Experts listed.	(1) Consider revisions to the psycho-pharmacology guidelines to improve ward interaction, advocacy, and monitoring. (2) Complete the training component (if not already completed per the policy's 60-day requirement) and provide documentation of who attended the trainings and when. (3) Provide documentation of implementation, including use of the forms related to the tiered administration system, and adherence to the timelines for reviewing and monitoring prescriptions with wards and parents.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
9	Continuation of Item									Second, even if the psycho-pharmacology guidelines were a consensus document, there is no indication that the policy has been implemented, thus falling considerably short of "ensuring systems are in place…". No documentation of implementation (other than the DJJ approval) was provided to the Disabilities Auditor during any of the facility audits or the Headquarters audit. No documentation of the training component contained in the policy has been provided. During the facility audits, while psychiatrists were not typically available for interview, interviews with senior psychologists gave no indications that such a policy was being implemented. During an interview with the new chief psychiatrist at O.H. Close (a critical facility for implementation of the guidelines due to the younger wards), he stated that he was not aware of the guidelines, and he did not appear to be following the process for tiered administration or improved monitoring. Interviews with wards throughout the early parts of 2009 also gave no supporting evidence that new procedures with respect to the prescription or monitoring of these medications was occurring.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
10	The CYA shall conduct annual compliance reviews of the court-approved Disabilities Program Remedial Plans in all CYA facilities to monitor compliance with the Remedial Plan, to ensure that wards with disabilities are being effectively identified, to ensure that the needs of those wards are being met and to reassess and 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.	NA	NA	NA	NA	NA	NA	PC	The Disabilities Auditor received DJJ's last quarterly report for the Third Quarter of 2008 (or the first quarterly report for the fiscal year 08-09) on 12/29/08. No other quarterly or annual DJJ reports were received. If completed, it is possible that DJJ-quarterly reports and facility monthly reports could form a part of the annual compliance review required by this item, although the annual report described by the remedial plan is more detailed in scope, and requires a self-monitoring component. Quarterly reports have also not provided assessments of the level of staffing and training needed to comply with the WDP Remedial Plan (see column 2, "Item"). It is the Auditor's understanding that a Farrell Compliance Unit is also conducting annual compliance reviews (in fact. members of this unit have accompanied the Auditor on the site visits), yet none of these reports or "Corrective Action Plans" have been provided to the Auditor.	Provide an annual, DJJ-prepared compliance review, or composite "Corrective Action Plans", to the Auditor for review.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
11	Within six months of the court approval and adoption of this plan the Department's Ward Disability Program Coordinator will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review the outside consultants training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedule to ensure all individuals complete the required training.	NA	NA	NA	NA	NA	NA	SC	Sandi Becker 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 discussed some additional training resources, such as additional training from disability advocacy consultants, which may also be helpful.	
12	Develop the Disability Health Services Referral Form.	Monitor for completion by December 2005.	NA	NA	NA	NA	NA	NA	SC-	A "Disability Referral/ Evaluation Form" (DJJ 8.288) was completed and distributed on February 25, 2008. The form is now in use at most facilities. T he form has many excellent features, yet it is not yet clear that the form will serve the intended purpose of this item. First, the form includes education, and the remedial plan requires the SCT process to refer and assess wards for this purpose. Second, the item was intended to serve as a basic "sick call" form, and it is unclear if wards will use it effectively.	It is recommended that the form remain in use with no revisions throughout the next fiscal year, and its usage and effectiveness monitored by the Auditor and WDP staff.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	C. Headquarters Policies										
13	The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006.	Review purchase orders (PO) (STD 65) to confirm purchase within established timeline.	NA	NA	NA	NA	NA	NA	SC*	Accessible vans have been purchased and are in use. ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND WILL BE REMOVED FROM FUTURE AUDITS.	
14	By July 2006, the Department shall develop and maintain system that documents the mental & physical impairments of wards with disabilities and any reasonable accommodations.	Audit to determine implementation within the given timeframe and review documentation to ensure compliance.	NA	NA	NA	NA	NA	NA	SC-	The monthly reports adequately document mental and physical impairments of wards at an aggregate, but not an individual, level. Reasonable accommo-dations are usually documented by the facility WDP coordinators. DJJ has developed a document-ation system through the WIN system upgrades and presented a comprehensive report format printed from WIN that provides this information. Although it could not be verified that most if not all wards have yet to be included, it is believed that DJJ is close to completing the task.	
15	The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all levels of care within the youth correctional system.	Review 10% of placements and all level of care for wards with disabilities.	NA	NA	NA	NA	NA	NA	SC	Reviews of random files did not indicate any specific lack of equal access.	It has been previously recommended that the Department prepare a documentation form to aid in assurances of equal access, but this has not yet been accomplished.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
16	All wards under the jurisdiction of the CYA shall be given equal access to all programs, services and activities offered by the Department. Programs, services, and activities shall be offered in the least restrictive environment, with or without accommodations.	Review 10% of placements and access to special programs for wards with disabilities.	NA	NA	NA	NA	NA	NA	SC	Reviews of random files did not indicate lack of equal access to special programs.	It has been recommended that the Department prepare a documentation form to evaluate the least restrictive environment requirement (see item above).
17	Establish policies to assure that placement of wards with disabilities into restrictive programs is not based either directly or indirectly on a ward's physical or mental disability, or on manifestations of that disability.	On-going audit.	NA	NA	NA	NA	NA	NA	PC	It is believed that TDO #07-82, while comprehensive in many areas, does not contain the degree of specificity necessary to assure that disability is not a factor in assigning a ward to a restrictive program.	It has been recommended that specific policies and procedures be documented in writing to evaluate a ward's (with or without a disability) placement into any restrictive program.
18	By December 2005, the Education Branch shall establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of Special Education to study and make recommendations to improve the adult ward's and parents' meaningful participation during IEP meetings, to encourage more active participation, and to provide informational materials for parents and/or surrogates.	Review recommen-dations and develop appropriate implemen-tation plans.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
19	The Education Branch working committee shall also study the need for and evaluate the ability of the various public or private groups or agencies to assist with the means of attending IEP meetings for parents. (This is not be interpreted as requiring the Dept. to provide such means.)	Review recommendations and provide support if applicable.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
20	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.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
21	In consultation with the disabilities expert, the CYA will conduct a study regarding the need for a residential program for wards with certain developmental disabilities. The study will commence within 6 months from the date that the Disabilities Remedial Plan is filed with the court.	Review documented study for meeting timeline and evaluate recommen-dations.	NA	NA	NA	NA	NA	NA	BC	The Disabilities Expert attended two meetings regarding this item during the fiscal year. The first meeting, held in November, 2008, was non-productive and had little follow-up. The second meeting, held in April, 2009, and chaired by Jay Aguas, was productive and signaled the beginning of what should be a responsible study on the topic.	A follow-up meeting, and/or a detailed outline of future activities of the group should be prepared by DJJ as soon as possible.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
22	The visiting facility at Ventura is currently under construction & will be fully operational by 1/06. The new facility at Preston will be fully operational and safe for all wards, visitors and staff by July '06. The CYA will confer with the Disability Expert to explore and implement, 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 completion/level of operation by established dates.	NA	NA	NA	NA	NA	NA	SC	The new visiting facility at Ventura is now open and in use. The Auditor revisited Preston in May, 2009, to review alternate procedures for continuing to use thew previous entrance. Based on these observations, the Auditor would agree that usage of the previous entrance would be acceptable in complying with this item, as long as a few modifications were made. The Auditor will monitor these during the next round and verify that the facility is still suitable for accessible visiting.	
23	The CYA shall conduct a needs assessment and prepare Department wide disability training materials, with the assistance of an outside disability advocacy organization or consultant, in consultation with the Disability Expert, by June, 2006.	Review needs assessment and training materials.	NA	NA	NA	NA	NA	NA	PC	The needs assessment, while believed to be cursory and non-specific, has nevertheless been completed. A course curriculum for sensitivity & awareness portions of the training has been developed and reviewed by the Disabilities expert, with some pending recommendations, and it is now in use.	It is still recommended that an outside (non-State) disability advocacy consultant be utilized, as required by the remedial plan, to assist in developing the final curriculum for all training modules. It is our understanding that the DJJ-selected consultant is completing the contractual process, and should begin work soon.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
24	The CYA shall develop a screening tool to assess the current ward population in order to identify any developmentally disabled wards who may not have been previously identified. The CYA shall complete this assessment by December, 2006.	Review screening tool to ensure validation. Ensure that the assessment is completed within the given timeframe.	NA	NA	NA	NA	NA	NA	NC	The Disabilities Expert has not been involved in the development of the screening tool, nor reviewed a draft or prototype of the process to be used. (Note: this item should not be confused with the KBIT testing being appropriately provided to all incoming wards. See also items 86 & 115.	Written procedures and the screening tool or method should be developed and presented to the Disabilities Expert.
25	Within 12 months of the court approval of the plan, all staff will receive training, prepared with the assistance of an outside disability advocacy organization or consultant, and in consultation with the Disability Expert in sensitivity, awareness & harassment. This training will be provided to all staff on an annual basis. Until such time as this training is incorporated in the basic training academy curriculum, this training will be provided to all new hires within 90 days of placement in the facility.	Review the outside consultant training material to determine compliance with the requirements contained in the WDP Plan. Review and confirm training schedules and document attendance to ensure all staff and new hires are provided training.	NA	NA	NA	NA	NA	NA	PC	A course curriculum for the sensitivity, awareness, and harassment portion of the training has been developed, and training sessions for current staff have begun at all facilities, with the approximate staff inclusion rate being about 80% (see Introduction). No outside (non-State) disability advocacy consultant has been utilized, as required by the WDP remedial plan, to assist in developing the final curriculum for all training modules. It has been verbally reported that the training academy has instituted training sessions for new hires, but no curricula or attendance records have been provided to the Auditor.	It is still recommended that an outside (non-State) disability advocacy consultant be utilized, as required by the remedial plan, to assist in developing the final curriculum for all training modules. It is our understanding that the DJJ-selected consultant is completing the contractual process, and should begin work soon.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
26	The Department shall ensure that a ward is not precluded from assignments to a work or a camp program based solely upon the nature of a disability.	Review departmental list of wards with disabilities; conduct interviews. Audit work / camp program rosters to determine placement of wards with disabilities.	NA	NA	NA	NA	NA	NA	PC	Reviews of random files and interviews with wards indicated several problems in this area at the facilities during the last fiscal year. It was previously recommended that the Department prepare a documentation form to aid in assurances of equal access, but none has been presented. This review was not able to include fire camps, since the Disabilities Auditor was not allowed to visit the two fire camps during the fiscal year and audit ward files and documents contained there.	(1) It was previously recommended that the Department prepare a documentation form to aid in assurances of equal access. (2) In order to monitor and audit camp programs, the Auditor will need to visit the two fire camps to review ward files and records. (Note: if all parties agree that camps are not actually included in Farrell, this audit item should be modified or removed.)
27	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.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
	D. Headquarters Programs/Screening										
28	Maintain a contract for sign language interpreter services, as well as a record of use of this service.	Review contracts (STD 213/210) for sign language interpreter's services.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
29	The Intake and Court Services Unit staff shall review incoming documentation from the committing courts and counties of all wards for indicators of impairments that may limit a major life activity and require accommodations or program modifications.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	NA	NA	NA	NA	NA	NA	SC-	This is a very marginal distinction between an "SC" and a "PC" compliance rating; the "SC-" rating is being used primarily to acknowledge the conscientious efforts of Eleanor Silva and the Intake and Court Services Unit staff in wading through the poor documentation received from the committing courts. There were no specific indications that incoming documentation from the courts and counties was not adequately reviewed. It should be noted that records from the courts and county jails are poorly prepared, and while DJJ maintains that this is beyond its control; it may be necessary to require better documentation from these parties. See also item 31.	(1) I would again (as described last year) recommend additional documentation verifying the extent of review within the Intake and Court Services Unit. (2) I believe that DJJ should take more proactive measures to compel the courts to provide sufficient documentation. Some of the potential methods were discussed with the Intake and Court Services Manager during the audit, but these are not discussed herein.
30	The CYA will revise the Referral Document, YA 1.411 by replacing the term “handicap” with “disability” within 30 days of the filing date of this plan.	Review form for completion.	NA	NA	NA	NA	NA	NA	SC*	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
31	When indicators of impairment exist, the Intake and Court Services Unit staff shall complete the disability section on the Referral Document and forward to the designated Reception Center and Clinic.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	NA	NA	NA	NA	NA	NA	SC-	See item 29 above, as all of those comments also apply here. This year's review of intake files indicated that Intake and Court Services Unit staff improved dramatically in consistently being able to accurately identify known disabilities, or question their presence for future assessment. As with the item above, the fact that records from the courts and county jails are poorly prepared is a contributing factor to difficulties, but the Referral Document should still used as an important resource by the clinics, and complete information on this form is important.	See item 29 above, as all of those recommendations also apply here.
	Facility Administration										
	A. Superintendent										
32	Maintain a current copy of the Wards With Disabilities Program Remedial Plan retained in Superintendent's office.	Verify current copy is retained.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
33	Superintendents shall ensure wards with disabilities are informed, during orientation, of the existence of electronic equipment in libraries, what equipment is available, how and when equipment can be accessed, and where the equipment is located.	Review orientation program for inclusion of information.	SC-	SC	SC	SC-	SC	SC-	NA	The intake and reception center's procedures have not instituted the formal orientation program for wards with disabilities (see WDP Remedial Plan, page 10, and item 66 below). However, facilities have typically prepared a reasonable degree of information describing these types of features, and it is believed that wards receive this information, although presentation is not consistent. See also item 96.	Headquarters should provide detailed procedures (consistent among all reception centers) for providing an effective orientation at the three centers, including a coordinated package of information on the types of electronic equipment available and effective usage by wards with disabilities.
34	The Superintendent shall report to the Deputy Director, within twenty-four hours, when a ward with a disability that requires accommodation is placed in a restrictive setting, i.e., TD or lockdown.	Interview wards & SAs. Audit TD forms for compliance. Review Special Incident Reports related to Administrative Lockdowns.	SC-	PC	SC	PC	SC	SC	NA	A system of reporting by e-mail is in place at each facility, and records provided to the Auditor indicated that notifications were made when a facility WDP coordinator was present. The turnover of WDP coordinators hampered regularity at two facilities.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
35	The Superintendent shall be responsible for ensuring that due process and equal access occurs for wards with disabilities who require accommodations during institutional Youth Authority Board (YAB) hearings.	Audit Case Report Transmittal Form.	PC	PC	PC	PC	PC	PC	NA	"Case Report Transmittal" forms were available in electronic format, but the facility WDP coordinators and Casework Specialists used other methods and procedures to document accommodations, mainly the provisions of Staff Assistants, to the Board. It was noted in last year's report that the "Case Report Transmittal" forms should be used in the future, when made available through WIN, to standardize procedures department-wide. These forms have been revised to provide more details on the specific accommodations required. However, the forms were not in use during the audits. It is believed that the consistent use of these forms is crucial to the Board's ability to be apprised of and understand the needs of wards with disabilities and to provide due process. See also item 65.	The Casework Specialists should print hard copies of these forms and place them in the Board packets prior to the Board meeting, and then place them in the Case Reports section of the ward's field file upon completion of the hearing, as described in the WDP Remedial Plan, page 51. Alternatively, DJJ may propose alternate methods for ensuring due process during Board hearings, for approval by the Disabilities Expert and for consistent use at all facilities.
	B. Facility WDP Coordinator										
36	Maintain WDP Coordinators at each facility.	Verify positions are in place and filled.	SC-	PC	SC	SC-	PC	SC	NA	Only two facilities had a WDP coordinator the entire fiscal year. Some facilities were more proactive in assuring continuity of coordinators than others.	Headquarters and personnel should develop improved procedures for the interviewing and hiring of new coordinators when needed.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
37	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	NA	Each current facility WDP Coordinator has signed an appropriate duty statement.	
38	The facility WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documentation maintained by the facility WDP Coordinator.	SC	SC	SC	SC	PC	SC	NA	When present during the audit, the current facility WDP Coordinator was believed to be performing the required oversight functions.	
39	Within six months of the court approval and adoption of this plan the facility Ward Disability Program Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review outside consultants training material to determine compliance with requirements in the WDP Remedial Plan. Review & confirm training schedule to ensure individuals complete the required training.	PC	PC	SC	PC	PC	SC	NA	The two continuing facility coordinators received training several years ago. While the departmental WDP Manager provided a general degree of orientation and WDP Remedial Plan training to the four new facility coordinators, the type of independent training required by the WDP Remedial Plan has not been provided to them. Budgetary issues also played a negative role in their ability to travel and/or take independent courses.	It is our understanding that an outside disability trainer/consultant is about to be retained by the department. All facility WDP coordinators should be provided with the additional training designed by the new consultant, or new coordinators could alternately attend similar, independent disability trainings. The Auditor should be provided with curricula and schedules for all future trainings.
40	The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	Review monthly reports.	PC	PC	SC	PC	SC	SC	NA	Monthly reports were prepared in a timely manner when the particular facility had a WDP coordinator, but there were periods during the fiscal year when report filing was sporadic due to a vacant position.	A short executive summary and more detailed service-related information would be an excellent addition to these reports. These reports tend to be mainly statistical in nature, with no real qualitative value.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	Facility's Policies										
41	Efforts to identify wards with disabilities within youth correctional facilities shall be continuous, and shall include self-referrals, staff-referrals, facility ADA screening and assessment, and special case conferences.	On-going audit.	PC+	PC	PC+	PC	PC	PC+	NA	There were some improvements in each facility's identification efforts during the last fiscal year. However, Headquarters (primarily medical and mental health) have not disseminated comprehensive guidelines appropriate for proper identifications, screenings, and assessments, although there have been some memos regarding some specific impairments. In general, it is believed that the various disciplines are using their best efforts to identify affected wards, but clarifications from Headquarters are needed. Better coordination among departments is also needed. Special case conferences were held for the first time during this fiscal year.	More detailed clarifications from Headquarters are needed to make the proper determinations of disability, particularly in the areas of medical and mental health. New clarifications as included in the ADA Amendments Act of 2008 also need to be incorporated into identification procedures. These should be reviewed by the Disabilities Expert prior to implementation.
42	Assistive devices may be taken away from a ward only to ensure the safety of persons, the security of the facility, to assist in an investigation, or when a Department physician or dentist determines that the assistive device is no longer medically necessary or appropriate.	Interview wards and review supporting documentation.	SC	SC	SC	SC	SC	SC	NA	There were no documented or known specific instance where a ward's assistive device was taken away due to security concerns.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
43	Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	Interview wards and WDP coordinators to verify presence of operational TDD.	SC	SC	SC-	SC	SC	SC	NA	A TDD was present at each facility. One ward reported some difficulties in the ability to have a TDD available, although it could not be determined if any actual problems existed.	
44	Wards with hearing impairments shall have access to at least one facility television located in their assigned living unit that utilizes the closed captioning function at all times while the television is used.	Interview wards and WDP coordinators to verify presence of operation closed captioning function TV.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
45	Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to wards with disabilities.	Conduct site visits to verify presence of accessible posted materials.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
46	A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her assigned PA, Casework Specialist or by completing the Referral for Sick Call (RSC) form. A ward may make a self-referral for an accommodation for a documented or perceived impairment through an Education Advisor by completing the Self-Referral to the School Consultation Team form.	Review submitted RSC (YA 8.229) and SRSCT (YA 7.464) forms and determine appropriateness of disposition. Observe random interviews at intake.	SC-	PC	SC	PC	SC-	SC	NA	This item continued with the transition from the previous RSC (YA 8.229) form to the new "Health Care Services Request Form" and the "Disability Referral/ Evaluation Form" (DJJ 8.288), with both being available to and used by wards for self-referrals (although later audits found that many living unit staff failed to keep the forms available in the boxes provided). Less documentation was typically provided to the Auditor by the Education Departments to indicate that the SCT form YA 7.464 and the related forms were routinely being used by wards for self-referrals, although follow-up interviews with Education staff at most facilities indicated a basic understanding of the requirements and a commitment to better documentation in the future.	Prepare current, written guidance and clarifications about how the proper forms are to be used consistently by all facilities.
47	The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	Interview wards and Principal for proof of practice.	SC-	SC-	SC-	SC-	SC-	SC-	NA	Although wards with physical disabilities who would be most affected by this item were not specifically identified by DJJ, facilities appeared prepared to provide the necessary and appropriate training, if needed. Short memos had been prepared by most facilities, but there was little actual information on how students with disabilities would use the equipment (see also item 96).	Headquarters should provide detailed procedures for providing effective training to students with disabilities, including a coordinated package of information on the types of electronic equipment available and effective usage by students with disabilities.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
48	Students who take the CAHSEE with a modification and receive the equivalent of a passing score are eligible for the waiver request process. Students who are eligible will be granted waivers based on the SBE process and policy.	Verify by records review of students taking state-mandated exams that waivers were requested for students with modifications who receive equivalent passing scores (in accord with CDE guidelines.)	SC	PC	SC	SC	SC	SC	NA	Since the requirement for passing the CAHSEE was previously deferred for special education students until December, 2007, this is the first audit period in which the "waiver request" process has been applicable. It appeared in most cases that the schools were ready to use the waiver request process if necessary, and that the waiver would be granted, although there were no waiver requests for the past year. In some cases, there appeared to be some confusion about the differences between the previous "exemption" process and the new "waiver" process, and Headquarters should do more training on how the waiver process is correctly applied.	Even though substantial compliance was credited in most cases, it was not evident that all wards with disabilities were provided with the accommodations contained in their IEP's during the CAHSEE exams. Improved documentation on providing these accommodations, as well as the exact procedures for granting a waiver, should be provided to the Auditor at future audits. Head-quarters should do more training on how the waiver process is to be correctly applied and how it is different from the previous exemption process, perhaps with assistance from CDE.
49	Each ward with a disability shall have a High School Graduation Plan.	Review randomly 10 or 10%; whichever is greater, of students with IEP's graduation plans.	SC	PC	PC	SC	SC	SC		Of the student files reviewed, each ward with a disability had a current and reasonably accurate High School Graduation Plan at four of the six facilities. Procedures for filling out current High School Graduation Plan should be reviewed at two facilities.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
50	Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan.	Review randomly 10 or 10%; which-ever is greater, of students with IEP's graduation rates and uses of the exception to the graduation requirements.	SC	SC	SC	SC	SC	SC	NA	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
51	The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities.	Review randomly 10 or 10%; whichever is greater, of access for students with IEP's.	PC	NC	PC	PC	PC	PC	NA	Most facilities showed some improvement from last year. However, based upon the student files reviewed and interviews, there were still 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. IEP procedures also improved, although a few special education students had outdated IEP's.	(1) Fully implement the Program Service Day and other policies designed to improve attendance at school. (2) Provide compensatory services for special education students unable to attend classes. (3) Better coordinate IEP documentation with intake services. (4) Provide IEP tracking logs to assure that time lines for IEP's are met.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
52	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 communi-cations.	SC	SC	SC	SC	SC	SC	NA	Standardized written operational procedures were provided to the Auditor at all facilities. Since only one ward with hearing disabilities was present, it was not possible to determine if any significant problems in this area might exist. The flicking of lights is not currently a common occurrence at the living units	It is recommended that this item be continued in the auditing process until the non-emergency and emergency protocols are fully implemented, and until wards with hearing impairments are present to the extent necessary to evaluate the procedures.
53	CYA staff shall be aware of accommodations afforded to wards with disabilities in developing and implementing security procedures including use of force, count, searches, transportation, visiting and property.	Interview 10 security personnel and wards yearly for specific inquiry regarding security issues.	PC	PC	PC	PC	PC+	PC	NA	Interviews and observations indicated ongoing problems, including effective documen-tation procedures, in this area. While alternative conflict and violence resolution tech-niques were described by DJJ as being utilized by custody staff to the maximum extent feasible, there was little adequate documentation provided to show how these procedures were used. Procedures contained in the new departmental use of force policy had not been fully implemented at any facility.	Recommendations for documenting the procedures contained in the WDP Remedial Plan (pages 40-44) were discussed with security staff during the audit. These included documen-tation in behavior, use of force, and serious incident reports. It is recommended that security staff meet again with the depart-mental WDP Manager, prior to the next audit date so that this information can be reviewed in detail during the next audits.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
54	Prior to placing a ward with a disability into a restricted setting, the Superintendent shall review the referral form and ensure that any accommodation required by a ward has been documented.	Review records of 10 or 10%, whichever is greater, of wards placed in restrictive settings.	SC	SC	SC	SC	SC	SC	NA	Lists of wards placed in restricted settings were provided to the Auditor. There were indications that such placements were reviewed as required by the remedial plan.	
55	Each Education Specialist that is assigned as a case carrier, or alternate, will discuss the tenets of advocacy with the ward and surrogates prior to the IEP meeting to encourage active participation. During the IEP meeting, the specialist or alternate, will serve as the advocate of the student.	Attend pre-meetings and IEP meetings to determine degree of participation and advocacy roles.	SC	SC	PC	PC	PC	SC	NA	This policy is beginning to be implemented, and reasons and methods for providing the advocacy discussions were discussed during the audit. Education staff were beginning to document such "pre-meetings", and an "advocacy meeting log" has been established. It appeared that wards in restrictive units occasionally had no advance preparation available.	Provide departmental approved procedures (more detailed than the current short memo) for documenting the dates, times, and participants in IEP "pre-meetings". Investigate procedures to assure that wards in restrictive units are better served in this area.
56	All individuals who serve as surrogate parents will receive annual training in the role and responsibilities of a surrogate as identified by the State Department of Education. 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	SC	SC	NC	SC	SC	NA	A training for surrogate parents was held at most facilities during the fiscal year.	Provide the surrogate training annually, and assure that all surrogate parents to be used attend.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
57	Reasonable accommodation shall be afforded wards with disabilities to ensure equally effective communication with staff, other wards, and the public. Assistive devices that are reasonable, effective, and appropriate to the needs of a ward shall be provided when simple written or oral communication is not effective or as necessary to ensure equal access to the programs and services. (A list of potential devices omitted for brevity)	Interview wards and WDP coordinators to determine level of availability and accessibility of assistive devices.	SC	SC	SC	SC	SC	SC	NA	Procedures for providing the required variety of accommodations and assistive devices have been adequately developed at most facilities, Medical issues, including the provisions of glasses, hearing aids, and mobility aids showed continuing progress since the last audit.	The compliance rate usually had more to do with the degree of assistance and cooperation from other departments than the efforts of medical staff. Better assistance and transfer of necessary information from other departments, as well as specific guidance from Head-quarters, is needed to assure continuing compliance in this area.
58	The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards. Accommodations shall be made to afford equal access to the court, to legal representation, and to health care services for wards with disabilities.	Interview wards with disabilities and WDP coordinators to confirm accommodations.	SC	SC	SC	SC	SC	SC	NA	Reasonable accommodations or modifications were usually provided, though written documentation of specific procedures still needs improvement.	Procedures for providing the required variety of reasonable accommodations or modifications should be developed more fully, and department-wide documentation procedures should be implemented for continuing compliance.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
59	Qualified sign language interpreters shall be provided as necessary to ensure effective communication; at a minimum, for all due process functions, medical consultations, video-conferencing and special programs.	Review record of use logs for qualified interpreters.	SC	SC	SC-	SC	SC	SC	NA	There was only one deaf wards represented to be present at the facilities during the fiscal year. This ward presented distinct challenges, but it is felt DJJ responded appropriately considering contractual issues beyond its control. A use log form for interpreters was provided to the Auditor.	Continue to fine tune contracting procedures for interpreting services.
60	Reasonable accom-modations may only be denied if the accom-modation 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 accommo-dation to determine if alternative method provided reasonable access.	SC	SC	SC	SC	SC	SC	NA	Refer to two items 27 and 28 above for the basic provision of reasonable accom-modations. For this specific item, there were no specific instances identified where written requests for accommodation were denied in writing.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
61	The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings.	Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance.	SC	SC-	SC-	SC	SC-	SC	NA	Staff Assistants were usually provided for Board proceedings. It is unknown if other reasonable accom-modations were usually provided by the facility WDP coordinator or a member of the SA team. For further discussion, see items .	While Casework Specialists are doing a good job in assuring the presence of Staff Assistants, it should be realized that other accommodations may be necessary for certain disabilities, to allow wards with disabilities to represent themselves inde-pendently. Procedures for these should be prepared.
62	Departmental staff shall ensure wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans & the completion of required forms.	Interview wards with disabilities and Staff Assistants to ensure compliance.	SC	SC	SC	SC	SC	SC	NA	Assistance is adequately provided in parole planning, although the identified Staff Assistants are not usually involved in this process.	
63	Institutional parole staff will provide detailed information regarding the ward's needs and make recommendations to field parole staff regarding referrals to key community agencies and service providers.	Review sample of Parole Consideration reports for identified wards with disabilities. Interview institutional parole agents / Casework Specialists to ensure compliance.	PC	PC	PC	PC	PC	PC	NA	While a degree of information about wards with disabilities needs was typically included in parole reports, specific guidelines have not been developed in this area, nor were there any specific indications that community groups were utilized based upon a specific ward's disability.	Specific department-wide procedures should be developed to assure that parole reports provide more detailed information on wards' with disabilities specific needs for the continuation of accom-modations and special services. Standardized lists of local community support agencies should be developed so that they can be included in the parole reports.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
64	Institutional parole staff shall work collaboratively with field parole staff and Regional Center personnel to coordinate services, as forth in the remedial plan, for individuals with developmental disabilities and their families upon release.	Review sample of parole plans for identified wards with developmental disabilities. Interview institutional Parole Agents/Casework Specialist to ensure compliance.	NA	NA	NA	NA	NA	NA	NA	No wards with developmental disabilities were identified as recently paroled.	
65	The IIPA/Casework Specialist shall complete & forward the Case Report Transmittal Form, along with all supporting documents on the issue of a disability, to the PA III or Supervising Casework Specialist II, when scheduling a YAB hearing. PA I/C.S. shall be responsible for requesting accommodations for wards with disabilities during YAB hearing when a ward requests an accommodation, or when the PA I/C.S. is aware of a disability or should have been aware of a disability.	Review copies of Case Report Transmittal Forms. Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance.	PC	PC	PC	PC	PC	PC	NA	The Case Report Transmittal Form has been updated to include some disability information. However, these are not routinely placed in the wards' field file or otherwise used or referred to by Board members. See also item 35.	The Casework Specialists should print hard copies of these forms and place them in the Board packets prior to the Board meeting, and then place them in the Case Reports section of the ward's field file upon completion of the hearing, as described in the WDP Remedial Plan. Alternatively, DJJ may propose alternate methods for ensuring due process during Board hearings, for approval by the Disabilities Expert.
66	The Department shall ensure that aid is provided to all wards with disabilities who request assistance in requesting accommodations during YAB hearings.	Interview wards with disabilities and SA's to ensure compliance.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	1. Disciplinary Decision Making System										
67	To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct), all wards with disabilities who 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*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
68	Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education.	Review composition of SA teams.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
69	Disposition chairperson shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of disposition chairperson for compliance.	SC	SC	SC	SC	SC	SC	NA	The current disposition chairperson at each facility has been trained along with the SA team by the facility WDP coordinator or other facility trainer.	Since the "disposition chairperson" may change frequently, it is recommended that this item not be removed from future audits. There has been some confusion about who the "disposition chair-person" is intended to be. The Auditor's interpretation is that this is the DDMS Coordinator, who should review dispositions regularly to determine if effective communication is provided.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
70	The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive/ emotional disabilities & present an overview of the DDMS process.	Audit training module and review training records for compliance.	SC	SC	SC	SC	SC	SC	NA	The SA team members completed training given by the facility WDP coordinator during the fiscal year.	Since SA team members may change frequently, it is recommended that this item not be removed from future audits.
71	The facility WDP Coordinators shall review all DDMS/ grievance forms at least monthly to identify any patterns of misbehavior that may be related to cognitive and emotional disabilities.	Review monthly audit documents to confirm compliance.	PC	PC	SC	PC	SC-	PC	NA	Continuing and previous facility WDP coordinator were aware of the require-ment and generally reviewed DDMS forms and dispositions. Due to coordinator turnover at four facilities, it was difficult for the new coordinators to monitor this item. While mental health staff may have undertaken a general degree of review, there was no documentation that patterns of misbehavior were monitored to the extent necessary to determine if these played a role in the behavior.	Further review and refinement of procedures by Headquarters is needed, and further auditing is appropriate. Headquarters has indicated that mental health staff should undertake the detailed review of the patterns, and although there was no indication that this was occurring as described by DJJ, such additional policy is acceptable to the Disabilities Expert. However, this should not totally remove the facility WDP coordinator's general periodic review of the mental health staff's results.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	Grievance Procedures										
72	The SA shall be assigned to each grievance (from filing to resolution) involving a ward with a mental or physical disability who currently requires an accommodation.	Review completed grievance documents (Grievance Form-YA8.450, Appeal Form-YA 8.451) concerning wards with disabilities to ensure SA assistance through confirmed signature.	SC	SC	SC	SC	SC	SC	NA	The new grievance procedures (utilizing a grievance box in lieu of grievance clerks) was still not in full operation at most facilities during the audits. The facility WDP coordinator has usually (but not always) placed a sign stating that a ward may request a Staff Assistant to assist with filing, but it is unclear what effect this will have until the new policy is fully implemented.	It is recommended that auditing on this item be continued until the new grievance procedures have taken effect and can be audited and evaluated.
73	All grievance respondents shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of grievance respondent for compliance.	SC	SC	SC-	SC	SC	SC	NA	This is an open-ended item, since a number of staff members may be involved in the initial filing of a grievance. Effective communication training was given to a large number of staff during the last year, and while it is not known if this included all staff, it seems to have been a sufficient number.	Completed staff training at the departmental level would be needed to comply with this requirement.
74	The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental / physical disabilities and present an overview of the grievance process.	Audit training module and review training record of SA for compliance.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
75	The WDP Coordinator shall review all grievance forms at least monthly to identify any patterns of repetitive involvement that may be related to mental and physical disabilities and refer such cases to the appropriate supervisory staff.	Review monthly audit documents to confirm compliance.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM INITIALLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
76	Completed grievance forms should be randomly monitored by the facility WDP Coordinator to determine if indeed disability is an issue, even though the ward filing the grievance may not have specifically cited it.	Included in meetings with WDP Coordinators.	PC	PC	SC	PC	SC-	SC	NA	Continuing and previous facility WDP coordinator were aware of the require-ment and generally reviewed grievance forms and dispositions. Due to coordinator turnover, it was difficult for new coordinators to monitor this item. There was little documentation that patterns of grievances were monitored to the extent necessary to determine if a ward's disability may have been a factor in the grievance.	Further review and refinement of procedures is needed, and further documentation of this activity is appropriate.
77	The grievance screening process for accommoda-tions, 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.	SC	SC	SC	SC	SC	SC	NA	Records reviewed during the audits indicated general compliance that medical disability issues were resolved in a timely manner.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
78	The Wards Rights Coordinator, within 24 hours of receipt, shall review grievances, with attached documentation, that request accommodations or allege discrimination to determine whether the grievance meets one or more of the following criteria for review and response: allegation of non-compliance 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.	NA	NA	NA	NA	NA	NA	NA	No specific issues requesting accommodation unrelated to the medical issues described in the item above were specifically encountered.	It is recommended that procedures to facilitate the Wards Rights Coordinator's review of grievances related to accommodations and discrimination be prepared and implemented.
79	The Wards Rights Coordinator shall forward to the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 48 hours of receipt.	Audit grievances from ward with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination to confirm meeting timelines.	NA	NA	NA	NA	NA	NA	NA	No specific issues requesting accommodation unrelated to the medical issues described in the item above were specifically encountered.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
80	Grievances referred to the CMO when medical verification of a disability or identification of an associated limitation is required and returned to the Wards Rights Coordinator are handled within timeframes as defined within the remedial plan.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination to determine compliance of protocol within time constraints.	NA	NA	NA	NA	NA	NA	NA	No specific issues requesting accommodation related to the medical issues described in the item above were specifically encountered.	
81	If medical verification is not available in the UHR, and medical staff determines that a referral to an expert consultant, external to the department, is required, an 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.	NA	NA	NA	NA	NA	NA	NA	No specific issues requesting accommodation related to the medical issues described in the item above were specifically encountered.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
82	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 accom-modations or allege discrim-ination to deter-mine compliance of protocol within stated time constraints.	NA	NA	NA	NA	NA	NA	NA	No specific issues requesting accommodation related to the medical issues described in the item above were specifically encountered.	
83	The Wards Rights Coordinator shall refer a grievance to the facility WDP Coordinator when verification of a non-medical disability is required and ensure it is handled as defined within the remedial plan and within timeframes.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accom-modations / allege discrimination.	SC	SC	SC	SC	SC	SC	NA	It is believed that this procedure is being handled informally, although no departmental report form has been prepared. The facility WDP coordinators appeared to be aware of this requirement and reviewing such grievance forms.	
84	Wards may use the WDP Grievance process to file a grievance based on the denial of a request for a reasonable accommodation during YAB proceedings.	Interview wards with disabilities. Review grievances to determine compliance.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND WILL BE REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
85	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.	SC	SC	SC	SC	SC	SC	NA	There were no instances where a ward had an unresolved grievance relating to this item during the auditing period.	The new policy regarding additional time frames for wards with disabilities, as contained in the new Safety and Welfare policy, has only recently been approved and not yet fully implemented.
	D. Programs										
	1. Reception Center and Clinic Functions										
86	As part of the clinic screening and assessment process, all wards shall be screened at the reception centers, and as indicated, throughout their stay in the Department, to determine whether they have a develop-mental disability which may make them eligible under criteria set forth in the ADA and/or may make them eligible to receive services from a Regional Center.	Review screening documents in ward field files.	SC	NA	NA	SC	NA	PC	NA	Records provided showed that incoming wards were beginning to be formally screened using the KBIT for the presence of a developmental disability at the reception centers, during the fiscal year, with some beginning as early as September, 2008. See also item 115.	Reception centers should continue use of the KBIT, (as required on pages 27 & 28 of the WDP Remedial Plan) to screen and assess all incoming wards.
87	During the initial wards interviews, advise wards of their rights under the ADA and section 504, and receive formal documentation that they have received and understood this.	Observe random interviews at intake facilities.	SC*	NA	NA	SC*	NA	SC*	NA	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
88	Assigned Casework Specialists shall refer a ward to a mental health professional on a Mental Health Referral Form when indicators of a mental impairment exist that may limit a major life activity.	Review copies of Mental Health Referral Form for completeness.	PC	NA	NA	SC-	NA	SC-	NA	Documentation of a consistent use of a standardized referral form, as required by the WDP Remedial Plan, was not usually provided to the Auditor. Currently, the referral information is usually only entered into the WIN system, and there is no ability to document or track these referrals. Casework Specialists could use various forms, including a "Disability Referral/ Evaluation Form" (DJJ 8.288), "Mental Health Services Referral" form (as required by the remedial plan), a "Ward's Request for Reasonable Accommodation" form, or a "Critical Factors Assessment for Determining Need for Mental Health Evaluation" form, to refer wards to a mental health professional during intake.	Standardization of forms used by the three reception centers and guidance from Headquarters is needed to assure long-term compliance.
89	Assigned Casework Specialists shall refer a ward to a medical professional on a Disability Health Services Referral form when indicators of a physical impairment exist that may limit a major life activity.	Review copies of Disability Health Services Referral Form for completeness.	SC-	NA	NA	SC-	NA	SC-	NA	Use and documentation of the "Disability Referral/Evaluation Form" (DJJ 8.288) has increased at all facilities, and examples were usually provided to the Auditor. However, Casework Specialists still use various other forms and methods to refer wards to medical professionals during intake, and it was unclear how the "Disability Referral/Evaluation Form" (or other forms) fit into their procedures.	Standardization of forms used by the three reception centers and guidance from Headquarters is needed to assure long-term compliance.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
90	Assigned Casework Specialists shall use a Referral to School Consultation Team (SCT) form to refer a ward to an educational professional to verify the existence of a learning impairment that may limit a major life activity.	Review copies of Referral to School Consultation Team (YA 7.464) for completeness.	PC	NA	NA	PC	NA	PC	NA	Casework Specialists still use other methods to refer wards with learning disabilities to educational services during intake. The RSCT form YA 7.464 form is not typically used for this purpose, and it was not evident that the School Consultation Team (SCT) is routinely utilized to document a learning impairment referred during intake. This situation is worsened by the fact that Court-committed wards often arrive without an IEP or any documentation regarding their educational status (see items 29 & 31). Improvements in the SCT process are needed at all facilities.	Standardization of forms used by the three reception centers and guidance from Headquarters is needed to assure long-term compliance.
91	Licensed mental health professionals and medical personnel shall complete the screening process on a ward within 10 working days of a referral from an assigned Casework Specialist.	Review screening forms for complete-ness and timeliness: MH – SPAN/ YA 8.216; Med – Medical HX/YA 8.260.	SC	NA	NA	SC	NA	SC	NA	Based upon records provided to the Auditor, medical and mental health screenings typically occur within 10 days of the referral at the facility.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
92	Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for complete-ness and timeliness: Ed – CASAS, CELDT, High Point Testing, HX in file	PC	NA	NA	PC	NA	SC-	NA	The initial intake interview includes a checklist for educational needs. Based upon interviews and records review, it appeared that initial assessment plans were usually developed if indicated by the checklist, but not always within 15 calendar days, primarily due to incomplete IEP records arriving with wards.	
93	Within 10 working days of completing the disability screening process, department staff members who are licensed mental health professionals and medical personnel shall use standardized psycho-logical test instruments, medical, dental practices to assess wards.	Review appropriate documentation for completeness and timeliness.	SC	NA	NA	SC	NA	SC	NA	Based upon records provided to the Auditor, medical and mental health testing typically occurs within 10 days of the screening process.	
94	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness.	SC	NA	NA	PC	NA	SC	NA	For standard educational assessments (as opposed to referrals, see items), records indicated that a wide variety of educational assessments are either utilized or developed. In some cases, recent assessments from other sources are used to provide interim placement or schedule the IEP.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
95	If it is determined prior to or during the ICR that a ward is in need of an accommodation in order to allow for effective participation, the Supervising Casework Specialist II shall ensure that such accommodations are provided.	Review random ICR reports for wards with disabilities.	SC	NA	NA	SC-	NA	SC-	NA	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.	Since much of this procedure relies on the diligence of the Supervising Casework Specialist II, I would recommend that these procedures be written for future documentation.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
96	All wards shall complete the orientation process at a reception center that contains a standardized Disability module which shall include: 1) a summary of the main points of the Disability law under Title II of the ADA and IDEA and their relevance to wards, 2) a summary of the main points of the Department Disability Policy as it relates to wards, 3) an explanation of the Disability self-referral process, and 4) the Ward's Rights Handbook section on Disability.	Review orientation program for required components and audit ward-signed orientation forms to confirm participation.	PC	NA	NA	PC	NA	PC	NA	A formal "orientation process" for wards with disabilities, as described in the WDP Remedial Plan (Section III.J., page 10), was not occurring at the reception center at the time of the audits. It is evident that wards receive a packet of information regarding the Wards with Disabilities Program (in combination with twenty-one other orientation packets related to various programs). However, it is not clear that the computerized, standardized WDP orientation module, as developed by DJJ and approved by the Disabilities Expert, is being presented as intended, and the effectiveness of the current orientation, when combined with so much other information and given in random formats, is questionable. The basic "standardized Disability module" also needs additional information, particularly with respect to applicable current (2008) disability law, the IDEA, and the referral process.	It is believed that Headquarters is in the process of developing and coordinating the WDP orientation process, and it is hoped that the Disabilities Expert will be consulted early in this process to assure future compliance. Orientation should be formalized into a group setting, utilizing the "standardized Disability module" in the manner that was intended by its preparation. The departmental WDP coordinator should assist in coordinating and supplementing these efforts, and possibly even present the first few orientations, to effect implementation of this provision. In order to assure appropriate presentation, the facility WDP coordinator should present or be primarily involved in the presentation.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
97	Presenters of ward orientation program shall make the reasonable accommodations or modifications necessary for wards with disabilities who require accommodations during the orientation.	Review ward-signed orientation forms for documented information regarding provided accommodations.	PC	NA	NA	PC	NA	PC	NA	A standardized, comprehensive ADA orientation module was not currently being provided to all new wards. Procedures for providing and documenting accommodations were not yet developed, although it is believed informal presenters used various methods to provide appropriate accommodations. No ward-signed orientation forms documenting an accommodation were provided to the Auditor.	Written procedures for providing accommodations at orientation (usually held prior to the initial determination of accommodation need) need to be developed.
	Residential Programs										
98	For each special program or activity, evaluate eligibility criteria to assure that wards with disabilities are not excluded when they can perform the essential functions of the activity.	On-going audit, based on detailed factors listed in the plan. Visit special program locations yearly.	SC-	PC	SC-	SC-	SC	SC-	NA	Visits to unique programs and interviews with wards and program directors gave some but few specific indications that wards with disabilities were not included on an equal basis in special programs. However, for some programs, there were also no specific policies or procedures to assure 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 all of these programs. This evaluation did not include any criteria related to the Fire Camp, which was not visited or audited.	Written procedures for assuring equal access to all special programs need to be developed. The food service program, which has been limited during the past year due to funding issues, has been somewhat of a concern in the past, and procedures assuring that wards with disabilities are not excluded from this program should be developed.

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

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
103	Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for completeness and timeliness. Educ.- CASAS, CELDT, High Point Testing, HX in file	PC	PC	PC	PC	PC	PC	NA	While procedures are improving, there was no documentation provided indicating that this time line (admittedly a difficult one, and one which would be given some leniency) was being met.	
104	Within 10 working days of completing the disability screening process, Department staff members who are licensed mental health professionals and medical personnel shall use standardized psychological test instruments and medical and dental practices to assess wards.	Review appropriate documentation for completeness and timeliness	SC	SC	SC	SC	SC	SC	NA	Based upon records provided to the Auditor, medical and mental health testing typically occur within 10 days of the screening process (except for the screening for a developmental disability).	
105	Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness	SC	SC	SC-	SC	SC-	PC	NA	Based upon records provided to the Auditor, educational assessments typically, but not always, occur within 50 days.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
106	The Treatment Team Supervisor/ Supervising Casework Specialist shall ensure that within five days of receipt of WDP Assessment reports, from licensed mental health professionals, medical personnel, or credentialed education staff, that the assigned PA /Casework Specialist conducts a special case conference.	Audit case conference forms (ICP) for wards with disabilities to ensure implementation and timeliness.	SC	SC	SC	SC	SC-	SC	NA	Special case conferences and reports related to WDP assessments were beginning to be held at the facilities, although the exact time limits could not be verified. The facility WDP coordinators, Treatment Team Supervisors, and Casework Specialists are to be commended for initiating these important special case conferences.	
107	The PA/Casework Specialist shall document on the Individual Change Plan (ICP) form the following information: Impairment, Accom-modations, Current level of care, Classification code.	Review the ICP for documentation of information.	SC	PC	PC	SC	SC	SC	NA	This information is typically documented in the ICP, although there is still some reluctance to describing the exact impairment due to what is deemed to be confidential information by DJJ	
108	The PA or Casework Specialist shall ensure that copies of the changes in the status of a ward with a disability documented on the ICP form are forwarded to the following: Education Services for inclusion in the School Records File, Health Care Services for inclusion in the UHR, Casework Services for inclusion in the Field File	Review the School Records File form, the UHR and the Field File for documentation of information.	SC	SC	SC	SC	SC	SC	NA		DJJ has proposed that a modification to this item be presented to the Court.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
109	The Department shall ensure that staff reviews the level of care placement and any reasonable accom-modations for wards with disabilities at regularly scheduled case conferences.	Audit ICP forms for wards with disabilities to determine level of review.	SC	SC	SC	SC	SC	SC	NA	These issues are typically covered at case conferences.	
110	The Superintendent shall ensure that the following data is documented for all wards with a disability: (1) Name, age, YA number; (2) Location by facility, living unit, or parole office; (3) Specific impairment; (4) Impairments that substantially limit a major life activity: (5) Impairments that substantially limit a major life activity and require accommodations; (6) Specific accommodations; (7) Need for a Staff Assistant; (8) Level of care designation; (9) Classification code.	Review documen-tation for completeness of information.	SC	SC	SC	SC	SC	SC	NA	DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. The system is currently in use, but it is inherent that perfecting of the system will take some time. The efforts of the IT staff involved in the WIN system upgrades should be commended for their willingness to work with the WDP coordinators and include WDP-specific data in the system.	Continue to improve data entry and report techniques. More training on how to generate detailed reports is needed.
111	The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities.	Review modified materials.	SC	PC	SC	SC	PC	SC	NA	Some specific procedures for modifying materials were provided to the Auditor at some facilities. Even though there were no indications that wards with disabilities did not have equal access to informational materials, it is not ensured that these materials would be available if needed.	Prepare departmental procedures for modifying presentation materials for wards with disabilities (see also item).

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
112	The Program Manager shall ensure that a Staff Assistant (SA) is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions.	Review list of SA and assignments. Conduct interviews with SA & wards with disabilities to determine effectiveness.	SC	SC	SC	SC	SC	SC	NA	The SA teams have been set up at the facility, and accommodations are typically provided.	
113	The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities.	Interview wards with disabilities to determine access and participation.	SC	SC	SC	SC	SC	SC	NA	There were no indications that wards with a disability did not have equal access to the non-educational services listed.	
	3. Developmental Disabilities										
114	No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	Tour facilities to ensure compliance.	SC	SC	SC	SC	SC	SC	NA	No such signs of identification were encountered, although this item is moot since no programs for wards with developmental disabilities exist.	
115	Services will be provided to all wards identified as being developmentally disabled or who have been determined to need supportive services similar to wards with developmental disabilities, irrespective of age of onset.	Review departmental list of DD wards, program placement (YA 1.503) and ICP.	NC	NC	NC	NC	NC	NC	NA	No wards were specifically identified by the DJJ as being developmentally disabled, although it is unclear how and to what extent such determinations would be made at the facility. See also item. No programs for wards with developmental disabilities currently exist. See also items 24 & 86.	Use the KBIT or other approved testing instrument or assessment process to assess all wards at each facility. Complete the departmental planning study to determine types of programs and supportive services needed to serve these youth.

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
	4. Removal of Architectural Barriers										
116	The Department committed to the renovation of one room at each facility, as a minimum, to ensure the provision of accessible housing for wards with disabilities. The total completion of this project is scheduled for June 30, 2006.	Monitor the project completion timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
117	The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006.	Monitor the project timeline and visit each facility area upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
118	The Department committed to the removal of critical disability related structural barrier projects that will be completed each year from FY 2005/06 to FY 2008/09. These projects are part of the barriers that were identified by the survey completed by Access Unlimited and are identified in Appendix B to the Disability Remedial Plan.	Monitor the project timeline and visit each institution upon completion to ensure compliance with accessibility criteria.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	

No.	Item	Method	Ve	HS	Ch	SY	Clo	Pre	HQ	Comments	Recommendations
119	The Department committed to analyze 3000 additional barriers identified in the report prepared by Access Unlimited and provides a report that would categorize the barriers into three distinct areas. This report is due July 15, 2005, and will be filed at Appendix C to the Disability Remedial Plan.	Review, approve and submit required report.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
120	Construction of the first category of projects, which involves projects that can be fixed in a short period of time with minimum costs, shall be completed by September 30, 2006.	Audit first category projects for compliance of completion within defined timeline.	SC*	SC*	SC*	SC*	SC*	SC*	NA	ITEM PREVIOUSLY RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.	
121	The second category of projects, which involve projects that will require substantial funding, will be completed by Sept. 30, 2008.	Audit second category projects for compliance of completion within defined timeline.	NA	SC	SC	NA	SC	SC	NA	Recent court rulings extended this time period until December 31, 2009. Nevertheless, it is believed that all of these projetcs have been completed at the four facilities rated "SC". It is believed that nearly all of these have been completed at the other two facilities, except for the purchase of an adjustable exam table for the OHU's.	

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

Based on Site Visits Conducted

September 5, 2007 to June 6, 2008

FARRELL MEDICAL EXPERTS

Joe Goldenson, MD
Madie LaMarre, MN, FNP-BC

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Introduction

From September 5, 2007 to June 6, 2008 the Farrell medical experts conducted site visits to each DJJ facility and to Health Care Services to perform audits of compliance with the Health Care Services Remedial Plan (HSRP). Following the last site visit to headquarters, we requested additional information to further evaluate areas that were not evaluated during our two day review.

This report contains the results of the Health Care Services headquarters review as well as the executive summary for each of the facility reviews. Mental health and dental expert reports are provided separately. Certain information in the report has been updated based on recent comments and clarifications that DJJ presented to the experts in a letter dated May 8, 2009.

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

Reference Documentation

Complete facility reports will be forwarded as addendums to this report. Please see the following documents for more information:

- Preston YCF Health Care Audit - September 5-6, 2007
- Heman G. Stark YCF Health Care Audit - October 30-November 1, 2007
- Ventura YCF Health Care Audit - December 4-6, 2007
- Southern Youth Correctional Reception Center and Clinic Health Care Audit - January 29-31, 2008
- NA Chaderjian YCF - February 25-28, 2008
- OH Close YCF Health Care Audit - June 2-4, 2008

Executive Summary

During this period of review the Farrell medical experts conducted the first round of clinical audits utilizing the agreed upon DJJ Health Care Audit Instrument. The compliance scores for the facilities ranged from 61% to 81%.[1] We view this first set of audit compliance scores positively, and as a baseline for measuring continued improvements in health care services.

We note that during this review period, two DJJ facilities closed[2] and the DJJ population continues to decline. Increased staffing resources as well as the declining population has enabled DJJ staff to focus efforts on putting health care systems in place and rapid improvement is being made in every facility. Progress has been made despite challenges posed by the merger of DJJ with CDCR, whereby DJJ resources were reallocated to the larger agency but DJJ did not receive reciprocal services in a timely manner. This was exemplified by delays in processing medical contracts and hiring personnel. Despite lapsed medical contracts, staff reported that there were no serious problems with access to care as vendors continued to provide services without payment; however, there is a risk that a vendor may not continue to provide services thus impeding access to care.

DJJ has established a centralized model for health care delivery, supervision, and oversight. Our site visits showed that initially there was confusion regarding organizational structure and lines of reporting both at the facility and headquarters level. The agency has published tables of organization and memoranda to clarify the organizational structure, and confusion has largely been resolved; however, there are a few reporting relationships that still require clarification.[3]

DJJ has created a health care budget to enable the agency to monitor the allocation of expenditures. This budget initially contained non-health care expenditures (e.g., correctional officer overtime) but the agency is in the process of distilling the budget to contain only health care expenditures and bring greater accountability to the budget process. Regrettably, delays in passage of the state budget do not permit DJJ to receive and manage its health care budget at the beginning of the fiscal year. Thus, facility leadership frequently reported that they, for all intents and purposes, did not have a budget and were operating through deficit spending. This does not facilitate good fiscal management.

Health care staffing has increased at all facilities and this has continued even as the population has declined. The process of putting health care systems in place is initially staff intensive, but once completed, facilities can often perform well with fewer staff. Health care services has not developed, collected, and analyzed health resource utilization data that would enable DJJ to adjust resources in accordance with the needs and size of the population. This is an essential component in any health care organization to ensure that the services provided are reasonably cost effective.

Health Care Services (HCS) has developed and implemented a Quality Management Plan. It does not, however, ensure that all aspects of the Health Care Services Remedial Plan are reviewed annually, and does not encourage the facilities to identify and study problems unique to their facility. HCS has not implemented an external auditing process as required by the remedial plan. An external audit process is important to validate the facility quality management study findings.[4]

At the facility level, most staff we met were motivated to provide quality services to youth under their care. The cooperation between health care and custody staff has improved in all facilities, although there are still problems with consistent escorting of youth for appointments at some facilities. Sanitation of health care and housing units was problematic. Policy and procedure training and implementation were uneven, with at least one facility not having a complete set of health care policies.[5]

With respect to the implementation of the various health care services, we found that some services were working well (e.g. pharmacy, preventive services) or have dramatically improved (e.g. medication services) at all facilities.

Other services still require significant improvement. At most facilities the medical reception process was problematic in that clinicians did not consistently perform and document adequate history and physical examinations, identify medical conditions, and develop appropriate treatment plans for each active medical problem. This is particularly disturbing because DJJ adolescents and young adults are by and large a medically healthy population and the failure to adequately address the medical conditions they do have is a serious concern.

Another area of the remedial plan requiring further development is nursing sick call. Our review of sick call logs revealed that youth return to sick call repeatedly for minor complaints that would not warrant a visit to the physician in the community and/or do not warrant the frequency of visits. These complaints include athlete's foot, acne, mild headaches, etc. In many cases, the youth requires only patient education. With the development and implementation of nursing protocols, registered nurses could easily manage many of these complaints; but currently, all are referred to a clinician. This is not cost effective.

Other services are in varying states of implementation and levels of quality at each facility.

Finally, it is notable that during our period of review there was a death in March 2008. The youth died suddenly of natural causes and, in all likelihood, his death could not have been prevented. Our review of the incident revealed problems with the timeliness of the medical response and failure of custody staff to initiate CPR that had not been noted in the Death Review. The CMO informed us that these issues have been addressed through changes in procedures, training, and the acquisition of new equipment. While it is commendable that this occurred, we are concerned that the Death Review Report did not reflect these problems and corrective actions. A critical function of the death review process is the identification and documentation of system issues that may have affected the delivery of care as well as possible problems in the care provided so that corrective action plans can be developed that will improve future care.

In summary, although many areas still require significant improvement, we commend DJJ staff for the progress made to date, and are confident that with continued HCS leadership and support, progress will continue. We offer our support to DJJ in their efforts to improve health care services.

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
HCSD	Health Care Services Division
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 on June 4-5, 2008 to conduct an assessment of HCS progress with respect to implementation of the HCSRP. At that visit, we evaluated the status of health care using the 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).

Assessment: Partial Compliance

At the time of our First Report, DJJ had not finalized its Headquarters, Health Care Services, and Facility tables of organization. In March 2008, DJJ distributed Tables of Organization (TO) to the Farrell Experts. As in previous drafts, Health Care Services is placed within the Division of Juvenile Programs, along with Education Services and Integrated Behavior Treatment Model. The Statewide Medical Director reports to the Director of Juvenile Programs.

When the TO was initially published, the Director of Juvenile Programs position was vacant; however, it has since been filled by Doug McKeever, formerly the Director of Mental Health, HCSD, CDCR. The medical experts met with Mr. McKeever not long after his appointment and found him to be engaged and motivated to make the health services program successful. His experience in mental health provides a background for understanding the complexities of health care delivery. At a subsequent meeting, he noted that he would like to devote more time to Health Care Services, but acknowledged the need to focus on challenges related to his other areas of responsibility, particularly Education Services, which lacked a Superintendent.

The current table of organization is not in compliance with the remedial plan, which requires that the Medical Director report to the Chief Deputy of DJJ. As noted in the First Report, the medical experts agree that the remedial plan organizational model is not the only one that can promote success of the health care program. However, the current model has not been in effect long enough for medical experts to fully evaluate its effectiveness in addressing the complexity of the issues related to health care delivery[6].

We noted during this review period that the Director of Nurses left the organization. She reported to the experts that she made this decision because the executive administration had communicated to her that, due to conflicting needs within DJJ, the resources needed to fulfill her duties and meet the nursing-related requirements of the Remedial Plan were not available. Although efforts were made to retain her once she announced her decision to leave, it was unfortunately too late.

The medical and dental experts reviewed the DJJ Health Care Services TO dated 5/30/08. With respect to nursing services, we noted that the Public Health Nurse (PHN)[7] did not report to the Director of Nurses (DON). The PHN's responsibility was the coordination of TB skin testing for the organization. When the DON attempted to have the PHN perform other nursing duties, she was informed that the scope of the PHN's duties had been limited to TB skin testing when she returned from retirement, and she was not required to perform additional duties. Subsequently, the PHN position was removed from the oversight of the DON. This is not consistent with the Remedial Plan that provides for the Director of Nurses to "coordinate the selection, supervision, monitoring, and evaluation of nursing staff."

We also note that the DJJ Health Care Services TO does not designate a chief dental authority that is ultimately responsible for decisions regarding dental care. The current dental management is comprised of three chief dentists who all work in the field. Any effort to implement system-wide changes in the DJJ dental program will be compromised by lack of central dental leadership. Lack of a central authority will relegate resolution of disputes among the three chief dentists to the DJJ Medical Director. A physician does not have the knowledge base to make decisions about dental clinical care. DJJ should move to appoint a headquarters chief dentist.

Question 2: 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.

Assessment: Partial Compliance

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. We noted in our first report that the CMOs did not administratively supervise dental and mental health staff.

The Medical and Dental experts reviewed a facility organizational chart template distributed to the CMOs in May 2008.[8] The organizational chart shows that the CMO has line authority over administration, nursing, mental health, and dental services. It does not distinguish administrative from clinical supervision. Line supervision suggests both administrative and clinical supervision. A separate TO shows that the health care leadership in central office does provide clinical supervision over their facility counterparts.[9] Thus, there is conflict between these two tables of organization, which should be corrected.

On 10/9 and 10/22/08, we were provided updated facility tables of organization.[10] Some facility organizational charts show the reporting relationships to headquarters (PYCF), and others do not (SYCRCC). Ventura's organizational chart does not show dental services. We recommend that the facility tables of organization be made uniform with respect to showing the administrative and clinical reporting relationships to all disciplines (e.g. dental, nursing, etc.)[11].

With the development and implementation of uniform facility tables of organization, which show administrative and clinical supervision in compliance with the Remedial Plan and are supported by actual practices in the facilities, this area will be in substantial compliance.

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

Assessment: Substantial Compliance

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.
- The Chief Psychiatrist has returned from military leave.
- Pharmacy Services Manager
- Standards and Compliance Coordinator
- The Clinical Record Administrator position is unfilled. However, in December 2007, DJJ posted an invitation to bid for Medical Records Director Services that resulted in a consultant being hired. In addition, a Health Program Specialist II has been hired to oversee medical records. This individual is not credentialed in medical records.
- The Director of Nurses (Nurse Consultant III) was filled at the time of our review in June 2008.[12]

<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.

Assessment: Partial Compliance

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. As stated in the previous report, Dr. Morris reported that he is available when he is not in the office and often works more than 40 hours per week.

Dr. Morris has successfully overseen the development and implementation of the initial policies and is in process of developing new policies and revising previous policies. We incidentally note the DJJ process for developing and implementing policies is cumbersome and does not lend itself to timely policy development, review, and implementation. Although Dr. Morris previously has distributed chronic disease guidelines to the physicians, we are not aware of any formal chronic disease training provided to them, and our review showed problems with physicians following guidelines for certain conditions (see SYCRCC report).

During this review period, a statewide quality management program was implemented and facilities were in various stages of implementation during our site visits. However, a headquarters auditing process has not been implemented as required by the remedial plan (see Question #12).

The remedial plan requires the medical director to establish a system to evaluate staff productivity and fiscal accountability. To our knowledge this has not occurred, despite continuing decreases in the DJJ population and dire condition of the state budget[13].

The process of putting health care systems in place is often staff intensive, but once completed, facilities can perform well with fewer staff. Monitoring resource utilization and staff productivity enables DJJ to adjust resources in accordance with the needs and size of the population. This is an essential component to any health care organization in order to ensure that the services provided are reasonably cost effective. Any state agency that does not provide services in a reasonably cost-effective manner hampers its own credibility and ability to carry out its mission.

In April 2008, with intent to assist DJJ in evaluating resource needs, we requested that DJJ collect and provide us key health care data to assess resource needs. This information has not been provided to us.[14] We remain available to assist the Medical Director with development, implementation, and evaluation of staff productivity and resource utilization.

<u>Question 5.</u> 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.

Assessment: Partial Compliance

The Statewide Director of Nurses position was filled from May 2007 until August 2008. During her relatively brief tenure the statewide DON demonstrated impressive leadership capabilities and improved nursing services. She conducted a systematic analysis of nursing services,[15] described the strengths and weaknesses of DJJ's nursing structure and organization,[16] established statewide priorities,[17] identified needed resources, implemented training, and effected strategies within her control to improve nursing services within DJJ.

She developed and implemented a Nursing Services Quality Management Plan that included an evaluation of Supervising Nurses' (SRNs) capabilities to evaluate nursing practice in their facilities, and identified educational needs of the SRNs to promote their ability to evaluate the nurses. Through this program she determined that not all SRNs were completing nursing audits within their respective facilities. Of those that were conducting audits, the accuracy of the audits (as compared to her findings) ranged from 62.5% to 86% with a mean of 74%. She also noted that the SRNs as a whole were not able to identify nursing system issues evident from audit reports, and had difficulty recognizing how to effectively prioritize problems and use their time and resources effectively. She developed a corrective action plan to address the educational needs and professional development of the SRNs as well as the systems issues that were identified during the reviews.[18]

Under her direction, a nursing physical assessment curriculum was developed and implemented. We reviewed the curriculum and found that it provided useful information in performance of general 'head to toe' assessments, EKGs, and interpretation of laboratory tests. However, there was a key error in the curriculum regarding a fundamental aspect of nursing assessment and nursing documentation using the 'SOAP' format.[19] In the curriculum example of SOAP

charting,[20] the note incorrectly identifies subjective data as objective data. Our facility reviews showed that nurses were repeating this error in their assessments of patients, often leading to inadequate evaluations. We discussed this with the DON who concurred with our assessment. The curriculum should be corrected and nurses retrained regarding this content.

With respect to the structure of nursing services at headquarters, the DON identified a lack of nursing and administrative resources available to her to effectively carry out her responsibilities. For example, as noted above, the Public Health Nurse position was not under her direct supervision, thus, she was not able to use this resource to assist her in the development of infection control and disease surveillance programs. Due to other demands and priorities, the DON did not author or adopt a set of nursing protocols to provide clinical guidance to nurses working in the facilities.

In addition, not all nursing positions in DJJ are under the clinical supervision of the DON. Licensed psychiatric technicians (LPTs) who are governed by the Board of Nurses are not clinically supervised by nursing services but rather by mental health. Consequently, facility LPTs were not assigned nursing duties such as medication administration in the specialized housing units. Supervising nurses had to assign registered nurses to administer medications in these housing units, resulting in duplication of services. The DON attempted to resolve this in a manner that would ensure appropriate supervision of the LPTs and is cost effective to the state; however, this did not occur. She concluded that the only practical alternative was ultimately to turn these positions clinically and administratively over to mental health, recognizing that this would result in duplication of nursing services and increase cost. The medical experts understand and respect that the psychiatric technicians' primary duties are to the mental health program. However, to not fully utilize their skills as nurses is to create duplication of services, which is more costly to the state. Medication administration is a nursing function and requires clinical supervision by the supervising nurses. We recommend that DJJ amend the supervisory structure so that LPTs are clinically supervised by the supervising nurses and administratively supervised by the psychologists.

We reviewed a number of documents and memorandums demonstrating her ability to develop a range of options and potential solutions to identified problems. However, she found that she was not able to effectively implement these plans due to lack of resources. Ultimately, this led to professional frustration and her decision to leave DJJ. The medical experts believe this is a significant loss to DJJ.

<u>Question 6.</u> 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.

Assessment: Deferred

This area was not fully evaluated during this period of review. We are aware from site visits that the Superintendents and CMOs do not receive budgets in a timely manner due to the state budgetary process. We will explore this further during the next round of site visits.

<u>Question 7.</u> 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).

Assessment: Deferred

This area was not fully evaluated during this period of review. We are aware from site visits that the Superintendents and CMOs do not receive budgets in a timely manner due to the state budgetary process. We will explore this further during the next round of site visits.

<u>Question 8.</u> 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

<u>Question 9.</u> 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.

Assessment: Substantial Compliance

HCS staff has developed a structured, written orientation program for headquarters staff. 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).

<u>Question 10.</u> 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.

Assessment: Partial Compliance

The Office of Health Services, in collaboration with the medical experts, has developed an initial set of policies and procedures and accompanying forms. Since our last visit, the Peer Review, Credentialing, and Organizational Structure policies have been finalized. The policies and procedures have been disseminated to the field as Temporary Departmental Orders (TDOs). Facility staff has, for the most part, written local procedures to implement the statewide policy.

The health record policies and procedures with accompanying forms have not yet been developed.

We also note that the DJJ process of policy development, review, and finalization is a cumbersome process as evidenced by the fact that the current policies are still Temporary Departmental Orders.

<u>Question 11.</u> 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.

Assessment: Partial compliance

HCS has developed chronic care policies and procedures. Clinical guidelines from the NCCHC have been distributed to the medical staff. Training still needs to be provided for the clinicians, especially regarding the necessary elements of an adequate history for specific chronic illnesses, the assessment of degree of control, and treatment.

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

Assessment: Partial Compliance

HCS has developed a Quality Management Plan. The plan establishes a HCS Quality Management Team (QMT) which coordinates and facilitates the performance of quality improvement activities at each facility.[21] The Standards and Compliance Coordinator (SCC) leads the HCS QMT.

The plan also provides for each facility Quality Management Committee (QMC) to monitor and evaluate 2 aspects of care from the remedial plan each quarter (using indicators from the Health Care Audit Instrument); a total of 8 per year. In addition to the two aspects of care each quarter, each facility QMC is to evaluate emergency medical response drills conducted at each facility each quarter, monthly emergency room visit reports, emergency response reviews, and sentinel events reports.[22] Following the review of each aspect of care, the facility is to develop a corrective action plan for deficient areas. Because there are 18 separate facility audit tools, this

frequency of review (i.e., 2 per quarter) does not ensure that all aspects of the remedial plan are reviewed annually.

We reviewed the results of facility reviews for the months of May and June 2008. We noted that only partial reviews were conducted for each aspect of care (e.g. nursing sick call, chronic disease management). For example, the chronic disease management review at Preston in June 2008 consisted only of 2 of 10 screens found in the audit tool, and 4 of 10 screens in the medical reception audit tool. None of the documents we were provided contained corrective action plans in response to audit findings.

In addition to HCS-mandated quality improvement monitoring, it is important that each facility identify its unique problems for which the facility leadership should design and implement studies.

The facility-based quality improvement activities are an important component to the quality management program and DJJ is to be commended for implementing this aspect of the program. However, the facility monitoring activities do not replace the HCS clinical auditing process required by the remedial plan.[23] The purpose of the external audit is to conduct an independent review to validate the results of facility monitoring.

Prior to her departure in August 2008, the Statewide DON conducted external reviews using the HCS audit instrument to compare her findings with those of the SRNs.[24] Of the SRNs that were conducting audits, the DON determined that the accuracy of the audit findings ranged from 62.5% to 86% with a mean of 74%. The DON used the external auditing process to both educate the SRNs on how to interpret the audit tool correctly as well as to discuss the review results, identify problems, and assist the SRNs in developing strategies to correct the problems.

In addition, the HCS audit results should be used to compare against medical experts audit findings to determine whether there is consistency and validity in audit tool interpretation, and to discuss discrepancies in findings and conclusions. For example, the medical experts found significant problems with a physician's performance at Preston Youth Correctional Facility; this raised questions as to why the internal auditing/peer review process had not identified and corrected the performance issues. Also, the medical experts requested that HCS conduct an internal assessment of the HCSRP audit tool that applied to headquarters.[25] The result was a score of 100% for all areas except one.[26] These findings are not consistent with the medical expert's findings and warrant further discussion.

Finally, the remedial plan requires a comprehensive audit process using a multidisciplinary team consisting of a physician, nurse, pharmacist, dentist, and administrator.[27] A team approach enables more effective communication, identification, and resolution of problems, particularly those that are interdisciplinary in nature.

Following the HCS audit, the Standards and Compliance Coordinator is responsible for coordinating the publication and distribution of audit reports, and monitoring the implementation of corrective action plans. We recommend that each facility undergoes an external review audited twice annually until the system is confident in the facilities' ability to self-monitor; and

after that, a minimum of annually. The medical experts offer our assistance to HCS to develop this aspect of the Quality Management Program.

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.

Assessment: Partial Compliance

At our last review, the Clinical Records Administrator position was vacant due to recruitment difficulties. DJJ issued a Request for Bid (RFB) for a contract health records professional and in the spring of 2008, hired a Registered Health Information Administrator and Health Program Specialist II to develop health records and a health record management program. At the time of our visit, they had developed a working plan to develop a unified health record policy and procedures manual. This involved conducting site visits to each facility to get an overview of UHR processes, inventory current health records forms, and assess current health record maintenance and staffing. They also planned to review internal documentation and work processes related to health records that included: health record forms and organization, health technician desk procedures and security, access to and release of confidential health information, etc. Their goal was to complete all processes by December 31, 2008. This area is in partial compliance because health record policies and procedures have not yet been developed.

Statewide Pharmacy Services

Since our last visit, DJJ has hired a Statewide Pharmacy Manager who is a Pharm.D.[28] We were impressed with both his knowledge and interest in providing quality and cost-effective pharmacy services to youth.

Question 1. The Statewide Pharmacy Manager (SPM) in collaboration with key staff (nursing, medical) has developed and implemented comprehensive pharmacy policies. Pharmacy policies are reviewed annually and updated as necessary.

Assessment: Noncompliance

At the time of our visit, the SPM had not yet developed comprehensive pharmacy policies and procedures[29].

Question 2. The Statewide Pharmacy Manager, in collaboration with the Statewide Medical Director has developed and implemented standardized and cost-effective pharmacy practices. This includes standardization of dispensing practices, and consideration of alternate pharmacy models such as regionalizing and/or outsourcing of pharmacy services.

Assessment: Partial compliance

The SPM has developed and implemented standardized pharmacy practices at all facilities. This was demonstrated by pharmacy audit scores that, with one exception,[30] ranged from 90-100%.

The SPM has initiated studies of pharmaceutical purchasing practices by site to determine individual facility total and psychotropic medication expenditures, and provide feedback to facility and DJJ stakeholders. He also tracks pharmaceutical expenditures by type of medication and provider. For example, the total DJJ medication purchases from July-September 2007 totaled $568,002.69. Of that amount $294,756.91 (52%) was for psychotropic medications.[31]

To date, consideration of alternate pharmacy models such as regionalizing and/or outsourcing of pharmacy services has not yet been performed. This is not inappropriate at this time in that DJJ is collecting and analyzing data, which may be used for comparison to other pharmacy models.

Question 3. The Statewide Pharmacy Manager monitors staff productivity levels and recommends adjustments in staffing levels as appropriate.

Assessment: Deferred

The medical experts could not fully monitor this question at this time. We requested health care data from DJJ[32] including the number of prescriptions filled per month by facility as a basis for discussion and evaluation, but the data was not provided.

<u>Question 4.</u> **The Statewide Pharmacy Manager has constituted and chairs the Statewide Pharmacy and Therapeutics (P & T) Committee that meets Quarterly. The Pharmacy Manager produces and distributes minutes of the meetings to committee members.**

Assessment: Substantial Compliance

The SPM has constituted and chairs the Statewide P & T Committee that meets quarterly.

<u>Question 5.</u> **The Statewide Pharmacy Manager attends facility P & T Meetings on alternate months in person or via teleconference.**

Assessment: Substantial Compliance.

The Statewide Pharmacy Manager attends facility P & T Meetings via teleconference.

<u>Question 6.</u> **The Statewide Pharmacy and Therapeutics (P & T) Committee has developed or adopted a statewide drug formulary that is appropriate to the needs of youth and includes a non-formulary request process. The Statewide Pharmacy Manager monitors compliance with the statewide formulary.**

Assessment: Substantial Compliance

DJJ has adopted the California Drug Formulary as its own. Because this formulary is not youth-specific, we recommend that the Statewide P & T Committee review expenditures to determine whether any drugs should be made non-formulary.

<u>Question 7.</u> **The Statewide Pharmacy Manager develops a per youth/per month cost. The Statewide Pharmacy Manager and Health Care Administrator monitor trends in aggregate and per facility costs and present data at Statewide P & T Committee Meetings.**

Assessment: Partial Compliance

The SPM has published some data regarding per youth costs for psychotropic medications. Review of HCS Statewide Quality Management Meeting minutes from 9/18/02007, 12/12/2007, and 3/12/2008 did not contain any references to pharmacy data and per facility costs.

Facility Findings

Preston Youth Correctional Facility

The Farrell Medical Experts visited Preston Youth Correctional Facility on September 5-6, 2007. The facility scored 77% (553 out of 714 applicable screens/questions). The outpatient housing unit and medication administration in the housing units were not evaluated during this visit.

Since our last visit in November 2006, the population at the facility has decreased from approximately 400 to 350 youth. Overall, a number of improvements have been made since our last visit. Dr. Evalyn Horowitz is the Health Care Manager and the facility has two full-time physicians and a Health Care Administrator (HCA). Nurse staffing has been increased to 18 RN positions with two RN vacancies for which they are still recruiting. Staff reported that it is difficult to recruit because of uncertainty about relocation of youth programs.

There are still no finalized agency, health care, or institutional tables of organization. This has led to confusion among reporting relationships at the institutional level, particularly among nursing staff and has resulted in the publication of two memoranda[33] seeking to clarify the reporting relationships.

Dr. Horowitz believes she has full authority over hiring decisions, but does not have control of the budget. The HCA was given a budget for major and minor equipment, but not other aspects of the health care budget. In addition, Youth Correctional Counselor (YCC) positions and overtime are charged to the medical budget, but when staff tried to find out how many YCC positions were assigned to the health care budget they were not provided this information. The HCA reported that the business office had informed him that he was over budget. When he investigated, he discovered that they were over budget because over $700,000 had been charged to the medical budget for YCC overtime.

The HCA also reported that the cost of equipment and supplies, including computers, is to be automatically budgeted with new positions, but they have had difficulty obtaining these supplies and equipment in a timely manner when new employees are hired. They reported having no problems ordering medical supplies, but office supplies take longer. Apparently there is no statewide contract for purchase of office supplies, computers, copiers, etc. This may result in medical purchasing items that are different (e.g. copiers) from what is purchased by the business office. For example, the facility contracts that support copiers for one user group may not support copiers for another user group.

The facility had four Medical Technical Assistant (MTA) positions, but one was reclassified to a Youth Correctional Officer position (YCO). MTAs are being paid from the medical budget and perform medical duties. There is currently a 24/7 correctional officer assigned to the medical unit at the front desk and a 1.0 FTE in medical reception. These 3.85 YCO positions providing coverage in the medical unit are paid for from the medical budget. Staff advised us that a Budget Change Proposal (BCP) for additional YCOs was approved.

Health care leadership stated that they currently have enough nurses; however, if the medical reception mission is moved and the nurses are transferred with it, then they may not have enough nurses. Also, if they lose medical reception, they are told the correctional officer position will be reassigned, yet this officer also supervises other areas in the medical section (doctor's sick call, dental, and lab).

Staff reported issues regarding obtaining access to youth due to scheduling issues, and lack of sufficient numbers of correctional officer escorts. There are no dedicated officers for medical transports. Custody is making an effort and staff reported improvement from last year.

New employees are oriented in the personnel office and receive an abbreviated security orientation. More comprehensive three-day training is only conducted once or twice a year by custody. Following the security orientation, the health care orientation lasts 3-4 weeks, and is extended if necessary. The TDOs are still in effect and policies have not been finalized.

Sanitation in the main hallway was good but poor in some individual treatment rooms and offices. This is despite the hiring of a new janitorial position. There have been leaks in the ceiling in the x-ray room for some time but they have not been definitively repaired. Plaster and water have dripped down onto the uncovered x-ray equipment, with the potential to damage it.

Summary of Health Care Review

Medical reception scored 72%. Areas needing improvement are the quality of the medical history and physical examination, notation of current medical problems on the Problem List, and documentation of a treatment plan addressing all current problems.

Intrasystem Transfer scored 56%. Areas needing improvement are ensuring that a reliable system exists for notification of health care staff of transferring youth, the physician legibly signing, dating and timing review of the intrasystem transfer form upon arrival, and providing continuity of essential medications.

Nursing Sick Call scored 51%. Nursing sick call is not being conducted in a clinical setting, instead is being conducted in the dayrooms, without adequate privacy, equipment and the health record. Nurses have not been trained in health assessment and use of nursing protocols and not unexpectedly, the quality of assessments is poor. Nursing referrals to a physician are working well.

Medical Care scored 83%. Improvement is needed in documentation of patient education and documentation of implementation of the physician treatment plan.

Chronic Disease Management scored 82%. Improvement is needed in the quality of the database medical history and physical examinations, and administration of appropriate vaccinations.

Infection Control scored 100%. Congratulations!

Pharmacy Services scored 67%. Areas needing improvement include sanitation, implementation of monthly inspections and quarterly pharmacy and therapeutics meetings, and computer software capability to identify drug-drug interactions.

Medication Administration Process scored 92% (we did not review medication administration in the specialized treatment units and will do so at the next visit). The only area of improvement needed was to separate and label internal from external medications.

Medication Administration Health Record Review scored 87%. Areas that need attention include clinician documentation of route of administration with each order, and accurate transcription onto the MAR (the pharmacy is documenting date prescription was filled, not date of physician order).

Urgent/Emergent Care scored 88%. Areas needing improvement include implementation and documentation of emergency response drills, the quality of nursing assessments and timeliness of physician referrals.

Health Records scored 25%. Areas needing improvement include implementation of statewide and local policies regarding health record management, development of a laboratory and consultation tracking report system, and a record tracking system.

Preventive Services scored 96%. Congratulations!

Consultations scored 91%. Areas needing improvement include the development and implementation of a consultation tracking log (that addresses tracking of consultation reports; timely review of the consultant's findings, and meeting with the patient to discuss the recommended treatment plan.

Peer Review scored 20%. Areas needing improvement include development and implementation of statewide and local peer review policies and peer review activities.

Credentialing scored 71%. Areas needing improvement include the development and implementation of statewide and local credentialing policies and credentialing files that contain all required elements.

Quality Management scored 50%. Areas needing improvement include implementation of quality management meetings and studies, physician peer review and annual Quality Management Report to the Statewide Medical Director.

Heman G. Stark Youth Correctional Facility

The Farrell Medical Experts visited Heman G. Stark Youth Correctional Facility on October 30-November 1, 2007. The facility scored 64% (421 out of 657 applicable screens/questions). The facility population at the time of our visit was less than 800 youth. The medical experts found that there was an increase in collaboration and cooperation between custody and health care staff since our last visit. Satellite health care clinics have been equipped and supplied, and are actively in use. The Superintendent has dedicated correctional officers for medical escort purposes in the housing units, with the exception of a mental health unit, which is currently having problems with youth escorts for medication administration.

Summary of Health Care Review

Facility Leadership, Budget, Staffing, Orientation, and Training scored 33%. The CMO is a board-certified family practitioner who has been in place since May 2007. The SRN III and both SRN II positions are filled. Staff reports that one of their key positions, a Correctional Health Services Administrator II position, is occupied by an individual in headquarters and not available to be filled. Nursing staff reported there is not pay parity with CDCR and that, for example, a nurse at the CDCR adult facility, Correctional Institution for Men (CIM), which is also located in Chino, is paid more than a nurse at HGSYCF. We were not able to confirm this during our visit and it should be explored further by headquarters staff.

The CMO reported that he does not have a health care budget and that he does not know how much money is allocated for health care expenditures. At this time, the facility only tracks expenditures. We attended a Farrell implementation meeting. The Superintendent indicated that, not only was there no medical budget, but that DJJ had not established institutional budgets and that Stark was operating in deficit spending as a result. Staff also reported that they had ordered printers for the satellite clinics. However, once the printers arrived, the person in charge of information technology took them and put them elsewhere in the institution in non-medical areas because they were "too nice for medical." While the medical experts understand the need for coordination of computers and related software purchases, it is inappropriate that these medically purchased items were reallocated to another institutional department.

With respect to policies and procedures, the superintendent was concerned that the medical TDOs were distributed and implemented prior to training being provided for other non-health care managers. He believes that implementation of the TDOs was hampered because they were not distributed through normal channels with timely training.

The SRN III is concerned that he has insufficient nurse staffing to meet the expectations of the new policies and procedures, and that existing staff are not matched to the appropriate duties. For example, registered nurses are assigned to administer medications instead of licensed vocational nurses (LVNs) or psychiatric technicians. He believes that he may not require more nursing positions if, in collaboration with mental health, he had the authority to clinically assign all nursing staff, including psych techs. The Health Care Remedial Plan indeed requires that all nursing personnel are under the clinical supervision of the nursing chain of command; however, this is not the case at this facility at this time. Finally, the SRN reported that he was told that the additional nurses he received were to be dedicated to mental health even if the BCP Farrell

Position spread sheet stated that a positions was designated HC (health care) instead of MH (mental health).

Medical reception scored 43%. Although Heman G. Stark is not a reception center, by policy, youth who enter the system through parole revocation are to undergo the medical reception process. Although nurses are completing the initial screening form, in only 1 of 9 records did physicians complete a history and physical examination, document an appropriate treatment plan, and update the Problem List. Staff reported that the physicians are resistant to using the new history and physical examination form due to its length (4 pages). In addition, visual acuity (VA) is not being consistently measured for new arrivals, even when the most recent VA documented is several years old.

Intrasystem Transfer scored 54%. Areas requiring improvement include the completeness of nursing documentation upon the youth's arrival, timeliness of physician review, and physician signature and dating of the intrasystem transfer form.

Nursing Sick Call scored 48%. The nursing protocols and health assessment training have not yet been implemented system wide. Areas needing improvement include the quality of the nurse's history and physical examinations, nursing diagnoses, and plan of care.

Medical Care scored 71%. Areas requiring improvement included the history and treatment plan, and ensuring that the plan is implemented in a timely manner.

Chronic Disease Management scored 53%. The program is in the early stages of implementation. Areas requiring improvement included the initial history, frequency of chronic care visits, the assessment, the treatment plan, education, and vaccinations.

Infection Control scored 71%. Areas requiring improvement include training of the infection control nurse, and scheduling and consistent implementation of sanitation activities and inspection.

Pharmacy Services scored 93%. Congratulations! While the facility met the goal of 85%, an area that could be improved is that the computer software does not have the capability to identify drug-drug interactions.

Medication Administration Process scored 66%. Areas requiring improvement include sanitation in satellite areas where medications are prepared and administered, implementation of needle and syringe control, security escorts during medication administration in the mental health unit (Unit 1, lower level), and ensuring that the designated time for administration of hour of sleep (HS) medications is 2100 hours. This includes a one-hour window period before and after (2000-2200) to accomplish medication administration.

Medication Administration Health Record Review scored 75%. Areas requiring improvement include physician order completeness and accuracy, and documentation of a clinical note explaining the rationale for the order. In one case, the physician documented an incorrect dose for an HIV medication that was corrected by the pharmacy; however, the original order was not corrected.

Urgent/Emergent Care scored 81%. Areas requiring improvement included the accuracy of the log, emergency equipment checks, training, nursing evaluations, and physician follow-up.

Outpatient Housing Unit. This area was not evaluated because the facility does not have an OHU at this time. Staff currently transfers youth requiring OHU services to Southern Regional Youth Correctional Facility (SRYRCC).

Health Records scored 50%. Areas requiring improvement included development of a local policy and the filing of the problem list.

Preventive Services scored 85%. While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.

Consultations scored 74%. Areas requiring improvement included timeliness of consults and follow-up after the consultation.

Peer Review scored 0%. Areas requiring improvement include development and implementation of statewide and local peer review policies, and peer review activities.

Credentialing scored 71%. Areas requiring improvement include the development and implementation of statewide and local credentialing policies, and having credentialing files for all physicians that contain all required elements.

Quality Management scored 50%. Areas requiring improvement include ongoing quality management meetings and studies, physician review of nursing sick call, SRN review of nursing sick call, and annual Quality Management Report to the Statewide Medical Director.

Ventura Youth Correctional Facility

The Farrell Medical Experts visited Ventura Youth Correctional Facility on December 4-6, 2007. The facility scored 76% (530 out of 699 applicable screens/questions). The facility population at the time of our visit was 125 females and 76 males in the camp. There are currently five living units, plus the camp. The facility has made significant progress in improving health care services. Clinic sanitation is excellent; clinics are clean and well organized. We note however, that local policies have not yet been developed or implemented.

Summary of Health Care Review

Facility, Leadership, Budget, Staffing, Orientation, and Training scored 63%. The facility has not been provided an institutional or health care budget for the fiscal year, which is almost half over. The facility spends money as they deem necessary, without being able to determine whether they are over or under their budget.

Nurses continue to report lack of pay parity for selected classifications. We were unable to verify this during our visit and this should be explored further by Health Care Services.

We did not fully evaluate staffing during this visit. We did note that there were seven nursing vacancies for 21 budgeted positions. We toured the special counseling units Alvarado and BV. We interviewed the unit manager regarding daily activities of the youth and staff in the unit. He indicated that the youth are in school from 8:00 am-3:30 p.m., Monday through Friday. A registered nurse and two psych techs provide coverage for the two units for days and evenings. As of the week prior to our visit, it was decided that the registered nurse will not conduct sick call in the housing unit because the room does not have an exam table and youths are not permitted to be in the room unescorted for security reasons. Thus, the sole duties of the registered nurse are to administer medications for a total of 30 wards. On the day of our tour, there were no psych techs in the unit and we inquired as to their whereabouts. The unit manager reported that he didn't know.

Although there has been improved cooperation between medical and custody staff, there is a need for further cooperation and coordination of activities. Staff reported that officers do not consistently permit youth to be escorted to the medical clinic for scheduled appointments when medication administration is occurring. This is primarily because there is only one officer posted in the medical section who must be present during medication administration. If any other youth are brought to the medical section, another officer must be present and this does not consistently occur. Scheduled and unscheduled visits, as well as medication administration, are to be anticipated on a daily basis; custody posts should be established to provide supervision of these dual activities. During our review, we observed that a youth in emotional crisis was left alone and unsupervised in the medical clinic while the nurse called a physician to report the patient's condition. There must be adequate custody posts to provide health care services 24 hours per day.

Another area requiring improved cooperation is that when youth are scheduled for medications or clinical appointments and want to refuse these services, medical policies require that the youth refuse in person. However, we were advised that officers do not uniformly enforce the requirement to have youth report to the medical clinic to do so. Although youth have a right to refuse care, they do not have the right to refuse direction from a correctional officer.

Medical Reception scored 69%. Medical reception is generally occurring in a timely manner with exceptions. Areas requiring improvement include performing accurate and complete reviews of current symptoms; identification of active problems with a corresponding treatment plan for each problem, including known risk factors (obesity, tobacco, and substance abuse); and documentation of laboratory test result counseling. We recommend that clinicians review initial progress notes carefully to ensure awareness of problems not initially identified on the day of arrival.

Intrasystem Transfer scored 83%. The intrasystem transfer process is occurring in a timely manner. There is staff confusion regarding when to use the Intrasystem transfer versus medical reception logs. Areas requiring improvement include the development and implementation of a local policy, and to ensure that clinicians review, date, and sign the intrasystem transfer form in a timely manner.

Nursing Sick Call scored 62%. Youth requests are being collected and triaged in a timely manner; however, sick call is not being uniformly performed in clinical areas providing privacy. Not unexpectedly, nursing assessments are poor. Nurses have not received training in health assessment and nursing protocols. Areas requiring improvement include development of local policy, performance of nursing sick call in clinical areas with privacy, training of nursing staff regarding health assessment skills and nursing protocols, and a system for ongoing peer review and feedback to assist nurses in improving their assessment skills.

Medical Care scored 81%. Areas requiring improvement included the history of the presenting complaint, clinical assessment, and treatment plan.

Chronic Disease Management scored 77%. Areas requiring improvement included the initial history and frequency of chronic care visits.

Infection Control scored 50%. The infection control program is in development. Areas requiring improvement include provision of training to the infection control nurse, conducting infection control meetings a minimum of quarterly, and addressing key infection control indicators. As the program develops, staff should focus on data showing trends that health care staff should address (e.g. positive culture reports, % of TB skin test conversions, % of youth completing hepatitis vaccinations, etc.)

Pharmacy Services scored 92%. Congratulations! While the facility met the goal of 85%, an area that could be improved is that the computer software does not have the capability to identify drug-drug interactions.

Medication Administration Process scored 77%. Nurses administering medications to youth adhered to accepted nursing practices. The medication room was neat and organized, and all narcotics were accounted for. Areas requiring improvement include the development of a local

policy, compliance with time requirements for administration of hours of sleep medications, and improved cooperation between nursing and custody staff during medication administration. (Staff reported feeling rushed by custody because of scheduling issues, which nurses perceived did not permit them to follow proper medication administration procedures, increasing the risk of medication errors.)

Medication Administration Health Record review scored 84%. Although this area did generally well, there should be increased attention to accurate and timely transcription of orders, proper documentation of discontinuation of medications, and signatures on the MAR.

Urgent/Emergent Care scored 75%. Areas requiring improvement included the use of the SOAP format by nursing staff, nursing evaluations, checking emergency equipment, and performance of emergency training and drills.

Outpatient Housing Unit. This area was not assessed during this visit.

Health Records scored 25%. Areas requiring improvement included development of a local policy, need for a tacking system for laboratory and x-ray reports, and need for an accountability system for the UHRs.

Preventive Services scored 88%. Congratulations! While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.

Consultations scored 84%. Areas requiring improvement included follow-up after the consultation.

Peer Review scored 40%. Areas requiring improvement included development of a local policy, monitoring by statewide Medical Director, and biannual reviews.

Credentialing scored 88%. Congratulations! While the facility met the goal of 85%, an area that could be improved is the development of a local policy.

Quality Management scored 38%. Areas requiring improvement include development of a local policy, conducting of CQI studies, physician review of nursing sick call, SRN review of nursing sick call, and annual Quality Management Report to the Statewide Medical Director.

Southern Youth Correctional Reception Center and Clinic

The Farrell Medical Experts visited SYCRCC on January 29-31, 2008. Overall, the facility scored 72% (500 of 693 indicators). The facility population at the time of our visit was 202 youth in five housing units. In addition to the main clinic areas, there are two satellite nursing stations, one in the Marshall Intensive Treatment Program (ITP) and a clinic in Drake for youthful offenders. Youth housed in Drake are brought to the main medical unit on Tuesdays for medical services. The Outpatient Housing Unit (OHU) currently uses five beds for medical/mental health purposes. SYCRCC provides infirmary services for the population of Heman G. Stark YCF. We would particularly like to thank Ms. Sharon Brooks, Health Care Administrator, for the assistance she provided us during the review.

Summary of Health Care Review

Facility, Leadership, Budget, Staffing, Orientation, and Training scored 43%. All key leadership positions are filled at SYCRCC. Staff reported that they did not have an institutional table of organization. An area of concern was that health care leadership did not have a complete set of health services policies (24 out of 32). Some local policies had been developed but were missing sections from the statewide policy and had numerous typographical errors. Thus, staff have not been properly trained in health care policies and procedures. Although it was reported to us that the Chief Medical Officer was provided a health care budget, it is unclear to the medical experts that this is a functional budget. Staff reported that they have been given budget figures, but that the facility does not actually have the dedicated funds, and health care invoices are paid from a general fund.

Although there has been improved cooperation between medical and custody staff, staff reported that youth are not being consistently escorted to the medical unit, particularly when in temporary detention. Finally, although we did not conduct a formal staffing assessment during this visit, we note that staff continues to be added to the facility despite the decreasing population. For example, with respect to clinical staffing, there is a Chief Medical Officer and nurse practitioner. Yet recently a full time physician was hired. Moreover, the facility has a Chief Dentist and two full-time dentists. At the time of our visit, the facility was interviewing candidates for a fourth dentist. In the face of the current state budget crisis, we recommend that DJJ re-evaluate staffing needs before hiring new staff.

Medical Reception scored 63%. From the period of October-December 2007, the facility averaged 35 new arrivals per month. The staff uses the Medical Reception Tracking Log but it is not consistently filled out. The medical reception screening is not conducted in a manner that ensures visual and auditory privacy. Youth are not provided accurate written orientation materials. Review of medical records show that clinicians who perform the reception history and physical examination do not consistently obtain thorough histories and perform pertinent physical examinations. For example, a clinician did not document an adequate examination of the neck of a patient who reported a history of a neck mass that was potentially malignant. Moreover, in such cases previous medical records should have been requested. Clinicians also do not complete accurate and complete Problem Lists, and develop a treatment plan for each active

problem. In our view, the history and physical examination form contributes to these problems.[34] Clinicians should also address known risk factors (obesity, tobacco, and substance abuse).

Intrasystem Transfer scored 59%. The facility receives very few transfers. From June to December 2007, the facility averaged 3.5 transfers per month. We requested 12 records but only 4 were available for review. In general, the process is occurring in a timely manner. The nurses did not consistently complete all aspects of the form and clinicians did not sign the transfer form to indicate that they had reviewed the form and the record for pertinent medical problems requiring follow-up. Youth eligible for the chronic disease management were not referred for enrollment.

Nursing Sick Call scored 60%. The room where nurses conduct sick call in the main clinic is not properly equipped (no otoscope or ophthalmoscope). Youth health service requests are generally being collected and triaged in a timely manner, except for dental requests. Nurses forward all requests for dental services, including youth complaining of dental pain, directly to the dentist without first seeing the youth. We found instances of requests not being triaged by a dentist in a timely manner, despite having three dentists at the facility. In one case, a youth complaining of pain was not seen for six days after he submitted his complaint. Areas requiring improvement include development of local policy, performance of nursing sick call in clinical areas with privacy, training of nursing staff regarding health assessment skills and nursing protocols, and a system for ongoing peer review and feedback to assist nurses in improving their assessment skills.

Medical Care scored 69%. Areas requiring improvement include the documentation of the medical history, pertinent physical and laboratory findings, and the plan (follow-up).

Chronic Disease Management scored 51%. Not all patients with chronic problems were on the chronic disease log, including two patients with thyroid disease. Other areas requiring improvement include the initial and interval history, disease assessment, and vaccinations. We also found that the providers need additional training on the treatment of asthma. Numerous patients had histories of using their inhalers on a daily basis and were not prescribed inhaled steroids. While some of these patients may not be using their inhalers correctly and, in fact, may not require inhaled steroids, it is an indication that the providers are either not treating appropriately or not providing appropriate education.

Infection Control scored 63%. The infection control program is in development. Staff currently is not submitting case reports to the health department as required by local, state, or federal laws. Areas requiring improvement include provision of training to the infection control nurse, conducting infection control meetings a minimum of quarterly, and addressing key infection control indicators. As the program develops, staff should focus on data showing trends that health care staff should address (e.g. positive culture reports, % of TB skin test conversions, % of youth completing hepatitis vaccinations, etc.).

Pharmacy Services scored 100%. Congratulations!

Medication Administration Process scored 75%. In the main clinic, the medication room has old cabinets in disrepair with broken drawers and locks. Narcotic keys were kept in an unlocked drawer. The cabinetry and locks in this room should be replaced. An inspection of the medication cart showed that nurses pre-poured medications and did not document administration status on the MAR at the time of administration status.

Medication Administration Health Record review scored 88%. Congratulations! Although this area did generally well, there should be increased attention to proper documentation of discontinuation of medications.

Urgent/Emergent Care scored 70%. Staff maintained two separate logs to record urgent/emergent events, one for the daytime and one for the nighttime. There should only be one log. Other areas requiring improvement include the quality of clinician history, physical examination and assessments, checking emergency equipment, and performance of emergency training and drills.

Outpatient Housing Unit scored 63%. Patients housed in the OHU were not within sight or sound of the medical staff. Other areas requiring improvement include the admission and discharge nursing notes.

Health Records scored 100%. Congratulations!

Preventive Services scored 88%. Congratulations! While the facility met the goal of 85%, an area that could be improved is clinician identification and development of a treatment plan for youth who are obese.

Consultations scored 98%. Congratulations!

Peer Review scored 67%. Areas requiring improvement include development and implementation of statewide and local peer review policies.

Credentialing scored 67%. Areas requiring improvement include the development and implementation of statewide and local credentialing policies and having credentialing files that contain all required elements.

Quality Management scored 63%. Areas requiring improvement include QM studies, physician review of nursing sick call and OHU, and annual quality Management Report to the Statewide Medical Director.

NA Chaderjian Youth Correctional Facility

The Farrell Medical Experts visited NA Chaderjian YCF on February 25-29, 2008. Overall, the facility scored 61% (453 of 744 indicators).

The facility population at the time of our visit was 210 youths. Staff reported that there are plans to increase the population to 330 youth when departmental program moves are completed. Currently, they have 11 housing units open and ultimately plan to have 12 units. In addition to the main outpatient clinic, there is a clinic in the Intensive Treatment Program (ITP).

With respect to contracts and personnel, staff reported continued problems with both processes. The CMO advised us that the contracts for the local hospital (San Joaquin) and for Alpine orthopedic services have not been completed for the current fiscal year. In July 2007, they applied for an extension of the other specialty contracts for 60-90 days, which was approved, but it expired and was not renewed. Despite the lack of a contract, they are using the services but the respective vendors have not been paid. Staff believed the process worked more efficiently when DJJ had the ability to develop and implement local contracts.

The statewide nursing registry contracts for July 2007 to July 2008 were only recently approved and sent to them in January. Prior to this they were not able to use registry nurses because they did not have a contract. Moreover, these registries are statewide and they are required to call registries that may not be in their geographical area (e.g., West Covina for psych and pharmacy techs). After the registry recruits people, they have to go through the personnel approval process, which takes 2-3 months. In addition, staff reported that the primary delay in hiring is in the Livescan fingerprinting process. Apparently, the Livescan machine at the facility does not work properly resulting in some prospective employees having to come back five times for repeat fingerprint scans. Staff said they often are not even notified that there is a problem until a significant amount of time has elapsed. A request has been made to replace the machine but it has not been approved for reasons that were not made clear to us. They have lost a number of prospective employees due to the lengthy approval process.

We noted that significant improvements in sanitation had occurred in the Stockton complex OHU where there is a full time janitor. On the other hand, there are not dedicated or consistent janitorial services in the separate Chad outpatient clinic and Chad ITP clinic.

At the Chad outpatient clinic, there have been physical plant improvements. The walls in most rooms were painted and the hallway, office, and clinical examination room floors were recently stripped and waxed. The main clinic treatment room is somewhat cluttered and not as clean as other areas. This is undoubtedly due to its frequent use, which should result in more, not less cleaning and disinfection activities. There was no posted schedule of cleaning and disinfection activities in any of the clinical areas.

The ITP clinic is cluttered and the floors are dirty. Some of the furniture is old and in disrepair, and equipment is broken (e.g. copier). We understand that the youth are currently being housed in Mohave while Merced is under renovation, and strongly recommend that the ITP medical clinic be renovated as well.

Summary of Health Care Review

Facility Leadership, Budget, Staffing, Orientation, and Training scored 55%. Key health care leadership positions are filled. The Chief Medical Officer, Dr. Gabriel Tanson, is board-certified in family practice. Although it was reported to us that the Chief Medical Officer was provided a health care budget, it is unclear to the medical experts that this is a functional budget. Staff reported that they have been given budget figures, but that the facility does not actually have the dedicated funds; health care invoices are paid from a general fund. Although there has been improved cooperation between medical and custody staff, health care staff reported that youth are not being consistently escorted to the medical unit for medical appointments.

Contributing to this is the fact that the medical waiting area is used for youth awaiting parole hearings, which often prevents other youth from being brought up for medical appointments. There is no posted security staff assigned to the Chad outpatient medical unit, other than in the control unit outside the clinic. There is also no security post in the control unit after 5 p.m. When nurses give out medications, there is no dedicated correctional officer to facilitate the process. We recommend that the facility establish a correctional officer post for the medical clinic and control station for 16 hours per day, 7 days per week.

Although we did not conduct a formal staffing assessment during this visit, we noted that staff continues to be added to the complex despite the decreasing population. The Northern California Youth Correctional Complex (NCYCC), currently consists of NA Chaderjian (population 210), OH Close (population 184), and Dewitt Nelson (population 183). Dewitt Nelson is scheduled to close by 7/31/08. NCYCC is budgeted for a Chief Medical Officer, three physicians, and a 0.7 FTE nurse practitioner for approximately 580 youth. Even with the projected increase in population at Chad, the overall population of the complex will decrease by 63 youth with the closure of DeWitt Nelson. The 0.7 nurse practitioner was only recently hired and had not yet started at the time of our visit. In addition, physician permanent intermittent employees (PIEs) are used to fill in when physicians are on vacation. As previously recommended, in the face of the current state budget crisis, we recommend that DJJ re-evaluate staffing needs at these facilities.

Medical reception scored 42%. Youth who are parole revocators are receiving timely medical reception evaluations. The clinician who conducts these evaluations appears to be very conscientious. However, there are some system and clinical issues that affect the quality of the evaluations. One issue is that both the receiving medical screening and the history and physical examinations are being performed the day the youth arrives, yet staff reported that the health record was available only about 50% of the time. This has resulted in the clinician not having access to, and not addressing important historical information.

Moreover, the clinician does not adequately explore historical information that is provided at the time of the physical such as a history of asthma, TB infection, etc. One youth reported a history of hypertension and a 'mild stroke' for which no further information was obtained. The history and physical examination form contributes to the lack of a complete history. It contains a review of symptoms but the form does not require a yes or no response to each symptom, and it is unclear whether each question is asked. This should be done. The lack of access to the health

record also results in the Problem List not being updated when the physical examination is performed.

Nurses are not measuring visual acuity for newly arriving youth and both routine and specifically ordered lab tests are not consistently being implemented. Because DJJ policy does not require clinicians to write orders for ‘routine’ admission labs (RPR, Chlamydia and Gonorrhea urine screening, voluntary HIV antibody, and tuberculin skin tests), there is no system of transcription and accountability for carrying out the orders. Clinicians are not reviewing laboratory results until approximately three weeks after results are available, which is an undue delay. In addition, nurses are conducting post-test counseling in the housing units. This was reportedly due to escort problems. Post test counseling requires a confidential setting in which to answer questions and provide risk reduction counseling.

Finally, the clinician does not consistently identify each active medical problem, document a plan, and monitor the patient until the plan is implemented and the desired clinical result achieved.

In summary, we recommend that the health care leadership develop a medical reception process, in which the clinician does not perform the history and physical examination until the health record has been obtained and lab results are available. Clinicians should address all pertinent historical information and explore current symptoms more fully. Nurses should measure visual acuity of all newly arriving youth and notify patients of their test results in a medical setting that provides confidentiality. We recommend that clinicians write orders for any lab test, diagnostic procedure, and treatment the patient is to receive, and that completion of these tests be documented in the health record. DJJ may wish to develop a standardized physician order sheet for newly arriving or returning youth to save time for clinicians writing orders (sample is attached).

Finally, the clinician should update the Problem List with all current medical problems (including health risks such as obesity, tobacco, alcohol and drug use, etc.) and develop a treatment plan for each problem.

Intrasystem Transfer Scored 56%. The intrasystem transfer review process is occurring in a timely manner. However, in three of nine applicable records, the sending facility did not complete the top portion of the form. Nurses need to complete all portions of the form, including disposition of the patient. In four of ten records a clinician did not review and sign the form in a timely manner, or at all. Three of seven patients did not receive medications or have them renewed in a timely manner. Most significantly, five of seven youth did not receive appropriate and timely follow-up for chronic disease management, previously ordered consultations, and clinical monitoring. We recommend that clinicians perform a more thorough review of the youth’s previous medical history and treatment plan, and ensure appropriate follow-up and clinical monitoring.

Nursing Sick Call. We did not evaluate nursing sick call during this visit because health care leadership reported that all patients were being referred directly to a clinician. We will evaluate this area during our next site visit.

Medical Care scored 65%. Areas requiring improvement included the history and plan, and ensuring that the plan is implemented in a timely manner.

Chronic Disease Management scored 60%. Chad does not have a reliable chronic disease tracking system. The main clinic and ITP maintain independent tracking systems. When we requested the chronic disease tracking log, we were provided only the main clinic log, not the ITP. It was only after we inadvertently found a youth with HIV infection who was not on the list (who was housed in the ITP) that we realized there were two lists. Moreover, neither list contained the names of all chronic disease patients. This was not unexpected given that we found that newly arriving youth were not consistently enrolled in the program. In addition to the development of a reliable tracking system, other areas requiring improvement included the initial history, frequency of chronic care visits, the assessment, the treatment plan, education, and vaccinations.

Infection Control scored 38%. There are no local polices regarding the implementation of the infection control program. There is a nurse who is assigned infection control responsibilities. She is relatively new to her job duties and appears to be very conscientious. She has not received any formal training. Infection control meetings have been recently implemented but do not address all required areas. We discussed this with the infection control nurse and made some recommendations regarding meeting content and the need to address trends.

Pharmacy Services scored 100%. Congratulations!

Medication Administration Process scored 60%. Areas requiring improvement include sanitation of both the main clinic room and the Intensive Treatment Program clinic area. There is an accountability system for narcotics and syringes; however, during our review, we found narcotics in an unlocked bag and not double locked. It was reported that each evening narcotics are transported for the Chad clinic to the OHU to ensure that two nurses count and document accountability for the medication; this was reportedly why the nurse kept the narcotics in the bag for transport later that evening. However, this is a serious breach of security practices regarding narcotics. The DJJ Director of Nurses was present at the time of our observation, and addressed the situation with the nurse immediately and with the SRN the following day.

Medication Administration Health Record Review scored 80%. This area is doing generally well. However, nurses do not currently transcribe the physician order onto the MAR prior to the pharmacy filling the order. This should be done since there are no other checks and balances (aside from checking the original order) to assure that the dispensed medication is what the physician ordered or that the ordered medication was actually dispensed by the pharmacy (i.e., if nothing is on the MAR, how does the nurse know that a medication should have been delivered from the pharmacy?). Other areas of improvement include nursing documentation of administration status (e.g., administered, refused, etc.) for every scheduled dose onto the MAR. Nurses should also discontinue medication orders according to policy and standard nursing procedures. Nurses should refrain from crossing out the original order on the MAR as a mechanism to signal that the order is discontinued.

Urgent/Emergent Care scored 60%. The evaluation of urgent care involved inspection of emergency equipment and supplies in the main clinic and ITP. In both areas, the emergency response bag did not contain a list of standardized equipment and supplies. Thus, when the nurse checks the bag each day, the nurse has nothing to compare it against for completeness. In the ITP, the bag was disorganized. There was no peak flow meter. Ace bandages were old and stuck together. No emergency drills have been conducted. Our record review included both a sample of charts from the Chad emergency log and also the OHU log, which included youth from Chad. Our review showed concerns regarding nursing and clinical assessments, and clinical follow-up after patient visits to the emergency room.

Outpatient Housing Unit scored 73%. Areas requiring improvement include physicians writing complete admission orders and nurses documenting complete and appropriate assessments.

Health Records scored 0%. At Chad, we learned that if the person responsible for health records is on vacation, no one is assigned to complete her responsibilities. The health records are not consistently organized. The Problem List was not consistently visible upon opening the record. In some records, there was a tab for physician orders and in other records, there was not. The Receiving Screening form and History and Physical Examination form were filed in the progress notes rather than the database. Physician orders were found in both the progress notes and physician order forms. In fact, we found primarily medication orders on the physician order forms. This was reportedly because the pharmacy requested only pharmacy orders on the physician order sheet; however, we were later told that this was not policy. There was no tracking system for laboratory and consultation reports, or a reliable health record filing system.

We recommend that the facility: develop local policies to ensure compliance with the statewide policies; organize health records consistent with statewide policies; develop a laboratory and consultation report tracking system; and assign responsibility for health record duties when the assigned person is on vacation.

Preventive Services scored 79%. Areas requiring improvement include clinician identification and development of a treatment plan for youth who are obese, and follow-up of abnormal blood pressures.

Consultations scored 38%. Areas requiring improvement include timeliness of consults and follow-up after the consultation.

Peer Review scored 60%. Areas requiring improvement include development and implementation of local peer review policy and review of sentinel events.

Credentialing scored 88%. Areas requiring improvement include the development and implementation of statewide and local credentialing policies.

Quality Management scored 50%. Areas requiring improvement include ongoing quality management meetings and studies, physician review of nursing sick call, SRN review of nursing sick call, and annual Quality Management Report to the Statewide Medical Director.

OH Close Youth Correctional Facility

The Farrell Medical Experts visited OH Close on June 2-4, 2008. The facility scored 81% (444 of 550 Screens/Questions).

We would like to thank Superintendent Yvette Marc-Aurele and her staff for their assistance and cooperation during the audit. We were impressed by the staff's desire to provide the youth with quality health services. This was the first formal audit for the facility and there were a number of health care services that are doing well including medical care, chronic disease management, and the medication administration process. There did not appear to be any contract issues affecting health care delivery as there were at our last visit to the Northern California Youth Correctional Complex (NCYCC) in February 2008.

There were, however, some fundamental structural aspects of health care services that were not in place. This includes a complete and current set of policies and procedures to which staff has been trained, and a timely and comprehensive orientation program.[35] DJJ also has not developed nursing protocols and guidelines for the treatment of common conditions among adolescents and young adults, which are required by the remedial plan.[36] Although there is a health care budget now under the control of the Chief Medical Officer (CMO), the budget was not available to the CMO until more than half the fiscal year had passed.

The facility population at the time of our visit was 198 youths. Currently, there are 1.6 primary care providers (physician and nurse practitioner) at the facility, which is a clinician-to-youth ratio of 1:124[37]. This appears to be more clinical coverage than is necessary to meet youth needs. There is only one exam room so on the days that both clinicians are at the facility they alternate seeing patients in the same room. Moreover, our review of clinician patient encounter logs for the months of March-May 2008 showed that for the three-month period, each provider saw an average of 9.8 patients per day. The majority of these encounters were for minor conditions such as previously diagnosed acne that could be managed by nurses if nursing protocols were in place and staff were properly trained.

Recognizing that there are areas needing improvement, we wish to congratulate staff on their progress to date.

Summary of Health Care Review

Facility Leadership, Budget, Staffing, Orientation, and Training scored 67%. Positively, all key leadership positions are filled. The CMO is board-certified in a primary care field. The budget is now under the control of the CMO; however, this did not occur until more than half the fiscal year had passed. The facility does not have a complete set of local policies and procedures, and staff has not been systematically trained regarding the policies. The medical space consists of an examination room and a small office adjacent to the exam room. The examination room is cramped and often two clinicians (a nurse and Medical Technical Assistant (MTA)) occupy this area. There was no schedule of sanitation activities and it did not appear that the room had been thoroughly cleaned in some time.

Staff expressed concern that there was no officer posted in the immediate medical area. The closest correctional officers to the medical clinic were in the communication center. However, if a disturbance were to occur, these officers could not leave their post and would have to call for assistance. Staff was concerned whether the response would be timely. This concern should be discussed and resolved among medical staff and facility management. There were only two correctional officers designated as youth escorts, which staff reported sometimes delays youth movement and appointments.

Medical Reception is not applicable. Medical reception was not evaluated because the facility is not a reception center and does not receive parole revocators.

Intrasystem Transfer scored 80%. We found that not all transferred youth were listed on the log, but a review of those records showed that the intrasystem transfer review process did occur. Of concern is that in only one of five records of youth who were taking prescription medication, did the record show that continuity of medication was provided. In two cases, the findings may possibly be attributed to documentation issues: a MAR was missing and in another record the nurse did not date when the youth was given his asthma inhaler. Also, in 4 of 10 cases, clinical follow-up was indicated and did not take place. In two cases, youths with previously abnormal labs that warranted repeating were not noted and did not take place: one was enrolled in an obesity program for which follow-up did not occur, and one saw a psychiatrist who wanted follow-up in six weeks but this did not occur.

Nursing Sick Call scored 55%. Only the structural aspects of this area were reviewed because nurses are not conducting sick call. We found that there is no policy and procedure for nursing sick call at OH Close. Nurses have not been trained regarding health assessment and use of nursing protocols because they have not been developed by Headquarters staff. Consequently, youth requesting sick call services are referred directly to a clinician. Many youth are being seen repeatedly for minor conditions that in the community, they would not go to a physician for and could be handled by a nurse (acne, colds, athlete's foot) with proper training and protocols. On the other hand, we know that DJJ is reconsidering nursing sick call and the use of nursing protocols. It is possible that primary reliance on clinicians will be most efficient and effective. NOTE: There is no policy with respect to making rounds in detention areas and rounds are not documented daily.

Medical Care Scored 97%. Congratulations! While the facility met the goal of 85%, an area that could be improved is ensuring that all aspects of the treatment plan occur as ordered. The facility should be proud of its achievement in this area.

Chronic Disease Management scored 87%. Congratulations! While the facility met the goal of 85%, areas that could be improved included the initial history and the treatment plan.

Infection Control scored 50%. This area was subject to a limited review.[38] Areas needing attention include updating the 2005 infection control manual, ensuring that exposure control and engineering controls are in place to prevent transmission of communicable diseases, and the development and implementation of sanitation schedules.

Pharmacy Services. Pharmacy services were not reviewed during this visit since the same pharmacy serves both Chaderjian and Close, and the services were reviewed during our recent visit to N.A. Chaderjian. The evaluation we did during that visit applies to O.H. Close as well.

Medication Administration Process scored 92%. Congratulations! The only area that requires attention is to ensure that when youth are transferred back to the facility from the OHU, their record (including the medication administration record) and medications are transferred with them.

Medication Administration Health Record Review scored 75%. Although the medication administration process is going well, documentation in the record requires improvement. With respect to physician orders, in 3 of 10 records the physician did not document the route of administration. In 3 of 10 orders, the clinician dated but did not time the order. A concern is that when the nurses document medication orders as being transcribed, they do not actually transcribe the order at that time, but wait until the medication arrives and then place the label onto the MAR. Thus, when subsequent nurses view the MAR, they do not know there is a new order for a medication. This presents a risk that the medication will not be administered to the youth in a timely manner or at all.

For example, in the case of one youth taking TB preventive therapy, the nurse did not transcribe the order and the pharmacy apparently did not receive the order. The patient's MAR showed the old January order that was automatically printed by the pharmacy and not the one written in March. In 6 of 10 records, the patient received the medication within 24 hours of the medication being ordered. In only 5 of 9 records did the nurse document the administration status (e.g. administered, refused, etc.) on the MAR for each dose of medication.

Urgent/Emergent Care scored 54%. Areas requiring improvement include the accuracy of the log, nursing documentation, and nursing evaluations.

Outpatient Housing Unit. The Medical experts evaluated this area during our recent visit to the complex in February 2008.

Health Records scored 25%. Areas requiring improvement include: development of a local policy; a functional tracking system for laboratory and diagnostic studies; and a functional system for UHR accountability, filing, and retrieval.

Preventive Services scored 76%. An area that required improvement is clinician identification and development of a treatment plan for youth who are obese. In some cases, the calculated BMIs may have been higher than the current BMI since the patients' heights were based on heights that had been obtained at intake into the system. This issue was discussed with Dr. Morris.

Specialty Services scored 80%. Areas requiring improvement include the ordering clinician's documentation and follow-up after the consultation.

Peer Review. Peer Review was not reviewed during this visit since it was reviewed during our recent visit to the NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Credentialing. Credentialing was not reviewed during this visit since it was reviewed during our recent visit to NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Quality Management. Quality Management was not reviewed during this visit since it was reviewed during our recent visit to NCYCC Outpatient Housing Unit and N.A. Chaderjian YCF.

Recommendations

Headquarters

1. Ensure that all Department, Headquarters, and Facility tables of organization include all key positions and are consistent with one another. Ensure that the organizational structure for nursing is consistent with the HCSRP.

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 standardized nursing protocols and related training program. Amend the nursing health assessment curriculum to accurately reflect the nursing process. Once that is done, retrain all nurses.

4. Develop a complete set of health care policies that address all NCCHC Juvenile Health Care standards. Review and revise initial policies. Streamline the policy and procedure review, and development process.

5. Develop and implement a HCS clinical auditing program, consistent with the Health Care Remedial Plan. Conduct a study to compare the results of internal peer review with the experts' peer review results. Address any discrepancies with the medical experts.

6. Provide ongoing, interactive training to primary care clinicians regarding management of chronic diseases.

7. Develop, collect, and analyze measures of staff productivity and health care resource utilization. Adjust staffing and resources in accordance with facility resource needs and population.

8. Develop and implement a plan to evaluate the cost effectiveness of pharmacy services.

9. Develop and implement a standardized health record manual that contains policies and procedures, and related health record and ancillary forms. Provide training to the field.

10. Consider establishing Licensed Vocational Nurse positions in DJJ as has been done in CDCR.

Facility

11. Continue to improve sanitation of the health care units and satellite sick call areas.

12. Improve the quality of nursing and medical staff clinical assessments and documentation.

13. Conduct quality improvement studies for problems identified by the staff or medical experts.

14. Provide training related to the chronic disease program.

15. Develop a statewide program to address the problem of obesity in the DJJ population.

Endnotes

[1] Preston YCF 77%, HGS YCF 64%, Ventura VCF 76%, SYCRCC 72%, NA Chaderjian 61%, OH Close YCF 81%.

[2] El Paso de Robles YCF and Dewitt Nelson YCF.

[3] See Health Care Organization, Leadership, Budget and Staffing Questions #1 and #2.

[4] See Health Care Organization, Leadership, Budget and Staffing Questions #12.

[5] See SYCRCC report.

[6] Although at the time the medical experts conducted this review the DJJ's organizational structure did not meet the requirements of the Remedial Plan because the Medical Director did not directly report to the Chief Deputy Secretary. Since that time, DJJ has requested a change in the Remedial Plan to allow the Medical Director to report to the Deputy Director of Programs. When this change is approved by the Court, this reporting relationship will no longer be required.

[7] The Public Health Nurse is a retired annuitant.

[8] Memorandum dated 5/30/08 from Robert Morris MD to Chief Medical Officers regarding Facility Organizational Charts.

[9] DJJ Health Care Services, Field Structure Clinical Oversight, dated 4/25/08.

[10] See Proof of Practice documents #266 and #272.

[11] In DJJ's letter to the medical experts dated 5/8/09, DJJ states that their organizational charts are not designed to make a distinction between administrative chain of command and clinical oversight. The medical experts disagree with this position since clear reporting relationships are key to a successful program and due to the Remedial Plan, organizational relationships have changed. In addition, we note that several facility tables of organization do make the distinction between administrative and clinical oversight. The medical experts believe that organizational charts showing administrative and clinical oversight should be uniform throughout DJJ.

[12] The DON left her position in August 2008.

[13] In the letter to the experts dated 5/8/09 the State comments that DJJ Health Care has collected information on work product for clinicians and CMOs. The medical experts have requested this information since April 2008 and it has not yet been provided, nor an analysis of this work product. If this information exists, the medical experts look forward to reviewing and discussing it with Dr. Morris.

[14] We understand that DJJ is now conducting an internal staffing assessment; however in the absence of utilization data, it will be difficult to precisely determine staffing needs.

[15] Conceptual Considerations for the Function and Structure of DJJ Nursing Services, dated June 3, 2008.

[16] Statewide Nursing Services Structure within DJJ. Memorandum from Cathy Ruebusch to Doug McKeever dated January 11, 2008 and; Thoughts on Nursing Sick Call dated June 5, 2008

[17] Statewide Nursing Priorities within DJJ. Memorandum from Cathy Ruebusch to Doug McKeever dated January 11, 2008.

[18] Report on the Nursing Services Quality Management Plan, January to June 2008, dated May 28, 2008.

[19] SOAP documentation is a structured approach to documentation. The acronym stands for S=Subjective data, O=Objective data, A=Assessment or nursing diagnosis and P=Plan.

[20] Page 33.

[21] DJJ Health Care Services Quality Management Plan, page 1.

[22] DJJ Health Care Services Quality Management Plan, page 3.

[23] See Health Care Services Remedial Plan-Standards and Compliance Coordinator, page 12-13.

[24] Not all SRNs were conducting internal audits at that time.

[25] Health Care Organization, Leadership, Budget, and Staffing.

[26] Question #13 which relates to the clinical records administrator monitoring health record management at each facility a minimum of annually to ensure compliance with the HCSRP was assessed as being non-applicable when it should have been assessed as being partially compliant.

[27] Comprehensive means reviewing all aspects of the remedial plan requirements.

[28] A doctoral degree in pharmacy.

[29] In the letter to the experts dated 5/8/09 the state disputes this finding. The medical experts recognize that policies and procedures related to medication administration have been developed, but when we met with the statewide Pharmacy Director he reported to us that he had not yet developed policies and procedures related to pharmacy practices.

[30] Preston YCF.

[31] DJJ Pharmaceutical Purchases July-September 2007.

[32] Farrell Expert/Special Master Formal Request dated 4/16/08: Health Care Monitoring Requests.

[33] Reporting Relationships for Supervising Nurses dated August 29, 2007, and Utilization and Supervision of Licensed Psychiatric Technicians, dated August 29, 2007.

[34] Review of system questions such as ‘chest pain’ or ‘shortness of breath’ do not have a yes/no response so it is unclear whether the clinician asked the question or not. The physical examination section has prompts for examinations that may not be relevant to the patient’s problems. For example, under the Neck examination section it prompts an examination of the thyroid only. This is not the relevant examination for a youth with possible neck cancer. At the end of the form, instead of a section devoted to listing the patient’s diagnoses and a medical treatment plan, the clinician is only to indicate whether the youth is “cleared for all activity” or has any medical restrictions. Thus the form suggests its primary purpose is a medical classification tool. We have some suggestions and will forward them to Dr. Morris under separate cover.

[35] Basic facility orientation for new employees is not provided on a routine basis. We were informed that the most recent orientation occurred six months prior to our visit.

[36] DJJ has requested that the experts re-evaluate the value of nursing sick call. The experts are willing to consider replacing nursing sick call with clinician sick call. At this time, the plan requires nursing sick call. DJJ has placed the development of these protocols on hold pending the resolution of this issue with the experts.

[37] When the Farrell Medical Experts published their original report in 2003 the overall clinician to youth ratio was 1:262 which we determined to be more than adequate for the population size and medical acuity. At our February 2008 visit to the Northern California Youth Correctional Complex (NCYCC) we noted that the complex consisted of NA Chaderjian (population 210), OH Close (population 184), and Dewitt Nelson (population 183). Dewitt Nelson was scheduled to close by 7/31/08. The Complex is budgeted for a Chief Medical Officer, three physicians, and a 0.7 FTE nurse practitioner for approximately 580 youth. This is a clinician to youth ratio of one to 123 youth. In addition we noted supplemental physician staffing on a regular basis.

[38] OH Close does not have its own infection control nurse. There is a NCYCC registered nurse who has been designated the infection control nurse for the complex and this area was previously evaluated in February 2008 during the N.A Chaderjian visit.