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SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	Case No.: RGO3079344 EIGHTH REPORT OF SPECIAL MASTER

Pursuant to paragraph 28 of the November 2004 Consent Decree, the special master submits for filing the attached report. The special master's report and its appendices were circulated to the parties' in draft form. This final version reflects consideration of the parties' comments.

Dated: February 13, 2008

Donny Brorby
Special Master

SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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

EIGHTH REPORT OF SPECIAL MASTER

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. EDUCATION 1

III. ACCESS FOR YOUTH WITH DISABILITIES 8

IV. SEXUAL BEHAVIOR TREATMENT 12

A. Limited Progress in Sexual Behavior Treatment in Fiscal Year 2007-2008 13

B. DJJ Has Begun To Address Systemic Problems 15

1. DJJ Has Clarified the Responsibility and Authority of SBTP Coordinator But Has Not Established A Sufficiently Integrated Organizational Structure At The Facility 16

2. Little Progress Toward Curricula, Policies and Other Written Guidelines 18

3. Improvements in Record Keeping 20

4. Continued Failure To Develop And Implement An Assessment Protocol 22

5. Increased Management Flexibility May Result In More Appropriate Staff Assignments To The SBTP 23

V. CONCLUSION 24

APPENDICES

Appendix A: Gordon, O'Rourke, *California Division of Juvenile Justice Summary Education Program Report for School Year 2007-08*, (May 2008)

Appendix B: Hopper, *Introduction Auditing Activities for the 2007-08 Fiscal Year*, (February 2009)

Appendix C: Schwartz, Ph.D., *California Department of Corrections:Division of Juvenile Justice Sex Behavior Treatment Program Audit 3*, (August, 2008)

I. INTRODUCTION

This is a belated report presenting expert reports in the areas of education, youth with disabilities, and the sexual behavior treatment program. The expert reports were provided to the parties in mid-2008 and are appended. The reports are based on monitoring done during fiscal year 2007-08. To the extent that they document systemic issues, they are consistent with the evidence that was presented during the hearing on the order to show cause last year because they are based on monitoring during the time period that was subject of the hearing. The expert reports are not informative of what has happened since the hearing, though this special master's report provides some updated facts. The full update of these expert reports will be in the same experts' next reports, which the special master expects will be completed this spring or summer. The experts have completed a number of informal facility site visit reports since the period mid- and even late-2008, the results of which will be reflected in the "key indicators" or "dashboard" report that DJJ will file before the next case management conference.

Pursuant to the procedures that the parties, experts, and special master developed to guide the monitoring and reporting, the special master provided a draft of this report and the appended experts' reports for the parties' comments. The special master, monitor, and experts submit these final reports after consideration of the parties' comments.

II. EDUCATION

The Consent Decree education experts, Drs. Thomas O'Rourke and Robert Gordon, conducted their third round of compliance audits at all DJJ facilities during the period October 2007 through March 2008. Their third "Summary Education Program

Report" with two attachments 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 ("education plan"). Attachment A to the report details the education experts' findings with respect to each education plan compliance criterion. Attachment B displays the compliance status for each facility for each compliance criterion. The education experts reviewed and approved this section of the special master's report.[2]

DJJ's education policies are fully adequate and up-to-date as of the end of the 2007-2008 school year.[3] The special master previously has reported on DJJ's difficulties with policy development and promulgation in other areas.[4] It is particularly notable, therefore, that DJJ's education policies are in good shape.

DJJ quarterly reports now track expert findings relative to the *Farrell* standards and criteria. As DJJ reports, the experts' three annual reports show a trend of increasing compliance with education plan standards and criteria.[5]

The special master reviewed the experts' most recent facility-by-facility and item-by-item compliance report against their equivalent report for last year.[6] Of those findings that changed since the previous report, the majority reflected improvements in compliance. The special master also reviewed the education experts' commendations and

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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] E-mail of Gordon to the special master, September 16, 2008.
[3] *See,* Appendix A (O'Rourke/Gordon report), pp. 9-10.
[4] *See,* Seventh Report of the Special Master (April 2008), pp. 19-25.
[5] *See*, DJJ Quarterly Report (July 31, 2008), pp. 16-18. The special master's office has reviewed defendant's charts and calculations and has found them to be substantially correct.
[6] The education experts' report for last year, 2006-2007, is Appendix D to the Fourth Report of the Special Master. Both the 2006-2007 report and the most recent report, included here as Appendix A, each have three sections. The first section is a summary report. Each report's Attachment A provides a more complete description of each of the standards and criteria. Each report's Attachment B is a facility-by-facility and item by item compliance report

recommendations for this year against the prior year's commendations and recommendations.[7] Again, the changes reflect improvements in compliance.

The experts noted many areas of improvement in their report.[8] DJJ now employs a sufficient number and type of substitute teachers at five of seven facilities, compared with two of eight facilities last year. DJJ has established a teacher recruitment program and filled some vacant school psychologist positions. Three schools made progress towards semi-annual reviews of high school graduation plans for individual students, with only one school regressing. Central office staff provided training and technical assistance to sites that need to provide educational services to restricted housing units. At three facilities, site-based administrators consistently conducted quarterly teacher observations to document evidence of instructional planning, use of course syllabi, and delivery of the state approved curriculum, with only four facilities in noncompliance; no facility was substantially compliant with this requirement a year ago, when three sites were partially compliant and five sites were noncompliant. School sites have significantly improved their records of enrolling newly arriving students within four days and requesting their school records. DJJ has run a pilot program ("ABLE") for managing some youth who misbehave in school in a structured classroom, instead of suspending them from school. Some facilities have begun to provide distance learning opportunities. Central office personnel have made exceptional efforts to provide special education training statewide and to maintain training records. Regional program specialists have

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[7] This year's commendations and recommendations are Section III of their attached 2007-2008 summary report, Appendix A. Last year, the education experts' Section III only included their recommendations. The experts provided commendations to the special master in a memorandum that was not filed.
[8] The summary of improvements in this paragraph is based on Appendix A (O'Rourke/Gordon 2007-2008 report), pp. 5-9 (Section III) and Attachments A and B, criteria items 1.4, 2.3, 2.5, 2.8, 2.11, 3.3, 3.4, 3.34, 3.40, 4.15 -4.17, 4.21, 5.13, 5.14, 5.19, 5.24, 5.25, 6.5 and 6.6. and compare to the expert's 2006-2007 report, Appendix D to the Fourth Report of the Special Master. See also DJJ Quarterly Report (July 31, 2008), pp. 81-85; DJJ Quarterly Report (October 31, 2008), pp. 173-76.

conducted site reviews and are monitoring compliance with the consent decree's special education requirements. Central office and site-based administrators have developed collaborative agreements between clinic administrators and intake and courts services units regarding the IEPs of incoming students. There has been significant progress in transition planning for special education students, with five of seven sites in substantial compliance with the requirement that IEPs include related services and transition planning (four sites moved from partial to substantial compliance). There has been progress in ensuring that eligible students are granted waivers from the California high school exit exam and in providing remedial services to students who fail any part of the exam.

The education experts are optimistic that DJJ will succeed in implementing the education plan based on the considerable progress to date and the exemplary successes, particularly at Jack B. Clarke High School at SYCRCC, Johanna Boss High School at O.H. Close, and James A. Wieden High School at Preston.[9] Staff at these schools and facilities are congratulated on their efforts and achievements. The experts are not satisfied, however, with DJJ's progress to date in ensuring school attendance. Eligible youth must be in school to benefit from the improving educational services and make progress towards diplomas, GED certificates, and vocational certificates.[10]

State law and the educational remedial plan require DJJ schools to provide eligible youth with 240 minutes of instruction per day, for 220 days per year, in subjects leading to high school graduation. For the past two years, the experts have found two schools/facilities in partial compliance with these attendance requirements and the other

[9] Statements of O'Rourke and Gordon to the special master during the time that she prepared this report.
[10] *See*, Appendix A (O'Rourke/Gordon report), p. 6.

schools entirely noncompliant.[11] Also, the school sites generally failed to provide the compensatory services that are required for special education students to make up for missed and cancelled classes.[12] As the experts and special master exhorted a year ago, DJJ must implement strategies outlined in the remedial plan at both the central office and site levels to improve school attendance (e.g., the education plan requires policy and procedure to eliminate class cancellations, plans to remediate deficient attendance, attendance incentives, and school consultation teams for students with academic and behavioral problems).[13] All facilities must write agreements detailing how custody, treatment, and education management and staff will work together to ensure that youth receive education services, including a full school day.[14] The agreements should begin to address student absenteeism resulting from logistical issues and from conflicts between counseling and treatment appointments and class schedules. The education experts and the special master pointed to the critical need for these agreements two years ago.[15] Last year, the experts and master reported that two facilities audited in April 2007 had written cooperative agreements, following a written directive by DJJ's chief deputy

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[11] *See*, Appendix A (O'Rourke/Gordon report), Attachments A and B, criterion 3.15. No school/facility is substantially compliant with this requirement, and two are partially compliant, the same as last year.
[12] *See, id.*, Attachment B, p. 4, item 5.22. One school is substantially compliant; one is noncompliant; and five are partially compliant. Three noncompliant facilities progressed to partial compliance since last year's expert report.
[13] *See*, *id.,* Attachments A and B. Regarding items 3.6 - 3.8, the report reflects slight improvement in the use of SCTs, with nine substantial compliance ratings out of a possible 21. Three noncompliance ratings from last year's report converted to partial compliance ratings this year. However, only Weiden/Preston has a fully compliant SCT function. Regarding item 3.18, four of seven schools are rated substantially compliant with the requirement for plans to remediate deficient attendance; last year, only three facilities were rated as substantially compliant. As for item 3.19, two of seven facilities are substantially compliant with the quarterly corrective action plan requirement, compared to none last year. Two facilities are substantially compliant with the requirement for a policy and procedure to eliminate class cancellations (item 3.20); this is the same rating as given last year. Regarding item 3.23, there has been no net change in terms of students being held back from class. Three of seven sites are substantially compliant. Four of seven facilities are substantially compliant with the requirement for attendance incentives (item 3.29), whereas only three facilities were substantially compliant last year.
[14] Such agreements are required by the education plan. Education Services Remedial Plan, Section III.D.
[15] *See*, Second Report of the Special Master (June 2006), p. 19.

secretary.[16] It is inexplicable that, the following school year, none of the other facilities had put written agreements.[17]

Student enrollment in vocational classes continues to be very low.[18] Full utilization of these facilities and staff should be a priority for central office and site-based administrators to ensure that students are provided with employment skills to prepare them to re-enter the community.[19]

Instructional programs for both regular and special education students in restricted settings continue to be inadequate.[20] Segregated students are not offered access to full school day programming at any of the schools.[21] Central office and site-based administrators should pursue the use of technology, including distance learning, to increase educational service hours without compromising security for segregated students.[22] Additional staff and instructional space must be identified and provided in order to provide equal educational access to these students.[23]

Though progress is being made in the teacher recruitment and hiring process, only two school sites were able to finalize hires within a reasonable period of time.[24] This prolongs vacancies and reduces DJJ's chance of hiring the most competitive candidates.[25]

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[16] *See*, Fourth Report of the Special Master (July 2007), p. 25 and Appendix D, Attachments A and B, item 3.16.
[17] *See,* Appendix A (O'Rourke/Gordon report), Attachments A and B, item 3.16.
[18] *Id.*, p. 6.
[19] *Compare id. with* Fourth Report of the Special Master (July 2007), Appendix D (O'Rourke/Gordon 2006-2007 report). There has been no change in DJJ's level of compliance with this requirement.
[20] Appendix A (O'Rourke/Gordon report), Appendix A, p. 6.
[21] *Id.*, Attachments A and B, item 3.39.
[22] *Id.*, p. 7.
[23] *Compare id.*, p. 6 and Attachments A and B, items 3.36-3.39 *with* Fourth Report of the Special Master (July 2007), Appendix D (O'Rourke/Gordon 2006-2007 report). As noted above, DJJ began to implement distance learning at some sites last school year.
[24] *Compare* Appendix A (O'Rourke/Gordon report), p. 6 and Attachments A and B, criteria item 2.4 *with* Fourth Report of the Special Master (July 2007), Appendix D (O'Rourke/Gordon 2006-2007 report).
[25] *See*, Fourth Report of the Special Master (July 2007), p. 23.

As the education experts and special master reported a year ago, DJJ needs to improve the continuity of special education services as students enter DJJ and move between facilities.[26] DJJ needs to address many deficiencies in the processes for development and implementation of IEPs.[27] The ongoing issues of errors in the WIN management information system and difficulties establishing an interface between the WIN system and the special education data must be resolved.[28]

Beginning with the 2005-2006 monitoring cycle, the education experts and the special master highlighted the problem posed by DJJ's lack of a permanent superintendent of education.[29] DJJ's progress, particularly in the crucial area of school attendance, has been limited by the power vacuum in education administration. DJJ administrators rightly have refrained from hiring any candidate; a vacant position covered

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[26] Most sites have not implemented the system for requiring receipt of complete educational records for all students entering the DJJ system or transferring from one facility to another. Adherence to policies and procedures for records transfer needs to be monitored by central office and site administrators. There has been no progress in the development of written policy, procedures, or practices that would require DJJ and clinic administrators to work collaboratively with Intake and Court Service units to comply with regulations regarding the provision of IEPs prior to taking physical custody of the student. *See*, Fourth Report of the Special Master (July 2007), pp. 27-28 and Appendix D (O'Rourke/Gordon 2006-2007 report), Attachments A and B, Section V; O'Rourke and Gordon e-mail and memorandum to special master, June 5, 2007.

[27] School sites must immediately implement IEPs of incoming students. Any IEP change must be made by the IEP committee with adequate documentation or rationale. IEPs written by DJJ staff must address how the student's disability affects involvement in the general curriculum. All sites must improve the provision of general education classes in the frequency and duration indicated in IEPs. When the IEP requires access to the general curriculum, such access and a full school day must be provided. Supplemental aids and program modifications that support the student's involvement in the general curriculum must also be provided. IEP meetings must be held within the prescribed time frame, and documentation must be maintained indicating that regular education teachers absent from the IEP meetings were informed of IEP provisions for their students. Teachers must document progress reviews of IEP benchmarks and, when necessary, make IEP changes based on progress or lack thereof. Special education eligibility documents must be kept current according to guidelines. Central office and site-based administrators must address all of the issues of students' access and attendance in order to achieve compliance with both the Consent Decree and IDEA requirements. Central office and site-based administrators must not only monitor the completion of reports but also take responsibility for accuracy and timeline expectations to ensure quality control. *See*, Fourth Report of the Special Master (July 2007), p. 28 and Appendix D (O'Rourke/Gordon 2006-2007 report), Attachments A and B, Section V; O'Rourke and Gordon e-mail and memorandum to the special master, June 5, 2007.

[28] *See*, Fourth Report of the Special Master (July 2007), p. 28 and Appendix D (O'Rourke/Gordon 2006-2007 report), Attachments A and B, Section V.

[29] See, Second Report of the Special Master (June 2006), p. 20.

by an acting superintendent is better than an incapable permanent superintendent. Further, the education experts are impressed the capabilities of the current acting superintendent. Still, it is incumbent on DJJ administrators to determine why DJJ has not attracted competitive candidates and to devise a strategy to employ a strong, permanent superintendent.

III. ACCESS FOR YOUTH WITH DISABILITIES

From September 2007 through June 2008, the *Farrell* expert in physical and programmatic access for youth with disabilities, Logan Hopper, conducted his third round of compliance audits at all DJJ facilities. His "Wards with Disabilities Program Remedial Plan Auditor's Report," completed three years after DJJ filed the Wards with Disabilities Remedial Plan ("disabilities remedial plan" or "WDP plan") and two years after his first audit, is attached as Appendix B. The report's five-page summary of findings, conclusions, and recommendations is cogent and comprehensive.[30] The bulk of the report details central office and facility-by-facility findings.

DJJ has maintained the level of compliance with the disabilities remedial plan that was documented last year, largely due to the skillful efforts of the dedicated wards with disabilities program (WDP) coordinators and the support of superintendents and high-ranking supervisors.[31] Though there has been some turnover among central office coordinator staff, the coordinators remain a consistent force for implementation of the Wards with Disabilities Program.[32] Four facility-level WDP coordinators now have two

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[30] Appendix B (Hopper report), pp. 2-6.
[31] *Compare id. with* Fifth Report of the Special Master (October 2007), Appendix E (Hopper 2007-2008 report).
[32] Appendix B (Hopper report), p. 2.

or three years of experience, with concomitant gains in knowledge and effectiveness.[33] Every facility increased its percentage of substantial compliance ratings and decreased its percentage of non-compliance ratings between the second and third audit.[34] DJJ continues to progress ahead of schedule in modifying its buildings to improve accessibility.[35]

DJJ also has begun to address some noncompliance areas highlighted in Mr. Hopper's last report and in the *Fifth Report of the Special Master*.[36] Staff training in disability awareness and sensitivity has begun. All institutions now have qualified trainers and approximately 40% of staff has attended the training.[37] The training content is reasonably appropriate, though the disability expert still sees a need for DJJ to consult outside experts and consider their recommendations to improve the training, as required by the WDP remedial plan.[38] The version of the WIN system now in place has a new feature designed to permit recording and tracking of some information on disabilities.[39]

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[33] Appendix B (Hopper report), p. 2. After the completion of his last report, the disability expert learned that the facility WDP coordinator position was vacant at two of six facilities. Correspondence of Hopper to Angus, August 26, 2008. The remedial plan requires each facility to have a WDP coordinator. Disabilities Program Remedial plan, p. 4. The special master has no information whether any of the four most experienced coordinators noted above were among the two who were no longer in WDP coordinator positions as of August 2008.

[34] Data provided by Ugarkovich to the special master, August 19, 2008. Heman G. Stark's increase in substantial compliance was marginal (0.5%), but its level of non-compliance decreased by about 9%.

[35] Appendix B (Hopper report), pp. 4, 49-51.

[36] *Cf.,* Fifth Report of the Special Master (October 2007), pp. 32-33 (summarizing highlighted areas of noncompliance).

[37] Appendix B (Hopper report), pp. 4, 16. The disability expert once considered the lack of such training as one of DJJ's most significant noncompliance areas. *Cf.*, Second Report of the Special Master (June 2006), p. 17; Fifth Report of the Special Master (October 2007), pp. 32-33.

[38] Statements of Hopper during meeting with counsel and DJJ staff, February 29, 2008. The disability plan requires that DJJ obtain assistance from an outside disability advocacy organization or consultant in the preparation of the training materials. DJJ has not yet sought or received that plan-required assistance. Appendix B (Hopper report), p. 14.

[39] *See*, Seventh Report of the Special Master, pp. 35-36 (new disabilities tracking features installed for implementation of WIN Exchange, Spring 2008); e-mail of Eden to the special master dated March 10, 2008 (new WIN Exchange runs at most facilities, scheduled for installation at others within two weeks). Mr. Eden demonstrated the system for Mr. Hopper in August 2008, and Mr. Hopper informed him of

The omnibus WDP temporary departmental order, TDO #06-71, was distributed to institutions for implementation, starting with the training of all staff on the policy requirements.[40]

Despite the promulgation and training on the WDP TDO, "many DJJ staff are still not aware of how WDP Remedial Plan requirements relate to their department's activities."[41] Many facility line staff are not aware of requirements to accommodate disabled youth during uses of force, counts, searches, and transportation.[42] DJJ has not revised its specific policies governing discipline, use of force and other security procedures to require the accommodations provided in the WDP remedial plan and omnibus TDO.[43] As a result, facility staff do not and are not yet expected to comply with the omnibus TDO provisions concerning security procedures.[44] After the disabilities expert completed his report, DJJ provided the safety and welfare, mental health, and disability experts with draft policies on discipline and crisis intervention (including use of

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improvements that would be necessary. Mr. Hopper will continue to monitor the WIN disability feature. Statements of Hopper to special master during October 14, 2008 teleconference.

[40] DJJ Quarterly Report (January 31, 2008), p. 20 (policy and training materials promulgated); statements of Chief Deputy Secretary and WDP Coordinator, teleconference with OSM and experts September 16, 2008. Though the TDO provides new rules for discipline and use of force to accommodate youth with disabilities, those new rules are not yet binding on staff because general policies concerning discipline and use of force have not yet been modified to reflect the new rules.

[41] Appendix B (Hopper report), p. 3.

[42] *Id.*, p. 27. Again, the new requirements of the WDP plan which are also set forth in the omnibus WDP temporary departmental order have not yet been inserted into regular policies covering discipline and use of force. The requirements of the WDP plan and the omnibus disabilities TDO are not yet operationalized in DJJ.

[43] Statements of DJJ top management staff during teleconference with experts and OSM, September 16, 2008

[44] *Id.*

force) that have provisions for the accommodation of disabilities.[45] The experts have made extensive recommendations.[46]

Mr. Hopper observes 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.[47] Accommodations sometimes are delayed or not provided due to failure of other departments and staff to collaborate with WDP staff.[48] DJJ sometimes is slow to identify disabilities issues as they are presented and thus slow to consult the disabilities expert and/or DJJ WDP staff on issues of particular importance to youth with disabilities.[49] After the disabilities expert completed his report, DJJ provided him with draft policies on vision testing and eyeglasses, and psychotropic medications.[50] DJJ also provided the disabilities expert with a two-page summary "action plan" for youth with mobility or other physical impairments to integrate with the general population as soon as medical issues are resolved, including determining

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[45] The WDP plan (at pp. 40-45) requires that all staff be aware of accommodations afforded to youth with disabilities in developing and implementing these and similar facility procedures. DJJ conveyed draft policies by e-mails to Mr. Hopper and other experts dated August 12, 2008 (PoP #204, discipline) and September 5, 2008 (PoP #231, crisis prevention and management including use of force).

[46] Expert Hopper provided his comments to DJJ by e-mail dated September 4, 2008 (discipline) and September 18, 2008 (crisis prevention and use of force). The safety and welfare expert provided his comments by e-mail dated September 25, 2008 (discipline) and September 26, 2008 (crisis management and use of force) and during a meeting with DJJ on October 6, 2008 (crisis management and use of force). Statements of Krisberg to special master, October 6, 2008. The mental health experts provided comments on the draft policy on discipline by e-mail dated September 19, 2008. In December 2008, DJJ convened two conference calls with these experts and OSM during which expert comments on the disciplinary policy were thoroughly discussed.

[47] Appendix B (Hopper report), p. 3; statement of Hopper to special master during October 14, 2008 teleconference.

[48] *See, e.g.* Appendix B (Hopper report), p. 29 (commenting on variation in compliance rates with regards to provision of glasses, hearing aids, and medical devices).

[49] *Id*, p. 6; e-mail of Hopper to Ugarkovich, August 11 and October 3, 2008 regarding the psychopharmacology policy; e-mail Hopper to Ugarkovich, September 15, 2008 regarding vision testing and eyeglass procurement policy.

[50] E-mails of DJJ (Ugarkovich) to Hopper conveying PoPs #206 (psychopharmacy, August 11, 2008), #223 (vision testing and eyeglasses, September 3, 2008), and #260 (revision of vision testing and eyeglasses, October 1, 2008). The WDP plan (p. 14-15) requires DJJ to prepare adequate policies on psychopharmacy and vision-testing and vision aids in conjunction with the medical experts and disability experts and the no longer extant health care transition team. The medical and mental health experts also received and reviewed these policies.

the most physically accessible locations available and making required barrier removal improvements on a timely basis.[51] The disabilities expert has provided DJJ with his comments on these policies and action plan and awaits DJJ's next drafts.[52]

DJJ has failed to convene an interdisciplinary group to study the need for a residential program for youth with developmental disabilities, in consultation with the disabilities expert.[53] The disabilities expert and special master have repeatedly pressed DJJ to address this deficiency in its compliance with the WDP plan.[54] Director of Programs Doug McKeever promised Mr. Hopper that he would study the issue and then convene one or more meetings with Mr. Hopper and appropriate DJJ staff.[55]

IV. SEXUAL BEHAVIOR TREATMENT

The *Farrell* sexual behavior treatment expert, Dr. Barbara Schwartz, completed her third round of compliance audits in May 2008. She concluded her first round of audits in late 2005, and her second round in July 2007. The four DJJ institutions with residential sexual behavior treatment units were audited in all three rounds, but the Preston facility's "informal," outpatient SBTP was audited for the first time this year. Dr. Schwartz's report is attached as Appendix C. She has reviewed and approved this section of the special master's report.

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[51] E-mail of DJJ (Ugarkovich) to Hopper conveying PoP# 178 (action plan), July 11, 2008. The WDP plan (p. 14) requires DJJ to prepare the action plan in conjunction with the medical experts and disability experts and the no-longer extant health care transition team.

[52] Mr. Hopper sent his comments by email to Doug Ugarkovich dated September 15 (vision) and October 3, 2008 (psychopharmacology). Mr. Hopper informed the special master that he provided comments on the action plan by e-mail dated October 8, 2008.

[53] The study was supposed to commence in 2005. DJJ is required to develop and implement a plan to respond to the needs identified in the study, if any. The plan is required to include procedures to ensure that no outward signs of identification or labeling will be posted for wards involved in the program. Disabilities remedial plan, p. 26.

[54] *See,* Appendix B (Hopper report), pp. 5-6; *cf.,* Fifth Report of the Special Master (October 2007), p. 32; Second Report of Special Master (June 2006), p. 18 and Appendix E (Hopper 2006-2007 report), p. 2.

[55] Statements of McKeever during teleconference with experts and OSM, September 16, 2008.

A. Limited Progress in Sexual Behavior Treatment in Fiscal Year 2007-2008

Dr. Schwartz noted one significant advance during her third round of audits: all five facilities that offer sexual behavior treatment piloted the new "healthy living" curriculum on core treatment units and continue to use it.[56] The healthy living curriculum is conceived as the first step in sexual behavior treatment for most youth, and the only step for some.[57] The healthy living curriculum allows staff to assess youths' treatment needs and, if necessary, prepares youth for the curriculum delivered on a residential SBTP unit. Dr. Schwartz approved the curriculum before the pilot administration and she recommends that DJJ finalize the curriculum, continue to use it and attend to adherence to the curriculum design.[58]

DJJ has maintained the positive aspects of the sexual behavior treatment program that previously have been documented.[59] Each facility's multi-disciplinary team conducts client treatment reviews each quarter.[60] DJJ has implemented some aspects of a therapeutic community model (milieu therapy) in its residential SBTP units.[61] Individual facilities have implemented creative and successful initiatives, such as restorative justice

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[56] Appendix C (Schwartz report), pp. 2, 5, 6, 8, 16, 21, 23, 27, 49, 53, 62, 81, 98, 114, 115; DJJ Quarterly Report (July 31, 2008), p. 104; statements of McKeever during teleconference of DJJ staff, various experts, and OSM, September 16, 2008.

[57] *See* Fifth Report of the Special Master (October 2007), p. 29, n.115.

[58] During the monitoring period and pilot administration of the curriculum, it was not being presented uniformly. It was often taught without overhead projectors, or otherwise crucially deviated from the design of the curriculum's author. *Id.*, pp. 2, 4, 8-9, 16, 21, 23, 27, 114. Dr. Schwartz has expressed concern that the use of the curriculum without overhead projectors may have invalidated the pilot, though she generally approves of the curriculum. Statements of Schwartz during telephone conference, October 7, 2008; see also, Appendix C (Schwartz report) p. 48. A few DJJ SBTP clinicians also have expressed concern that the curriculum was not adequately piloted and modified in response to the pilot. OSM interviews at Chaderjian facility, October 2008. DJJ and the consultant who developed the curriculum apparently are in dispute over whether DJJ or the consultant owns the copyright. Statements of Dr. Schwartz during teleconference with the Special Master, February 9, 2009.

[59] *See* Fifth Report of the Special Master (October 2007), pp. 26-27; Second Report of the Special Master (June 2006), p. 14.

[60] *See* Appendix C (Schwartz report), pp. 41, 55, 72, 88, 102.

[61] Specifically, most facilities are holding large group sessions, and youth are becoming involved in charitable and other projects. *See id.,* pp. 37, 52, 68, 84, 99.

programs and mock parole boards at the Southern Reception Center, and theater and art projects at the Stark facility.[62] Many clinical and non-clinical counseling staff have therapeutic and caring interactions with youth.[63]

However, beyond the institution of the healthy living curriculum, which is a relatively small segment of the overall treatment program, DJJ has not made significant progress toward the development of a standardized sexual behavior treatment program.[64] Pre-remedial-plan curricular materials are in use but do not constitute an adequate or uniformly implemented curriculum.[65] Often, groups do not meet at fixed times[66] and youth do not receive the required number of treatment hours each week.[67] Inadequate program space also continues to be a problem for youth in the SBTP in some facilities.[68]

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[62] The Southern Reception Center's "Good Lives" model emphasizes positive goal development and community service. This facility also involves youth in a Victim Outreach Project which has included guest speakers for the youth. The youth raise money for a variety of charitable organizations, participate in mock parole boards, and present their Relapse Prevention Plans to the large community group. Appendix C (Schwartz report), pp. 15-17. Staff at the Stark facility have initiated a theater project and an art program coordinated by Pitzer College. Youth at Stark have also participated in a "Victim's Awareness Week." Appendix C (Schwartz report), p. 22. Dr. Schwartz recommends that such activities be incorporated into the overall model. *Id.*, p. 21.

[63] *See id.*, pp. 3, 7, 23.

[64] *See id.*, generally and especially p. 28.

[65] *See id.*, p. 8; statements of Dr. Schwartz during meeting of experts and OSM, August 29, 2008.

[66] Appendix C (Schwartz report), pp. 9, 27, 29.

[67] During fiscal year 2007-2008, documentation of treatment hours was incomplete and more treatment hours were provided than documented, but staff and youth report inadequate treatment hours. *See id.*, pp. 15, 21, 27, 29, 32-33, 51, 63-64, 82, 84, 95, 99. At the Southern Reception Center, for instance, the WIN system indicated that youth were receiving the required three hours per week of core group, but in reality they were not. Staff were frequently pulled away from delivering treatment hours by training, doctors' appointments, etc. Statements of Schwartz to OSM during meeting and teleconference with OSM, August 29, 2008 and September 5, 2008, respectively. At the Stark facility, group facilitators must send a written memo to security prior to every group session, requesting that security bring the youth to the designated room. Documentation revealed that sessions were not held because the facilitator "forgot to write the memo" or because security simply did not bring the youth to the session. Statements of Dr. Schwartz during teleconference with OSM, September 5, 2008.

[68] Treatment space is currently inadequate at the Chaderjian, Preston, and Stark facilities. Chaderjian and Stark are expected to move into new facilities, however. At Preston, "sensitive needs groups" and core groups meet in the visitors' hall, and it is unclear who has access to this area during the sessions. Dr. Schwartz observed both groups, and reported that "uniformed staff repeatedly interrupted the group to use the vending machines," and that a loud air conditioner made hearing difficult. Appendix C (Schwartz report), pp. 5-6.

Individual facilities and staff members currently apply varied and uncoordinated approaches to treatment.[69] Individual youth may receive beneficial treatment in this way, but the remedial plan requires DJJ to develop and implement a standardized treatment program.[70] That is the only way to provide evidence-based sexual behavior treatment to all relevant youth.

B. DJJ Has Begun To Address Systemic Problems

Dr. Schwartz and the special master noted DJJ's failure to make significant progress toward the development of a standardized sexual behavior treatment program in their last reports more than a year ago.[71] At that time, we identified at least six systemic issues: (1) the sexual behavior treatment coordinator's lack of authority and diffuse supervision of sexual behavior treatment staff; (2) the failure to develop core curricula, policies and procedures, and other written guidelines;[72] (3) multiple locations for record-keeping instead of a unified treatment record; (4) the failure to implement evidence-based initial and ongoing screening and assessment of risk and treatment progress and needs; and (5) labor rules and management practices that result in assignments of counseling staff to the sexual behavior treatment program without regard to training,

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[69] *See generally* Appendix C (Schwartz report). For example, one staff person at the Chaderjian facility "indicated that he or she has decided to make a major change in the treatment model without consultation with the rest of the Program." *Id.*, p. 11. Dr. Schwartz also reports that at Stark there is a "basic misunderstanding" of the existing treatment model. This may be due to the larger role played by youth counselors as compared to psychologists at Stark. *Id.*, p. 27.

[70] Sexual Behavior Treatment Program Remedial Plan, pp. 10-17.

[71] Fifth Report of the Special Master (October 2007), p. 27.

[72] The special master has previously reported in terms of "policies and procedures" and "curricula." The reference to "other written guidelines" above is the result of recent teleconferences with the *Farrell* experts and DJJ during which the experts have agreed with DJJ that not all written guidelines need to be in the form of formal policies and procedures. DJJ may prepare a program description or manual for the sexual behavior treatment program that covers matters that are not specified in formal policies and procedures. There will be formal policies and procedures establishing clear and binding rules in some areas, such as confidentiality and informed consent. Statements during teleconference of DJJ staff, some of the experts and OSM, September 16, 2008. Among other things, written policies, procedures and guidelines are necessary to establish criteria for the tracking of treatment progress. Fifth Report of the Special Master (October 2007), p. 30.

aptitude and program preference.[73] DJJ has been slow and tentative in addressing these issues, and little changed during fiscal year 2007-08. DJJ management began to address these systemic problems in spring of 2008. Continued management attention will be necessary.

1. DJJ Has Clarified the Responsibility and Authority of SBTP Coordinator But Has Not Established A Sufficiently Integrated Organizational Structure At The Facility Level

During the last monitoring period, DJJ clarified that the sexual behavior treatment program is a part of mental health services and that its coordinator reports to the top manager of DJJ mental health services.[74] In October 2008, Director of Programs Doug McKeever issued a memorandum explaining that the sexual behavior treatment coordinator "is the clinical and administrative authority for all treatment decisions for DJJ sexual behavior treatment" working "under the direction and with the support of the *Farrell* Mental Health Program Administrator, Dr. Arguello."[75] This was a positive step,

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[73] Fifth Report of the Special Master (October 2007), pp. 27-31. The need for systematic training to build clinicians' and counselors' treating skills is another systemic issue that belongs on this list. This report does not address the training issue in depth, however, because training content is largely dependent on the development of curriculum, policy, procedures, and other written guidelines.

[74] Staff reported in October 2007 that sexual behavior treatment was brought under mental health management. *Id.*, p. 27, n.107. Apparently that was not entirely official since neither mental heath services nor sexual behavior treatment were reflected in DJJ's October 2007 organization charts that were filed with the court. Sixth Report of the Special Master (December 2007), p. 5. Draft organizational charts dated February 29 and March 17, 2008 finally depicted mental health services and the sexual behavior treatment program, showing the coordinator reporting to the top manager for mental health services, but the first signed version of that chart that DJJ has provided to the special master was signed by Director McKeever on May 30, 2008. Before the decision was made to bring sexual behavior treatment under the aegis of mental health services, it was not clear who supervised the sexual behavior treatment coordinator. Fifth Report of the Special Master (October 2007), p. 27; e-mail of Schwartz to the special master, November 30, 2007.

[75] Memorandum dated October 1, 2008, to Superintendents, Chief Medical Officers, Chief Psychologists, Principals, Regional Parole Administrators, and Supervision Parole Agents regarding Authority and Role and Responsibility of the Sexual Behavior Treatment Program Coordinator. The October 1, 2008 central office health services organizational chart signed by Director McKeever is not entirely consistent with the memorandum. On the chart, Dr. Arguello is a senior supervising psychiatrist – supervising only psychiatrists -- and the SBTP coordinator reports to Dr. Morales, Chief Psychiatrist and Dr. Arguello's supervisor. DJJ provided the October 1, 2008 chart as PoP # 264, October 9, 2008. The mental health plan requires DJJ to have a senior mental health administrator to direct and coordinate implementation of

but no staff report to the coordinator; he thus has no authority to compel staff to take any particular action. Clinical staff have ignored important instructions that the coordinator has given.[76] Further, the McKeever October 2008 memorandum was addressed only to staff reporting to Director of Programs McKeever, not to the numerous non-clinical line counselor staff working within the sexual behavior treatment program at facilities.[77]

At the facility level, no sexual behavior treatment program manager has the authority to direct both the clinical and non-clinical sexual behavior treatment staff. At Chaderjian, there is no staff person who can be identified as leading the sexual behavior treatment program (even without the authority to supervise all staff providing services).[78]

The sexual behavior treatment expert believes that a clear and adequate organizational structure is a prerequisite to the development and delivery of the sexual behavior treatment program. She has raised this issue repeatedly in her reports and in contacts with top DJJ management.[79] Without clarity as to actual reporting relationships, the SBTP coordinator cannot ensure that remedial plan requirements are communicated to all appropriate staff by the appropriate supervisors. In November 2008, DJJ provided a

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the mental health and other remedial plans. Dr. Arguello was designated program administrator when he was acting Chief Psychiatrist. *See* Seventh Report of the Special Master (April 2008), p. 10. Apparently, now he is to be both senior supervising psychiatrist and the administrator responsible for the implementation of treatment programs.

[76] E-mail of Schwartz to OSM, December 16, 2008; statements of Schwartz during telephone conference with OSM, December 30, 2008.

[77] Sexual behavior treatment is provided to youth in facilities by clinical staff and by facility staff, mainly youth correctional counselors. The degree to which the facilities' SBTPs are administered by clinical versus non-clinical staff varies. *See* Appendix C (Schwartz report), p. 27.

[78] Statements of Schwartz during telephone conference with OSM and DJJ directors, September 16, 2008; *see also* Appendix C (Schwartz report), p. 11.

[79] Appendix C (Schwartz report), pp. 11, 15; statements of Schwartz to OSM during meeting of OSM and experts, August 29, 2008; statements of Schwartz during telephone conference with OSM and DJJ directors, September 16, 2008; e-mail of Schwartz to DJJ Litigation Coordinator Doug Ugarkovich, November 6, 2008; statements of Schwartz to OSM during teleconference, December 30, 2008.

diagram of "functional" and "direct" supervisory relationships among SBTP staff.[80] Although the diagram reflects an understanding of the expert's concerns, it is not an organizational chart that shows actual reporting relationships. It is instead a conceptual schematic, which does not affect management and supervisorial power and responsibility or staff accountability at the facility level. DJJ needs to establish an organizational structure within which clinical and facility staff work collaboratively, in order to foster an environment that serves treatment goals and to deliver treatment services in an organized and consistent manner.

2. Little Progress Toward Curricula, Policies And Other Written Guidelines

DJJ's only SBTP curriculum is the healthy living curriculum discussed above. This is an introductory curriculum. Previously documented CDCR contracting and payment difficulties disrupted the work of DJJ's SBTP curriculum consultant from April 2006 through at least July and perhaps September 2007.[81] The consultant was thereafter under contract to produce three curricula by June 30, 2008: the healthy living curriculum, a residential program curriculum, and an outpatient curriculum derived from the inpatient curriculum. The contract expired on June 30 and was not renewed.[82] The curriculum has not yet been completed.[83]

Now Dr. Schwartz is working closely with the SBTP coordinator to organize an internal effort to produce the residential program curriculum. Dr. Schwartz is cautiously optimistic that the sexual behavior treatment task force can produce an appropriate

[80] E-mail of Ugarkovich to OSM, November 5, 2008; PoP #278 (Sexual Behavior Treatment Programs Structure), November 5, 2008.
[81] *See* Fifth Report of the Special Master (October 2007), pp. 29-30.
[82] DJJ and the contracted consultant are in dispute regarding the reasons for the termination of this contractual relationship. Statements of Schwartz to OSM during teleconference, January 16, 2009; DJJ Quarterly Report (October 31, 2008), p. 209.
[83] Statements of Schwartz to OSM during meeting of experts OSM, August 29, 2008; *see also, e.g.*, DJJ Quarterly Report (October 31, 2008), p. 209.

curriculum with her assistance, based on her own expertise in curriculum development, Mental Health Program Administrator Arguello's representation that DJJ will procure necessary materials, and Director of Programs McKeever's professed support.[84] In approximately October 2008, the SBTP coordinator arranged for two on-line training courses that Dr. Schwartz completed and particularly recommended to be available free of charge to task force members.[85] Dr. Schwartz believes that these trainings will establish a sufficient basis for the curriculum development effort.[86] As of the end of 2008, however, none of the task force members had completed the trainings.[87]

A table of contents for the SBTP description and policies and procedures has been approved by Dr. Schwartz, but the content of the policies, procedures, and program description largely remains to be developed.[88] DJJ completed a draft program overview

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[84] Statements of Schwartz to special master during telephone conference, November 3, 2008. Her optimism is cautious because DJJ was been slow to follow her advice in June 2008 to seek certain materials and obtain necessary training to prepare for curriculum development. First, the SBTP coordinator randomly solicited curricula from across the nation and other English-speaking countries for possible use and received nothing of value to a program for youth in a correctional setting. Statements of Schwartz during telephone conference, October 7, 2008; *see also* DJJ Quarterly Report, (July 31, 2008), p. 104. Dr. Schwartz also strongly recommended to the chief deputy secretary and the director of programs that the SBTP coordinator attend an international sex behavior treatment conference in Atlanta Georgia at the end of October, because that would be a fast way for him to identify curricula and materials that would be useful to DJJ. Statements of Schwartz during telephone conference of DJJ directors and OSM, September 16, 2008. She was referring to the "ATSA" conference. DJJ management declined, citing time considerations and staff attendance at sexual behavior treatment conferences in the past. Statements of Warner during telephone conference with DJJ directors, OSM, and Dr. Schwartz, September 16, 2008.

[85] As noted above, on November 4, 2008, the SBTP coordinator instructed certain SBTP staff members to take the on-line NEARI training by November 30, 2008. E-mail of Martin to select SBTP staff, November 4, 2008.

[86] E-mail of Schwartz to special master, November 4, 2008. The trainings are by New England Adolescent Research Institute (NEARI).

[87] Statements of Schwartz during telephone conference with OSM, December 30, 2008; e-mail of Martin to Schwartz, December 16, 2008.

[88] Appendix C (Schwartz report), pp. 28, 41-42, 107, 109. In October 2007, this office reported that no discernible progress toward the development of SBTP policies and procedures had occurred. Fifth Report of the Special Master (October 2007), p. 28. In July, DJJ reported that a first draft of one of three sets of SBTP policies would be completed within the next quarter and provided to Dr. Schwartz for review. DJJ also states that completion of this policy is dependent on completion of program curricula. DJJ Quarterly Report (July 2008), p. 104.

in November 2008, which Dr. Schwartz found to be vague and lacking in substance.[89] DJJ still lacks sufficient informed consent and confidentiality policies and procedures, which means that youth continue to receive sexual behavior treatment without meaningfully consenting to it and without fully understanding the potential legal repercussions of their disclosures during treatment.[90] Providing sexual behavior treatment to youth without appropriately documented informed consent raises immense ethical concerns and jeopardizes the licenses of clinicians.[91] Dr. Schwartz has raised this issue with DJJ management and counsel since her involvement with *Farrell* began, thus far to no avail.[92] DJJ has included the policy on informed consent and confidentiality on its list of policies with the highest priority for development.[93] According to DJJ, development of confidentiality and informed consent policies is in the "[a]rchitecture [p]rocess," or the very beginning stages of its project management process.[94]

3. Improvements in Record Keeping

In 2005, Dr. Schwartz identified the need for a unified record of sex behavior treatment.[95] At that time, clinical and facility staff kept records of sexual behavior treatment in four locations, some of which were not accessible to all members of the

[89] E-mail of Schwartz to Martin, November 28, 2008.
[90] Statements of Schwartz during telephone conference with OSM, October 7, 2008.
[91] *Id.*; *see also* Appendix C (Schwartz report), pp. 6, 9.
[92] Statements of Schwartz during telephone conference, October 7, 2008; *see also* Second Report of the Special Master (June 2006), p. 14; Fifth Report of the Special Master (October 2007), Appendix C (Schwartz 2006-2007 report), pp. 2, 11.
[93] Defendant's Response to the Court's October 27, 2008 Order, Tab CC. On the other hand, DJJ has not included confidentiality and informed consent on its list of mental health policies slated for development by the end of 2010; the closest item on that list is "standards for protecting and granting access to confidential information." Defendant's Response to the Court's October 27, 2008 Order, Exh. AA. Top-priority mental health policies are scheduled to be developed by June 30, 2009.
[94] Defendant's Response to the Court's October 27, 2008 Order, Exh. BB. DJJ's most recent quarterly report indicates that a "project charter" for the development and implementation of the "treatment confidentiality policy" is being drafted. DJJ Quarterly Report (October 31, 2008), p. 172.
[95] Second Report of the Special Master (June 2006), p. 14; Appendix C (Schwartz report, October 2005) pp. 3, 4, 7.

treatment team. There was no coherent record of the treatment services provided to youth. There was no significant improvement by the end of fiscal year 2006-2007.[96] Through fiscal year 2007-2008, inconsistent, duplicative, and incomplete treatment-related recordkeeping continued to be a problem.[97] Staff at the O.H. Close facility developed local procedures to create program files that permit them to track services provided and treatment progress.[98] These records also permit the sexual behavior treatment expert to monitor whether youth receive the type and amount of treatment required by the sexual behavior treatment plan. The expert recommends that other facilities follow O. H. Close in this regard.[99]

Well after the sexual behavior treatment expert completed her round of monitoring and report for fiscal year 2007-2008, in November 2008, DJJ's top management clarified that facility staff who are members of treatment teams properly have access to the clinical treatment records for the youth to whom they provide treatment services.[100] The sexual behavior treatment expert supports this decision,[101] which removes what was a serious impediment to the development of a unitary treatment record for youth receiving sexual behavior treatment.[102]

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[96] Fifth Report of the Special Master (October 2007), p. 30; Appendix C (Schwartz 2006-2007 report), p. 3.
[97] Appendix C (Schwartz report), pp. 11, 27, 32, 33, 34, 64, 85. In group sessions attended by multiple therapists, multiple sets of notes are taken, which may differ, and are stored in different locations. Some documentation of one-on-one sessions with youth states that a 60-minute meeting took place, but the accompanying notes reflect a much shorter and very insubstantial interaction. Statements of Schwartz to OSM during telephone conference, September 5, 2008.
[98] Appendix C (Schwartz report) p. 2.
[99] *Id.*, p. 3.
[100] Memorandum from Chief Psychiatrist Morales to Director of Programs McKeever, with copies to Director of Facilities Youngen, Health Services Director Morris, Chief Medical Officers and Chief Psychologists, November 17, 2008.
[101] E-mail of Schwartz to OSM, December 3, 2008.
[102] The mental health experts have raised some questions and concerns about this decision that will need to be answered and resolved. E-mail of Lee to OSM, December 7, 2008.

The new version of the Ward Information Network (WIN) database allows DJJ to track the need for sexual behavior treatment services, services provided and youth progress. The new WIN was just coming on line as Dr. Schwartz completed her monitoring and reporting for fiscal year 2007-2008. She found the database very helpful in her monitoring and will continue to evaluate its effect on SBTP record-keeping in the coming year.[103]

4. Continued Failure To Develop And Implement An Assessment Protocol

DJJ has not developed and implemented a standardized, evidence-based screening and assessment protocol. The SBTP remedial plan requires the use of appropriate screening and assessment tools to evaluate risk and treatment needs initially and on an ongoing basis.[104]

Dr. Schwartz and the special master have been reporting since March 2006 that DJJ was set to follow Dr. Schwartz's recommendation to adopt the J-SOAP risk assessment tool.[105] Staff were trained on the J-SOAP in August 2007.[106] The California state legislature inexplicably required DJJ to use two different risk assessment tools, which have not been validated on this population.[107] On Dr. Schwartz's advice, DJJ intends to use the evidence-based J-SOAP as well as the legally mandated tools, but it is not yet using the J-SOAP.[108]

In addition to sexual behavior risk assessment, treatment must rest on comprehensive assessment of treatment needs and progress in treatment, so that treatment

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[103] Statements of Schwartz during meeting of experts and OSM, August 29, 2008.
[104] SBTP Standards and Criteria, item 3; *see also* Appendix C (Schwartz report), pp. 21 and 107-08.
[105] *See* Second Report of the Special Master (June 2006), p. 15 and n. 49.
[106] Fifth Report of the Special Master (October 2007), p. 26.
[107] Statements of Schwartz during meeting of experts and OSM, August 29. 2008.
[108] Statements of Arguello to OSM and mental health experts during Ventura site visit, December 3, 2008.

planning accounts for co-morbid interests, cognitive distortions, deviant sexual arousal, learning, style and other relevant factors.[109] Progress in treatment must be tracked based on clearly delineated criteria. At this time, sexual behavior clinicians and treatment teams are not using comprehensive assessments, such as those that might be generated by mental health and educational intake processes and the risk/needs assessment tool DJJ is implementing as a basis for its new treatment model. DJJ has not developed or procured tools to assess treatment needs and progress. DJJ needs to approach this problem across disciplines, so that sexual behavior treatment program is integrated into the larger treatment program.[110]

5. Increased Management Flexibility May Result In More Appropriate Staff Assignments To The SBTP

DJJ and the union representing counseling staff have agreed at least temporarily to allow management more flexibility in making assignments to individual living/treatment units, which may result in more appropriate staff assignments to the SBTP.[111] DJJ line staff bid for one of three shifts, rather than bidding for particular "posts" (housing unit assignments) based on seniority. This is an improvement. The "post-and-bid" system resulted in the assignment of staff who were not comfortable working with the SBTP population.[112]

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[109] Statements of Schwartz to special master during teleconference, January 12, 2009. Dr. Schwartz explained that this was encompassed in standards and criteria item 3.
[110] Statements of Schwartz to special master during teleconference, January 12, 2009.
[111] Appendix C (Schwartz report), p. 10; correspondence of Angus to Schwartz, September 30, 2008, p. 3.
[112] This process affects whether staff assigned are actually interested in working with this population. At the Chaderjian facility, for instance, at least one staff member has repeatedly asked to be reassigned; Dr. Schwartz urges DJJ to "devise some way of dealing with staff that may have been sexually assaulted and may have significant difficulty being exposed to discussions of sexual assault." Appendix C (Schwartz report), p. 10.

V. CONCLUSION

The special master respectfully submits this report.

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Donna Brorby
Special Master

California Division of Juvenile Justice Summary Education Program Report for School Year 2007-08

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 three monitoring cycles, from September 2005 through March 2006, from September 2006 through April 2007 and from October 2007 through March 2008 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 not audited in 2008 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 and in July 2007, training was provided to Central Office personnel and site-based administrators in order to provide a consistent framework for preparation prior to the site reviews.

- As a part of both the 2006-2007 and the 2007-2008 review cycles, all sites were notified to send specific written reports and other relevant documentation to the reviewers 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 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 Reports – reports indicating the compliance ratings on specific items in the Remedial Plan for the system as a whole and 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 two (2) attached tables:

Attachment A **California Education Services Remedial Plan Summary 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.)

Attachment A The first column on the table lists specific items selected from the Remedial Plan in each of the six areas. The middle column specifies the auditing method, describing which approaches (e.g., file review, interview, or observation) will be used to determine compliance with each part of the item. In the last column, the findings from the seven (7) site reviews are summarized to provide a system wide picture of compliance levels.

Attachment B **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.)

Attachment B On this table, the name of each site and the date of its review is 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.

<u>Section III. Major Commendations & Recommendations from 2007-2008 reviews</u>

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

<u>Commendations:</u>

- 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.
- Implementation of the five period school day has been a significant step in providing a sufficient number of courses in content areas needed to meet the students' graduation requirements.
- The development of High School Graduation plans at the majority of the sites is indicative of the progress being made in planning for students to meet graduation requirements.
- There is substantial progress in screening, identifying and providing services to English Learner students. Teachers are now SDAIE or CLAD certified.
- The development and implementation of a transition class as a part of the required curriculum helps to ensure that students are better prepared to successfully return to the community.

<u>Recommendations:</u>

- Appoint a permanent Superintendent of Education to provide leadership, develop and carry out the educational program statewide.
- Fill the vacant central office education positions noted on the organizational chart. This is necessary to provide direction, support and monitoring of the education program.
- Community feedback is necessary in order to evaluate the success or failure of the DJJ programs. A system should be developed to determine whether youth released from the DJJ are enrolled in school, employed, or have recidivated.

II. Staffing

<u>Commendations:</u>

- Progress continues to be made in hiring teachers that hold valid California teaching credentials and teach as highly qualified teachers in the appropriate fields.
- A recruitment plan is now in place. Steps have been taken to recruit appropriately credentialed staff to provide instruction in the content areas needed for graduation.
- A competitive salary schedule has been adopted to enable the DJJ to attract qualified teachers to the system.
- Each high school with a restricted program has a minimum of 2 psychologists.

Recommendations:

- Based on the recent population changes at many of the sites, remedial plan staffing allocations must be revised to ensure consistent teacher to student staffing ratios at all sites.
- Fire Camps should be required to comply with mandates of the Remedial Plan in order to meet IDEA requirements. Staffing patterns and allocations at those sites need to be examined and brought into compliance with plan requirements.
- Additional substitute teachers are needed at some sites to prevent class cancellations due to teacher absences. Substitute teacher lists were often found to be inaccurate and did not reflect the number of substitute teachers actually available at the site.
- DJJ Central Office must reduce the time between education vacancies occurring and the position being filled.

III. Student Access and Attendance

Commendations:

- The DJJ is commended for providing an academic calendar which meets the requirements of the California State Department of Education. The calendar enables all sites to standardize the school year, school day and instructional time. The school calendar also includes Student Advising /Case Conferences days that promote program consistency statewide.
- The DJJ is commended for its efforts to conduct system wide training to enable all staff to understand written policy, procedures and practices of the DJJ education program.
- The DJJ is commended for providing training and technical assistance for sites with special management units.
- Significant progress has been made in requesting records and enrolling students into appropriate educational classes within four days of arrival.

Recommendations:

- Provide appropriate GED classes for all eligible students in the system.
- Written policy and procedures require that students who fail to earn an average of five high school credits each month are to be referred to the School Consultation Team (SCT). This is not occurring consistently at all sites.
- Teachers should receive daily feedback as to the location of absent students and the reasons for their absence.
- Cooperative agreements between custody, education, and treatment to ensure access to education programs must be written and implemented at all sites.
- The program service day that has been developed must be implemented at all sites.
- Student absentee rates are unacceptable at all sites. Strategies outlined in the remedial plan to improve school attendance must be fully implemented.
- The Alternative Behavior Learning Environment (ABLE) classroom program that has been piloted at two sites must be fully implemented.
- Instructional programs for both regular and special education students in the restricted settings are inadequate. Staff and adequate instructional space must be identified and provided in order to ensure equal educational access for these students.
- All sites have excellent vocational facilities; however, student enrollment in vocational classes continues to be very low. Full utilization of these vocational resources should be provided to ensure that students receive the employment skills necessary to prepare them to re-enter the community.

IV. Curriculum

Commendations:

- DJJ staff is commended for their efforts to insure that all courses offered by the individual sites are California Education Standards driven and meet state curriculum guidelines.
- Core academic guides are available electronically to the classroom teachers.
- The DJJ meets 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.
- Educational policies are available electronically at all facilities.

Recommendations:

- Mini-libraries on the living units must be provided at all sites.
- The automated library system must be fully implemented at all sites.
- The Global Classroom Distance learning opportunities must be provided at all facilities.
- 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.
- Site based administrators must conduct quarterly teacher observations to document evidence of instructional planning, use of course syllabi and delivery of the state approved curriculum. Observations with documentation must be based on the rubric for classroom observation aligned with the California Standards for the Teacher Profession (CSTP).

V. Special Education

Commendations:

- The DJJ continues to update and provide sites with the Special Education Policy Manual designed to meet all state and federal standards.
- Instructional staff continue to report awareness of informal procedures to identify special education students.
- DJJ central office staff has made exceptional efforts to conduct special education training statewide and to maintain training records.
- Significant progress is noted in meeting special education timeline requirements.
- Regional program specialists have conducted quarterly site reviews at each school and are monitoring compliance in each special education area covered by the consent decree.
- Central Office staff has been able to document the establishment of an Education Stakeholders' Committee that is holding quarterly meetings.

Recommendations:

- DJJ Central Office staff must continue to update the current Special Education Manual to include changes mandated by IDEA revisions and No Child Left Behind legislation.

- The system for requiring receipt of complete educational records for all students entering the DJJ system from the community or transferring from another facility must be fully implemented. Adherence to policies and procedures for records transfer must be monitored by Central Office and site administrators.
- DJJ school administrators and Central Office staff must fully implement a system to verify that students are being referred for psychological testing as needed to update expired eligibility reports.
- All sites must improve the provision of general education classes and provide the frequency and duration of all service hours indicated in IEPs.
- A full continuum of services is not being offered to students on the special management units. Students continue to be denied access to a full educational day and compensatory services are less than adequate. All relevant parties must be involved in developing cooperative agreements for the provision of a full school schedule and required compensatory services. The integrity of the school day must be protected while providing for the safety and welfare of all individuals on these units.
- IEPs written by DJJ staff must address how the student's disability affects involvement in the general curriculum. When the IEP requires access to the general curriculum, such access and a full school day must be provided. Supplemental aids and program modifications designed to support the student’s involvement in the general curriculum must also be provided.
- Central Office and site-based administrators must monitor the completion of reports. They must also take responsibility for accuracy and timeline expectations to ensure quality control. The ongoing issues of errors in the WIN system and difficulties establishing an interface between the WIN system and the special education data must be resolved.
- Central Office and site-based administrators have now developed collaborative agreements between clinic administrators and intake and court service units regarding IEPs of incoming students. The school sites must document full implementation of these agreements.
- Schools must provide each student with access to a full instructional day when it is specified in a pre-existing IEP. Any IEP change must be made by the IEP committee with adequate documentation or rationale.
- Special education eligibility documents must be kept current. Expired or off timeline IEPs cannot support continued eligibility and must be reviewed by the IEP team.
- Teachers must document progress reviews of IEP benchmarks and, when necessary, make IEP changes based on progress or lack of progress.
- Compensatory services must be provided to eligible special education students. Student absences and pull outs create needs for compensatory services and must be addressed.
- The Regional Program Specialist conducts quarterly site reviews at each school, monitoring the school’s compliance in each special education area covered by CDOE monitoring findings. Central Office and site-based administrators must develop a system for monthly follow-up on monitoring recommendations.
- The Assistant Principals responsible for special education programming must document that they independently conduct monthly direct observations and monitoring of compliance efforts.

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.

- DJJ staff is commended for providing instruction in all areas tested on state mandated tests.
- DJJ staff is commended for providing multiple opportunities and accommodations for students who participate in the state assessments.
- Significant progress has been made to ensure that eligible students are granted waivers.
- All students failing at least one part of the exam are being provided remediation through a test preparation class or enrollment in a course designed to review and specifically remediate deficit areas.

Recommendations:

- All sites must provide a full range of alternatives for students to complete their education, including students on the restricted units.
- Site-based administrators must provide documentation of efforts to provide a full range of alternatives to students unable to obtain a high school diploma.

ATTACHMENT A

California Education Services Remedial Plan Summary Report

Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon — **From September 2007 through April 2008**

Item	#	Auditing Method	Findings
I. Overview, Philosophy & Program Policy			
All school sites meet WASC Accreditation Standards.	1.1	Verify WASC accreditation status at all school sites. Review WASC records at each site.	All schools are now accredited by the Western Association of Colleges and Schools.
The written policy, procedure and practice document that the CYA core curriculum meets the Content Standards for California Public Schools adopted by the State Board of Education (W&I Code 1120.2)	1.2	The CYA will provide written verification that their courses are California Education Standards driven and that they meet state curriculum standards.	**All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
The written policy, procedure and practice document that all non-high school graduates have a High School Graduation Plan. The plan is reviewed semi-annually by education staff for student progress in completing required courses. Students must earn 200 credits in a range of subject matter consistent with the California Education Code and pass the state required academic assessment in order to qualify for a high school diploma.	1.3	Review 10 or 10%, whichever is greater, of the student records at each site to determine the presence of a High Graduation Plan.	Six sites continue to be in substantial compliance with the requirement to develop High School Graduation Plans for all non-high school graduates. One site is partially compliant.
	1.4	Verify whether semi-annual reviews have been conducted.	Documentation and interviews continue to indicate that the required reviews are not being consistently conducted. Two sites were in substantial compliance with the requirement for semi-annual reviews of the High School Graduation Plans. Two sites were found to be noncompliant and the remaining three sites were found to be partially compliant.
	1.5/6	Review 10 or 10%, whichever is greater, student records at each site to determine whether progress is being made in meeting high school diploma requirements.	File reviews indicated that students at two sites were making satisfactory progress toward meeting graduation requirements. Four sites were partially compliant and one site was noncompliant. Progress is being made in this area.
Written policy, procedure and practice document that screening and identification are provided to all English learner eligible students and services are provided to enable them to access the core education program.	1.7	Review 10 or 10%, whichever is greater, student files of students with a primary language other than English to verify the provision of English Learner services.	Document and file reviews indicated that six sites were in substantial compliance with requirements to screen, identify and provide services to English Learner eligible students. Only one site was partially compliant with this item.
Students are prepared for successful transition to the community upon release.	1.8	Review all files of students within 90 days prior to release to verify that transition planning is being provided to students.	Three of the sites demonstrated that they were consistently providing transition planning to all students within 90 days of release to prepare them for return to the community. Two sites were partially compliant and two sites were found to be noncompliant in this area.

II. Staffing			
Written policy, procedure, and practice require that all teaching personnel hold valid California credentials and work in the field of credential. Each high school has adequate credentialed staff to provide instruction in content areas needed for graduation.	2.1	Review all teaching certificates and teaching schedules of personnel.	Three sites indicated that all teachers held valid in-field credentials. Three sites were partially compliant and one site was noncompliant
	2.2	Review courses offered at each high school to determine if there are enough courses offered to prepare students for graduation, including the following: English, math, life science, physical science, history, economics, government, art or foreign language, physical education and career-technical.	Observations, interviews and records indicated that three of the sites failed to provide enough courses to prepare students for graduation in a reasonable amount of time. Three sites were found to be compliant and one site was rated as partially compliant for their efforts.
A recruitment plan is in place to obtain a sufficient number of appropriately credentialed education staff to implement proposed staffing patterns.	2.3	Review and evaluate the written recruitment plan and the qualifications and use of the 2 recruiters.	All sites were found to be compliant.
	2.4	Determine the length of time that positions are vacant and the length of time required to recruit and hire replacement teachers during the monitoring period.	At one site the length of time to hire replacement teachers was determined to be noncompliant. Five sites were partially compliant in this area. One site was able to fill vacant positions within reasonable time periods.
Written policy, procedures and practice document that qualified substitute teachers are provided for teachers who are absent.	2.5	Determine whether there is a pool of trained substitute teachers and specialists at each site which represents 15% of the permanent teaching staff.	At two sites the DJJ did not employ an adequate number of substitute teachers for both general and special education or failed to provide the substitute teachers when needed. At five sites they had an adequate pool of substitute teachers for teachers who were absent from work.
	2.6	Document class cancellations due to teacher absences that are not covered by substitute teachers.	Class cancellations due to teacher absences (not covered by substitute teachers) continue to be a major problem in the DJJ. Four of the sites were noncompliant, one site was partially compliant and two sites were fully compliant in this area.
	2.7	Verify the use of an in-field teacher for any teacher vacancy which exceeds 45 consecutive days.	The DJJ provided in-field substitutes for teacher vacancies of more than 45 consecutive days at four sites. They did not provide in-field substitute teachers at two sites. One site was not applicable.
Written policy, procedure, and practice require programs and services to meet the guidance, counseling, testing, social services, psychological and career development needs of students.	2.8	Verify that each facility has a psychologist and related service providers available to ensure psychologist participation in the development of IEPs, administration of psycho-social assessments, and consultation with teachers and staff.	In providing school psychological services, five sites were identified as being in substantial compliance, one site in partial compliance and one site was found to be noncompliant.
	2.9	Use a sample of 10 or 10%, whichever is greater, of special education students referred for testing during the monitoring period; determine how long it was from referral to testing and report.	Four of the programs have demonstrated the ability to complete special education assessments within DJJ allowable timelines. Two sites were noncompliant in this area. One site was not applicable.
	2.10	Use a sample of 10 or 10%, whichever is greater, of special education students referred for related services during the monitoring period; determine how long it was from referral to provision of services.	Three programs documented that students referred for speech/ language or court-mandated counseling received those related services within the allowable 50 days from the initial referral date. Four sites reported that no students had been referred for related services within 30 days prior to the review and could not be rated.
Each high school having a restricted program shall have a minimum of 2 school psychologists.	2.11	Verify employment of 2 school psychologists at schools with restricted programs.	Each of the three facilities housing restricted programs provided documentation that a minimum of two school psychologists were employed at the time of the review.

III. Student Access and Attendance			
Written policy, procedure, and practice document that the length of the school year, school day and instructional time are in accordance with the California law and the requirements of the California State Board of Education.	3.1	Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student.	The annual 220 day Standardized DJJ Academic Calendar had been approved by the Director and has been implemented at all sites.
Written policy, procedure, and practice document that educational services are provided to the eligible students based on the system wide Standardized Annual Academic Calendar.	3.2	Verify the existence and implementation of a Standardized 220 day Academic Calendar which provides for at least 240 minutes of instruction each day for each eligible student.	The annual calendar including a 240 minute average instructional day has been implemented at all sites.
Written policy, practice and procedure require that all students will be enrolled into appropriate educational programs within 4 school days of arrival.	3.3	Review 10 or 10% of student files, whichever is greater, to document enrollment in appropriate education programs within 4 school days of arrival for students entering during the monitoring period.	Significant progress has been made in enrolling students within 4 days of arrival. Six sites were found to be compliant in this area. One site was found to be noncompliant.
	3.4	Verify that high school registrars request transcripts from any prior school within 4 school days of the student's arrival at the facility for students entering during the monitoring period.	Observation and file reviews indicated that all sites were requesting transcripts within . days of the student's arrival. Significant progress has been made in this area.
Written policy, procedure, and practice, require that in all sites serving older students, the CYA will have in place a system designed to determine the most appropriate educational placement of students based on individual need.	3.5	Review 10 or 10% of student files, whichever is greater, to verify that students meeting criteria for GED preparation are provided the opportunity for classes to prepare for GED testing.	Students at five sites who met the criteria for GED preparation were being provided opportunities to work towards attaining a GED. Two sites were partially compliant. Progress is being made in this area.
Written policy, procedures and practice require the use of Student Consultant Teams to develop instructional services for students experiencing problems of an academic, social, or behavioral nature.	3.6	Verify SCT committee make up and function. Interview SCT committee members. Interview 10 or 10% of students, whichever is greater, who have been the subject of SCT team meetings to verify the provision of SCT developed instructional services.	DJJ sites continue to lack uniformity in the implementation of the Student Consultation Teams. Three sites received ratings of substantial compliance, two sites were found to be partially compliant and two sites were found to be noncompliant in this area.
	3.7	Review SCT minutes and records for planned interventions and referral to supplemental service providers.	Documentation at four sites indicated substantial compliance in providing interventions and referrals for students reviewed by SCT teams. Two sites were partially compliant and one site is noncompliant.
Written policy, procedure, and practice require that students failing to earn an average of 5 high school credits each month are referred to SCT, Special Education and/or Case Conference Teams.	3.8	Review 10 or 10%, whichever is greater, files of students not making minimal progress to determine if referrals have been made to SCT (general education students), the Special Education Team (special education students) and/or the Case Conference Team (all students) for evaluation and possible intervention plans.	Students meeting criteria for SCT referral were consistently being served at two sites. At those sites, the SCT was fully functioning according to DJJ policy and procedures. Five sites were partially compliant in this area.

Written policy, procedures, and practice require that the CYA shall establish a functional SCT tracking system that documents the effectiveness of recommended interventions and provides verification of on-going progress reviews.	3.9	Verify development of the tracking system by April 2005.	At five sites there was documentation that the SCT tracking system had been developed and fully implemented. One site was partially compliant and one site was noncompliant in this area.
	3.10	Review 10 or 10%, whichever is greater, of files of students having SCT Intervention Plans for documentation of on-going progress reviews.	Three sites were substantially compliant in documentation of progress reviews of SCT plans. Three sites were noncompliant and one site was partially compliant.
The CYA shall insure that the SCT provides appropriate identification, referral and assessment of students not previously identified as eligible for special education services, including those students in restricted settings for extended periods of time.	3.11	Review the SCT log at each site for proper documentation and follow-through with students that should be referred for eligibility testing.	Three sites demonstrated substantial compliance in SCT follow-through on students referred for eligibility testing. One site was non-compliant and at three sites it was not applicable.
	3.12	Review each individual student's file that has been referred from SCT for special education evaluation in last 30 days to verify that special education evaluation has been conducted.	Three sites did not have any recent referrals for special education evaluation; three of the sites were found to be in substantial compliance and one site was noncompliant in this area.
The CYA shall provide in-service training on SCT policy and procedures, including the use of standardized SCT forms and staff roles and responsibilities.	3.13	Review in-service training including the outline of topics, the schedule and the dates. Verify attendance at staff training.	Records reviews indicated that SCT training had taken place at six sites since the last review cycle. One site was noncompliant in this area.
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.	3.14	Note the procedure for security and/or dorm personnel to inform teachers of missing student's whereabouts.	Observation indicated that teachers were posting absences on the door for each class period. At two sites, there was sporadic or no daily feedback to teachers as to why students were absent. Two sites were partially compliant; three were substantially compliant.
	3.15	Review 10 or 10%, whichever is greater, student files to document school attendance for the last 30 school days.	Student absenteeism continues to occur at an unacceptable level; five sites received a noncompliant rating and two sites received partial compliance. School attendance remains a major problem.
Cooperative agreements exist between education, custody and treatment to ensure students' access to programs. Management teams will implement a program service schedule to allow service needs to be met during the work day/week without loss of mandatory instructional time.	3.16	Review the cooperative agreements to Ensure students' access and attendance in the school program. Interview staff and students to verify implementation of the agreements.	The remediation plan stated that a cooperative agreement would be developed by representatives from education, custody and treatment in order to ensure student access to instructional programs. File review and interviews indicated that no written agreement existed at four sites. Two sites were substantially compliant and one site was partially compliant in this area.
Written policy, procedure and practice document that the Director and Executive Team monitor attendance data quarterly to ensure compliance with laws, regulations and policies. Facility superintendents and principals will present their collaborative plans to remediate deficient attendance or access by April 2005. On a quarterly basis, schools with absence rates of 10% or more will continue to make corrective action plans until absence rate is below 10%.	3.17	Verify quarterly reviews of school attendance reports by Executive Team.	All of the sites except one were rated substantially compliant on this item. One site was noncompliant because they did not provide documentation.
	3.18	Review and evaluate April 2005 plans to remediate deficient attendance/access.	File reviews indicated that four sites had developed collaborative agreements to remediate deficient attendance. One site was partially compliant and two sites were noncompliant in this area.
	3.19	Review and evaluate quarterly corrective action plans for sites that have an absence rate of more than 5%.	File review indicated the existence of quarterly corrective action plans at two sites. Four sites were rated noncompliant in this area. The remaining site provided partial documentation of its efforts and was rated as partially compliant.

Written policy, procedure and practice document that class cancellations will be eliminated except for verified safety or security reasons.	3.20	Review school schedules for the last 30 days. Review WIN Data and verify individual class cancellations at each site. Interview teachers, other staff and students.	In eliminating class cancellations except for verified safety and security reasons, data review indicated that four of the sites remain noncompliant, one site remains partially compliant and two sites are substantially compliant in this area.
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 or her exclusion, the reason for his or her exclusion, and the duration of the exclusion.	3.21	Review attendance records of a minimum of 5 teachers to verify that the location of missing students is identified.	At four sites, teachers were able to verify the location of missing students. One site was partially compliant and two sites were unable to document implementation of this requirement.
	3.22	Review exclusion from school forms at each site for 10 days out of the previous month for completeness of data recorded.	Six sites are now using Exclusion from School forms appropriately and they are substantially compliant in this area. One site is partially compliant in this area.
	3.23	Observe any students being pulled from class, held back on housing unit, or held over after meals to perform work details.	At some facilities, regular and special education students continue to be held back on the housing units for "programming" and for other reasons throughout the day. Two sites were noncompliant and two sites were partially compliant in this area. Three sites were substantially compliant during this monitoring cycle.
The attendance system will be integrated into the current WIN Data Base and will reflect accurate student attendance data.	3.24	Verify existence and accuracy of WIN Data Base attendance information for the last 10 consecutive school days.	There is still some inconsistency in the implementation of the WIN Data Base. Two sites were non-compliant in this area. Five sites were substantially compliant.
A management team will review monthly data to remove barriers to the 240 minute minimum instructional day.	3.25	Review logs and minutes documenting the management team's monthly review of instructional time requirements.	Four of the sites documented substantial compliance with the requirement for management team review of the instructional time requirements. One site was partially compliant and two sites were noncompliant in this area.
Superintendent of Education and the Deputy Director, Institutions & Camps will review policies, data and practices related to education attendance and develop performance expectations by July 2005. Department wide staff training (including staff in restricted settings) will be provided by December 2005. Final implementation will take place in December 2005. Policy and procedures will be updated by July 2006.	3.26	Review and evaluate performance expectations on attendance developed in July 2005.	File reviews indicated that the requirement for review of performance expectations on attendance had been compliant at four sites, partially compliant at two sites and noncompliant at one site.
	3.27	Review and evaluate training plan, outline of topics and schedule. Verify staff attendance at the training.	File review indicated that training on attendance expectations had been provided at five of the sites. The remaining sites failed to document or reported no training in this area, resulting in findings of noncompliance at those two sites.
	3.28	Review and evaluate final implementation of attendance policies and procedures in December 2005. Review and evaluate revised policy and procedure in July 2006.	There was documentation at five of the sites that attendance policies and procedures had been developed and implemented. One site was partially compliant and one site was noncompliant in this area.
Instructional teams will be required to develop incentives for increased school attendance.	3.29	Verify the development of incentives for increased school attendance.	Four of the sites had implemented incentives for increased student attendance, receiving ratings of substantial compliance. Two sites were able to provide partial documentation of efforts, resulting in partial compliance ratings. One site was unable to provide documentation of attendance incentives.

The Superintendent of Education will develop an Annual Academic Calendar each year by May 15. The Annual Academic Calendar will include 44 Student Advising/Case Conference days from the days that teachers and education specialists are scheduled to work.	3.30	3.30 Review and evaluate annual school calendar.	The annual 220 day Standardized DJJ Academic Calendar had been approved by the Director and implemented at all sites.
	3.31	Review scheduling and utilization of the 44 student advising/case conference days per year.	All of the local school calendars indicated the inclusion of 44 student advising/case conference days per year. All sites were found to be in substantial compliance on this item
Adequate instructional space is provided at all facilities. A study on the adequacy of instructional space will be completed by May 2005.	3.32	Review number and size of classrooms and CYA study of instructional space in May 2005. Monitor progress in meeting proposed classroom construction and renovation schedule.	The instructional space report has been completed and it identified where additional classroom space was needed. Only four sites were determined to have adequate instructional space. One site was partially compliant and two sites were noncompliant on this item.
Written policy, procedure and practice provide a structured positive behavior management system in each CYA classroom statewide.	3.33	Verify the implementation of the behavior management system in the classrooms at each site.	The consent decree indicated that a structured behavior management system would be developed and implemented. Full implementation has not yet occurred. Two sites were found in compliance. There were two findings of partial compliance and three findings of noncompliance.
An alternative behavior management classroom will be provided at each school.	3.34	Verify the use of the alternative behavior management classroom at each site.	The ABLE program is being piloted and implementation should occur at all sites within the next auditing cycle. Three of the sites were substantially compliant in providing an alternative behavior management classroom. Four sites were noncompliant in this area.
Staff will be trained in the operation of the behavior management system.	3.35	Review and evaluate staff training outline, schedule and attendance.	Six sites have received training on the behavior management system. One site had not conducted the training for the implementation of this system.
Staff are required to develop behavioral goals for special education students placed in restricted programs or review/revise existing goals.	3.36	Review behavioral goals in IEPs of all special education students placed in restricted programs. Interview IEP team members, psychologists and related service providers.	One of the three sites with a special management unit (SMU) adequately developed/revised and fully documented behavioral goals of special education students placed in the restricted units. One site was partially compliant and one site was noncompliant.
All services in restricted placements will be delivered in small classroom settings whenever possible.	3.37	Verify existence of classrooms in restricted settings. Verify that all classrooms meet minimum CDOE size standards. Report the number of students in restricted settings served in small classrooms and the number not being served.	Two sites were noncompliant in the provision of adequate classroom space on the restricted units. One site was partially compliant.
The CYA shall maintain a staffing ratio of 5:1 in all restricted programs. All staff assignments shall be aligned with specific course offerings as well as credential authorizations.	3.38	Review current and previous school days' class rolls for all restricted school programs to determine staffing pattern. erify teachers' credentials. Review high school graduation plans, IEPs and other documents to document assignment/instructional match.	None of the three sites with special management units provided an adequate number of fully credentialed teachers to meet the requirements.

<table>
<tr><td rowspan="2">Written policy, procedures, and practice require high school administrators, together with their living unit counterparts, to be responsible for the following in supervising staff assigned to restricted placements:

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.
3) In-service training for all education and living unit staff assigned to restricted programs regarding policy, guidelines, staff roles and responsibilities.
4) Technical assistance from the SB505 team process to assist in the development of guidelines and effective strategies for students frequently placed in restricted settings.
5) In-service training and assistance provided by special education teachers and specialists for living unit staff on effective strategies and interventions in working with students with disabilities.</td><td>3.39</td><td>Verify instructional program on restricted units by reviewing school schedule, education progress reports and school transcripts.

Conduct direct observation of instructional program.

Interview site administrators.

Interview teachers, custodial staff and students.</td><td>None of the three sites with special management units met all of the criteria listed.</td></tr>
<tr><td>3.40</td><td>Verify that staff training and technical assistance are being provided.</td><td>One of the three sites was providing training and technical assistance to staff in its restricted settings. One site was partially compliant and the other site was noncompliant.</td></tr>
</table>

IV. Curriculum			
Written policy, procedure and practice document that Curriculum Guides and instructional policies are aligned with the California Education Code for Public Schools related to curriculum, instruction and assessment.	4.1	Verify with written documentation that the CYA curriculum meets the Content Standards and Curriculum Frameworks for the California Public Schools.	All courses offered by the individual sites were California Education Standards driven and meet state curriculum standards. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
	4.2	Verify with written documentation that there is a process in place to coordinate curriculum revisions and develop curriculum guides on a cyclical basis.	The process to coordinate curriculum revisions is in place at all sites. This process satisfactorily satisfies this requirement. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
	4.3	Verify that Curriculum Guides with content, performance standards and process for instruction exist for all core area courses (English/Language Arts, Science, Mathematics, Social Studies) and vocational education courses taught in the CYA Schools.	Curriculum guides in all core courses and vocational areas were in place at all sites. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
Core Curriculum Guides are made available to staff in electronic form by December 2005.	4.4	Verify that the core academic guides are available to all staff electronically in December 2005.	Core academic curriculum guides were available in electronic form beginning 1/06. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
Written policy, procedure, and practice require all school sites to meet California DOE and WASC standards for textbooks, library books, and educational supplies and materials.	4.5	Compare the number of textbooks and library books at each site with applicable standards.	All sites have been found to meet the California standards for textbooks and library books**. All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.** .
Each site will conduct an annual inventory beginning in August 2005 and needs assessment to determine if additional materials and equipment are needed.	4.6	Verify in August 2005 that the annual inventory and needs assessment has been conducted.	The annual inventory and needs assessment is being conducted at all sites. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
Textbooks and library books are available to all students both in classrooms and on living units. The Education Services Branch will identify the core books that comprise the mini-libraries and the school librarian will maintain the inventory of the mini-library.	4.7	Observe whether adequate supplies and materials are available at each site to support the curriculum offerings. Verify the availability of textbooks and library materials to students in classrooms.	It was documented that six of seven sites had an adequate supply of textbooks and library books to support the educational program. One site was partially compliant in this area.
	4.8	Verify availability of core books in the mini-libraries on the living units according to the inventory prepared by the school librarian.	The mini-libraries continue to be in various states of completion. Three sites are compliant and four sites are partially compliant in this area.
Written policy, procedure, and practice require that opportunities are provided for school leadership personnel to continue professional development throughout their careers.	4.9	Verify the implementation of the Staff Development Plan for leadership personnel.	Six of the seven sites were able to provide complete documentation to indicate that staff development was being provided to leadership personnel. One site was noncompliant in this area.

Annual training including compliance requirements, updated policies and procedures, examples of best practice, implementation issues and other related topics will be provided to site administrators, teaching and custody staff and other stakeholders. The frequency of the training scheduled will be dependent on each individual’s role in the process and may vary from quarterly to annually.	4.10	Verify in-service schedule including dates and outline of topics.	Six of the seven sites documented compliance with the training requirements. One site was noncompliant in this area.
	4.11	Verify staff attendance at training through inspection of in-service roll information and review of rincipal’s onthly Report.	Six of the seven sites provided complete documentation verifying staff attendance at training. One site was noncompliant in this area.
Written policy, procedure, and practice require that Trade Advisory Committees are implemented to provide appropriate programming and liaison between the CYA, community and potential employers.	4.12	Verify the formation of advisory committees at each site by May 2005 and their quarterly meetings.	Trade Advisory committees are fully functional at four of the sites. Two sites failed to document the implementation of Trade Advisory committees. One site was partially compliant in this area.
	4.13	Verify the use of annual surveys to provide vocational course planning by July 2005.	The Division of Juvenile Justice continues to conduct annual surveys to provide vocational course planning, resulting in a finding of substantial compliance at all of the seven sites.
	4.14	Verify the use of annual Career Technical job studies to determine the effectiveness of CTE programs.	The Division of Juvenile Justice has conducted job studies to determine the effectiveness of the CTE program, resulting in a finding of substantial compliance at all of the seven sites.
Written policy, procedure and practice require a distance delivery system to provide opportunities for instruction and interaction in different locations. Distance education courses for high school graduation meet Content Standards for California Public Schools. Global Classrooms will be available at each site by June 2006.	4.15	Verify the existence of the use of technology at each site by June 2005.	Five sites demonstrated consistent use of the available technology resources. One site was partially compliant in this area and one site was noncompliant.
	4.16	Verify that distance learning course content meets Content Standards.	At five sites where distance learning was in use, the courses met content standards. One site received a rating of partial compliance and the other site was rated noncompliant.
	4.17	Verify implementation and use of Global Classrooms distance learning.	Only two sites had fully implemented Global Classrooms distance learning. Five sites were noncompliant in this area.
In restricted settings, distance learning will be utilized as one of the methods used to accommodate student instructional needs. Distance learning will not exempt the restricted settings from the use of instructional staff to provide direct support service to students and will not result in a reduction of the required 240 instructional minute per school day requirement.	4.18	Verify use of distance learning in restricted settings by direct observation, lesson plan and transcript review.	Two sites having special management units had not implemented distance learning at the time of the reviews. The third site was compliant.
An automated library system will be installed at each high school by June 2006.	4.19	Verify implementation and use of the automated library system.	Library automation has been fully implemented at four sites. Partial implementation has occurred at one site and the remaining two sites failed to meet the criteria for compliance in this area.

Written policy, procedures, and practice require the use of course syllabi, units of instruction and lesson plans by teachers.	4.20	Verify through teacher observation evidence of the use of course syllabi, units of instruction and lesson plans. Interview teachers, students and administrators for evidence of the use of lesson plans, course syllabi and units of instruction.	All sites monitored were either substantially compliant (five) or partially compliant (two) in the use of course syllabi and lesson plans by teachers.
Quarterly classroom observations will be conducted by school administrators based on a rubric aligned with the California Standards for the Teacher Profession (CSTP).	4.21	Verify the practice of quarterly teacher observations by administrators using the revised rubric for Classroom Observation.	Quarterly teacher observations were being conducted at three sites. Four sites failed to document compliant efforts in this area.
Implement the 5 Year Strategic Plan and Comprehensive Reading Initiative to improve the quality of instruction in reading/language arts and mathematics.	4.22	Verify that the strategic plan and reading initiative are being implemented at each site.	The comprehensive reading initiative, the Holt and Highpoint Reading program, was fully implemented at all of the seven sites.
Education policies will be revised and made available to staff electronically by June 2006.	4.23	Verify that policies have been revised to reflect changes in operations.	Policies have been revised to reflect changes in operations at all sites. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
	4.24	Verify that policies are made available to staff electronically by June 2006.	Policy revisions in electronic format were fully available at all of the seven sites.

V. Special Education			
The Special Education Policy Manual will be approved and available to staff by September 2005. The Special Education Manual will meet all state and federal regulations.	5.1	Verify that the manual is complete and made available to staff by September 2005. Verify that Special Education Manual meets all relevant state and federal rules and guidelines.	All sites were able to document that approved Special Education Policy manuals were available. The manual meets current CDOE requirements.
The CYA will provide special education and related services to all special education eligible students.	5.2	Review 10 or 10%, whichever is greater, of newly transferred student files at each site to verify that completed special education files are transferred to the receiving CYA facility and fully implemented within school days of student's arrival.	Four sites were implementing IEPs within four days of the student's arrival. Two sites failed to document complete compliance in this area. One site was found noncompliant on this item. Complete special education files continue to fail to be consistently transferred to the receiving facilities in a timely manner.
	5.3	Review 10 or 10%, whichever is greater, of newly transferred student files at each site to verify that special education screening procedures are followed and that students are referred for psychological testing as needed for new identification.	Six programs continued to fully document that DJJ special education screening procedures were being followed and that students were being referred for psychological testing as needed for new identification. One site was partially compliant in this area.
	5.4	Interview teachers to review informal procedures used to identify special education students in classrooms.	Five facilities were able to fully document that instructional staff are aware of informal procedures used to identify special education students in the classroom. Two sites were partially compliant.
	5.5	Review 10 or 10%, whichever is greater, of special education student files at each site to verify that students are being referred for psychological testing as needed to update expired eligibility reports. In the same sample, determine whether psychological testing and reports are done in a reasonable time period and if reports are complete and useful.	Three sites were able to verify that students are being referred for psychological testing as needed to update expired eligibility reports. Three sites were in partial compliance and one site was found noncompliant with the requirements.
	5.6	During site visits and staff interviews, determine whether each CYA facility provides a continuum of placement options, including the full range of time, frequency and duration within each option.	One site provided the required continuum of placement options, including the provision of a full school day to all eligible special education students. One site was partially compliant. The remaining five sites were noncompliant.
	5.7	During site visits and through staff interviews, determine whether the continuum of available special education services is provided to all eligible students including those assigned to restricted settings.	No site was able to document the ability to provide a full continuum of special education services to all eligible students, including those assigned to restricted units. Four sites were rated noncompliant, one site was found in partial compliance and two sites were rated not applicable.
	5.8	Review 10, or 10% whichever is greater, of special education student files at each site to verify that eligible students are receiving the required number of segments and full instructional day. Interview special education students to verify that services listed in IEPs are being provided.	One site documented that special education eligible students were consistently receiving the required number of segments and full instructional day. One site documented partial compliance in this area and five sites were noncompliant.
	5.9	Determine completeness and accuracy of special education data collection system (includes type of disability, number and type of segments, etc.)	The special education data collection system was verified as accurate at three sites. Three sites were able to partially document compliance in this area. One site failed to provide the required documentation and was rated noncompliant.

Written policies, procedures and practice require that assessment procedures and products be updated and standardized by August 2005. In-service training will be provided. Reports of assessment completion rates will be provided monthly as of October 2004. The process will be fully implemented, including the county intake process by December 2005.	5.10	Verify that the revised standards are established and that the timelines are being met.	All of the seven sites provided documentation indicating that assessment timelines were being consistently met.
	5.11	Verify that in-service training on assessments is provided. Review monthly reports of assessment completions.	Six sites were able to document that ongoing staff training on assessments had been provided. One site was rated in partial compliance. All programs were able to document that reports of assessment completions were compiled monthly.
	5.12	Verify whether the revised assessment procedures, including county intake processes, have been implemented.	Revision of assessment procedures, including county intake processes, was scheduled to be fully implemented in December 2005. Three programs have been able to document implementation of revised assessment procedures. One site was partially compliant and three sites were noncompliant.
Written policy, procedures, and practice require that the CYA and clinic administrators will work collaboratively with Intake and Court Service units to ensure compliance with regulations regarding the provision of IEPs prior to the acceptance of the physical custody of the student.	5.13	Verify existence of collaborative agreements.	Six sites failed to document that collaborative agreements exist between clinic administrators and intake and court service units regarding IEPs of incoming students. One site documented the existence of the agreement but not the implementation and was rated partially compliant.
	5.14	Verify established procedures that enforce requirements.	Six sites failed to verify the procedures that enforce requirements regarding responsibilities of intake and court service units for IEPs of incoming students. One site documented the existence of the procedures and was rated partially compliant.
The CYA shall substantially implement pre-existing valid Individual Education Plans (IEPs).	5.15	Review 10 or 10%, whichever is greater, of special education files at each site to verify that students were provided services according to requirements of pre-existing valid IEPs.	Only one of the seven sites demonstrated full compliance in providing services according to the requirements of pre-existing valid IEPs. Four sites were identified as partially compliant in this area, with two sites rated noncompliant.
f the previous school's E includes services that cannot be provided by CYA (e.g., community-based activities) or in the event that service hours or program offerings are reduced due to restricted placement, the cessation and rationale for the changes in these services must be noted on the interim/continued services information in the student's E .	5.16	Review 10 or 10%, whichever is greater, of special education files to verify that any changes in an IEP are documented with the rationale stated.	When service hours or program offerings were reduced, two sites were able to fully document justification in the form of minutes stating rationale or IEP team consensus. Four sites were in partial compliance and one site was rated noncompliant.
When there is no IEP, special education eligibility will be determined and team meetings will be held in a timely manner. Required participants will be in attendance.	5.17	Review 10 or 10%, whichever is greater, of special education files to verify that eligibility determination is made prior to holding IEP meeting.	Five sites were found to be substantially compliant with the requirement of determining eligibility prior to holding IEP meetings. One site was found to be in partial compliance and one site was rated noncompliant.
	5.18	In same files, verify that IEP meetings are held within prescribed time frame and if not, that proper documentation exists as to the reason. In same files, verify that IEP notices are sent as required and that required participants are present. If regular education teachers are not there, ensure that they are made aware of IEP provisions.	Two sites were fully compliant with requirements to document that IEP meetings were held within prescribed time frames and that regular education teachers not present at IEP meetings were made aware of IEP provisions designed to be implemented in regular education classes. Four sites were in partial compliance and one site was rated noncompliant.

Each IEP developed or modified at a CYA facility shall include documentation of the team's consideration of the student's need for related services and transition planning.	5.19	Review 10 or 10%, whichever is greater, of special education files at each site for consideration of need for related services and/or transition planning. Interview teachers regarding consideration of related services and transition planning.	At all sites consideration of students' needs for related services was documented in the IEP minutes. Transition plans are being written using a revised format. Five sites were found in substantial compliance with all of the requirements. Two sites continue to exhibit problems with transition plan measurability and development, resulting in ratings of partial compliance.
In-service training shall be provided to special education teachers in the following areas: 1) Alignment of goals and objectives 2) Periodic progress or benchmark reviews. 3) Use of the least restrictive environment 4) Transition services 5) Accommodations and modifications in the general education classroom 6) Compensatory services	5.20	Verify in-service training schedule including dates and outline of topics. Verify staff attendance through inspection of in-service roll information and review of rincipal's Monthly Report	All programs continue to be able to provide extensive documentation and verification of ongoing special education training.
The CYA shall develop and implement a system to provide for the documentation of student progress related to his/her IEP goals and objectives based on the dates identified on the IEP. The system will ensure that progress reviews are routinely practiced by each special education provider.	5.21	Verify that special education staff are provided with standardized formats for documentation of review. Review 10 or 10%, whichever is greater, of special education files to verify that progress reviews meet the IEP schedule. Interview special education teachers regarding progress reviews.	Four sites were able to document consistent review of IEP benchmarks. One site was found in partial compliance and two sites were rated noncompliant.
Written policy, procedures, and practice require that compensatory special education services are provided to students if significant gaps of missed service occur or are projected to occur, and if such services cannot be made up during the course of the week or designated period of time.	5.22	Review dministrator's Compensatory Services Plan. Through teacher and student interviews, verify that compensatory services are provided to students when required.	The Request for Compensatory Services form and log were located at all sites. he formal dministrator's Compensatory Services Plan was available. With regard to the consistent provision of compensatory services to eligible special education students, one site was fully compliant, five sites were partially compliant and one site was rated noncompliant.
The CYA shall establish an Education Stakeholders' Committee by ugust 2 consisting of departmental, other interagency participants and community members including parents of CYA students. This committee will meet quarterly and serve as an advisory body to the Superintendent of Education and the Executive Team.	5.23	Review formal minutes of Stakeholders' meetings including dates, agenda, membership and recommendations.	Six sites provided full documentation of the establishment of an Education Stakeholders' Committee that met quarterly and included departmental staff, other interagency participants and community members, including parents of DJJ students. The remaining site failed to produce documentation of compliance in this area.

Training on special education will be provided by the CYA to all education staff and administrators, treatment and custody staff and administrators and other stakeholders starting July 2005. Training will use the approved Special Education Manual, approved forms and data collection systems. The frequency of the training scheduled will be dependent on each individual's role in the process and may vary from quarterly to annually.	5.24	Verify in-services schedule including date and topics. Verify staff attendance through inspection of in-service roll information and review of rincipal's Monthly Report. Verify schedule using CYA Master Calendar	All sites documented efforts by DJJ staff to provide training on special education topics to all education staff and administrators, treatment and custody staff, and other stakeholders beginning in July 2005. All sites have implemented the DJJ Master Calendar.
The Regional Program Specialist shall conduct at least quarterly site reviews of each school's special education compliance efforts and status.	5.25	Review quarterly site review reports	Central Office staff assigned to the schools had conducted quarterly site reviews to document special education compliance efforts and status at all sites reviewed.

VI. California High School Exit Exam			
The state assessment program is conducted according schedules and procedures established by the CYA and the California Department of Education. State mandated tests are administered according to the guidelines prescribed by the CYA and the DOE. Each eligible student in CYA shall have access to each mandated educational assessment.	6.1	Verify the use of the state mandated testing schedule through observation and interviews. Through student interviews and file reviews, verify access of eligible students to the state mandated exam.	Documentation of the existence and adherence to the statewide testing schedule has been established. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
Instruction provided to students is relevant to all areas tested on California Graduation Test.	6.2	The CYA will provide written verification that the content of its curriculum guides in English-language arts and mathematics is related to items on the California Graduation Test.	**All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
Students have multiple opportunities to pass the CAHSEE according to state regulations.	6.3	Through student interviews and file reviews, verify that eligible students have appropriate opportunities to pass the state mandated exam.	Sufficient documentation has been provided to insure that students are provided with appropriate opportunities to pass the state mandated exams. **All sites were in substantial compliance in this area during two consecutive audits and they were not audited in this area during this review cycle.**
All students who are eligible for accommodations in testing will be provided the accommodations specified by their IEPs or Section 504 plans. Test variations are also available to English learners who regularly use them in the classroom. Students who are eligible for test variations must adhere to the CDE guidelines for test variations.	6.4	Verify by records review of students taking state mandated exams that appropriate accommodations, modifications or variations were provided as a part of testing procedures (in accord with CDE guidelines.)	All of the seven sites demonstrated that they were fully compliant with the requirement that students receive appropriate accommodations and modifications as a part of their testing procedures in accord with CDE guidelines.
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 (State Board of Education) process and policy.	6.5	Verify by records review of students taking state mandated exams that waivers were requested for students with modifications who receive equivalent passing scores (in accord with CDE guidelines.)	Students who were eligible were granted waivers based on the SBE process. The five sites that had obtained waivers for their students were found in full compliance. The two sites that had not sought waivers for students were rated non applicable.
Schools are required to provide remediation to students at risk of not graduating from high school due to the test requirements. Each site principal has a plan to track student progress on the test and provide direct remediation to any student failing one or both test sections.	6.6	Verify by records review of students taking the test that students failing at least one part of the exam were provided specific remediation related to test items.	At all of the seven sites, students failing at least one part of the exam were being provided remediation through a test preparation class or enrollment in a course designed to review and specifically remediate deficit areas.

Student achievement on the CAHSEE is monitored and evaluated. School improvement plans address efforts to improve student achievement in the areas tested.	6.7	Review and evaluate data on student achievement on the CAHSEE to determine whether school improvement plans are based on test achievement data.	At six of the seven sites, review of the School Improvement Plans indicated that achievement data was used to develop school wide goals and they were rated substantially compliant. One site did not provide adequate documentation and it was rated noncompliant.
Students who are unable to pass the CAHSEE have additional options to complete their education. Students may pass the GED or California Proficiency Exam. Students unable to achieve a high school diploma or pass an equivalency exam are awarded a Certificate of Course Completion.	6.8	Review and evaluate data on students to determine whether they are being provided the full range of alternatives available (diplomas, equivalency tests, certificates of completion).	Two sites failed to provide sufficient documentation indicating the provision of a full range of alternatives for students to complete their education when they are unable to obtain a high school diploma. Three sites were partially compliant and two sites were compliant in this area.

California Remedial Plan Site Compliance Report

Area : EDUCATION **Reviewers: Dr. Tom O'Rourke, Dr. Robert Gordon** **From October 2007 through March 2008**

Ratings: SC = Substantial Compliance **PC = Partial Compliance** **NC = Non-Compliance**

SC or N/A-no highlight **PC- yellow highlight** **NC- red highlight**

	Site	**Boss**	**Nelson**	**Chaderjian**	**Perry**	**Clark**	**Wieden**	**Egan**	**ALL SITES**
	Date of Review	**10/26/07**	**11/5/07**	**12/5/07**	**01/09/08**	**01/11/08**	**02/27/08**	**03/12/08**	**2007-2008**
	Items Reviewed								
I. Overview									
1.1	Schools meet WASC accreditation standards	SC	SC	SC	SC	SC	SC	SC	
1.2	Curriculum meets CA state standards								**Not Audited**
1.3	High School Graduation Plans in records	SC	SC	SC	SC	SC	SC	PC	
1.4	Semi-annual reviews of High School Graduation Plans	PC	PC	PC	NC	SC	SC	NC	
1.6	Progress being made toward high school diplomas	PC	PC	PC	PC	SC	SC	NC	
1.7	English Language Learner screening & services	SC	SC	SC	SC	SC	SC	PC	
1.8	Transition planning (90 days prior to release)	PC	NC	SC	NC	SC	SC	PC	
II. Staffing									
2.1	Teachers hold valid CA credentials and teach in-field	SC	PC	PC	NC	SC	SC	PC	
2.2	Adequate credentialed staff in content areas for graduation	SC	NC	SC	NC	SC	PC	NC	
2.3	Recruitment plan for education staff and 2 recruiters	SC	SC	SC	SC	SC	SC	SC	
2.4	Time between education vacancy and hiring	PC	NC	PC	PC	SC	PC	PC	
2.5	Pool of substitute teachers = 15% of teaching staff	SC	NC	SC	NC	SC	SC	SC	
2.6	Class not cancelled due to teacher absence/lack of substitutes	PC	NC	NC	NC	SC	SC	NC	
2.7	In-field teacher used for teacher vacancy of 45 days	NA	NC	SC	NC	SC	SC	SC	
2.8	Psychologist and related service providers available for input	SC	PC	SC	NC	SC	SC	SC	
2.9	Time from referral for testing and report completed	SC	NC	NA	SC	SC	SC	NC	
2.10	Time from referral for related services to service delivery	NA	NA	NA	SC	SC	SC	NA	
2.11	2 school psychologists for each restricted program	NA	NA	SC	NA	NA	SC	SC	

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

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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	PC	SC	SC	SC	
4.8	Books available in mini-libraries on living units	SC	PC	PC	PC	PC	SC	SC	
4.9	Professional development for school leadership personnel	SC	SC	SC	NC	SC	SC	SC	
4.10	Training schedule on new procedures-educ & custody staff	SC	SC	SC	NC	SC	SC	SC	
4.11	Training attendance-new procedures-educ & custody staff	SC	SC	SC	NC	SC	SC	SC	
4.12	Formation of Trade Advisory Committees & quarterly meetings	SC	NC	SC	NC	SC	SC	PC	
4.13	Annual surveys for vocational course planning (due 7/05)	SC	SC	SC	SC	SC	SC	SC	
4.14	Annual Career Technical job studies to evaluate CTE programs	SC	SC	SC	SC	SC	SC	SC	
4.15	Use of technology at each site (due 6/05)	NC	SC	SC	PC	SC	SC	SC	
4.16	Distance learning courses meet CA Content Standards	SC	SC	SC	NC	SC	SC	PC	
4.17	Use of Global Classrooms distance learning (due 6/06)	NC	NC	NC	NC	SC	SC	NC	
4.18	Distance learning provided in restricted units	NA	NA	NC	NA	NA	SC	NC	
4.19	Automated library system at each HS (due 6/06)	SC	NC	NC	PC	SC	SC	SC	
4.20	Teachers use course syllabi & lesson plans	SC	SC	SC	PC	SC	SC	PC	
4.21	Quarterly teacher observations using revised rubric	SC	NC	NC	NC	SC	SC	NC	
4.22	5 year strategic plan & reading initiative implemented	SC	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)	SC	SC	SC	SC	SC	SC	SC	

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V. Special Education									
5.1	Special Education Policy Manual revised & available (due 9/05)	SC	SC	SC	SC	SC	SC	SC	
5.2	Files transferred & services implemented in 4 days	PC	SC	PC	SC	NC	SC	SC	
5.3	Screening provided and referrals for psychological testing	PC	SC	SC	SC	SC	SC	SC	
5.4	Teachers identify special ed students in classrooms	SC	SC	SC	PC	SC	SC	PC	
5.5	Referral for testing-update eligibility; reports complete & timely	PC	PC	NC	SC	SC	SC	PC	
5.6	Site has full continuum of placement options	NC	PC	NC	NC	SC	NC	NC	
5.7	Continuum of services available in restricted settings	NA	PC	NC	NC	NA	NC	NC	
5.8	Segments & services listed in IEPs are provided	NC	NC	NC	PC	SC	NC	NC	
5.9	Accuracy & completeness of special education data system	NC	PC	SC	SC	SC	PC	PC	
5.10	Assessment procedures updated & standardized	SC	SC	SC	SC	SC	SC	SC	
5.11	Training and reports of assessment completion rates	SC	PC	SC	SC	SC	SC	SC	
5.12	Procedures standardized, including county intake (due12/05)	PC	NC	NC	NC	SC	SC	SC	
5.13	Clinics-agreements with Intake & CS on providing IEPs	NC	NC	NC	NC	NC	NC	PC	
5.14	Procedures for Intake & CS on providing IEPs	NC	NC	NC	NC	NC	NC	PC	
5.15	Pre-existing valid IEPs implemented	PC	PC	NC	SC	PC	PC	NC	
5.16	Changes in IEPs documented w/rationale	PC	PC	NC	SC	PC	SC	PC	
5.17	Eligibility determined prior to IEP meeting	SC	SC	NC	SC	SC	SC	PC	
5.18	IEP eligibility meetings held timely & with notices, participation	PC	PC	NC	SC	PC	SC	PC	
5.19	IEPs include consideration of related svc/transition planning	SC	SC	PC	SC	SC	SC	PC	
5.20	Training on specific topics for special ed teachers	SC	SC	SC	SC	SC	SC	SC	
5.21	System of IEP progress reviews implemented	SC	SC	NC	SC	PC	SC	NC	
5.22	Compensatory special education svc provided when needed	PC	PC	NC	PC	SC	PC	PC	
5.23	Education Stakeholders' Committee w/quarterly meetings	SC	SC	SC	NC	SC	SC	SC	
5.24	Training to education and custody staff on Spec Educ Manual	SC	SC	SC	SC	SC	SC	SC	
5.25	Regional Prog Specialist site reviews of spec ed compliance	SC	SC	SC	SC	SC	SC	SC	
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	SC	
6.5	Students with equivalent passing scores- waivers requested	SC	SC	NA	SC	SC	SC	NA	
6.6	Students failing test receive remediation	SC	SC	SC	SC	SC	SC	SC	
6.7	Test data is monitored & basis of school improvement plans	SC	SC	SC	NC	SC	SC	SC	
6.8	Students have range of alternatives to complete education	SC	PC	NC	PC	SC	PC	NC	

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
DIVISION OF JUVENILE JUSTICE
Wards with Disabilities Program Remedial Plan - Annual Auditor's Report for FY 2007-08

Introduction

Auditing Activities for the 2007-08 Fiscal Year

This report represents the third auditing report by the Disabilities Expert and Auditor, Logan Hopper, in response to the Consent Decree entered in the matter of *Farrell v. Tilton/Cate*. The Consent Decree requires that the Disabilities Expert visit each of the eight DJJ correctional facilities 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, 2007, through June, 2008, the Disabilities Auditor visited the following facilities:

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

For the fiscal year 07-08, the Disabilities Auditor typically scheduled two one-day site visits to each correctional facility. The first audit date involved a more general review of all items contained in the Wards with Disabilities Program (WDP) Audit Instrument. The second audit date focused on a follow-up 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 each first facility visit, a summary report describing the basic activities of the audit and general findings was submitted, as requested by Bernie Warner and Don Specter in their joint letter dated June 8, 2007. 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 WDP facility coordinator and other staff on ways to gain compliance by the end of the 07-08 auditing cycle.

For each facility visited, the Disabilities Auditor completed an evaluation of the facility's compliance using the approved Disabilities Auditing Instrument, dated May 31, 2005. At the end of the second round of facility audits, the Disabilities Auditor prepared this final, detailed report for each facility, providing the compliance ratings and a commentary on the implementation progress for each item.

The only exceptions to these procedures were for the two facilities closed during the fiscal year, Dewitt Nelson YCF and El Paso de Robles YCF. Each of these sites was visited for only one day. There were some questions as to why these facilities were included in this fiscal year's audit, but my perspective was that they still served wards with disabilities for a full year and that there could be practices and procedures instituted at these facilities that would have broader application to the overall program. Each of the WDP facility coordinators at these facilities prepared a comprehensive binder of documentation; however, since there was no opportunity for follow-up, some items in the detailed compliance charts that comprise the majority of this report may include the reference for "Not Available" to denote that there was not adequate information to arrive at a definitive compliance evaluation.

Executive Summary

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

During the fiscal year, the Wards with Disabilities Program was impacted significantly by the departure of the original program manager and departmental WDP coordinator, Karen Smith, in December, and with the naming of Sandi Becker to the permanent position in March. During the last four months, Ms. Becker has worked diligently to assume these duties and is believed to be gaining understanding of the program and her duties rapidly. She brings a new perspective to the position and appears to be very capable and dedicated to the task. Still, the program obviously experienced some degree of delay during this period when there was no permanent coordinator. It should be acknowledged that Maria Correa, the Assistant Program Manager, provided much needed continuity and performed her duties admirably in keeping the development of policies and procedures moving forward. For most facilities, this was the second or third fiscal year with an active WDP facility coordinator, with SYCRCC being the only facility to experience a change in the position. The extent to which the program has progressed at each facility is almost directly proportional to the length of tenure of the WDP facility coordinator. Despite the varying degrees of experience with the details of the program, the actions of all of these WDP coordinators represent the strongest aspects of the Wards with Disabilities Program. The WDP departmental and facility coordinators and staff members go about their tasks in different ways, but they have all demonstrated remarkable patience and skill in setting up processes and undertaking the necessary tasks.

As a result of the combined efforts of these coordinators, the WDP program has progressed steadily 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. "Proof of practice" documentation of compliance efforts and activities as required by the remedial plan continue to progress, although it is clear that greater standardization and coordination among the facilities and Headquarters is still needed. 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. 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. The newly-instituted SSI assistance program is now also being handled by the WDP facility coordinators, and there has been some discussion regarding one or more of these coordinators taking on other responsibilities unrelated to the Wards with Disabilities Program.

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 a need for more meaningful acceptance of the program's goals by all correctional staff. The WDP Remedial Plan is a complex and comprehensive document that touches upon all operations of the DJJ as it relates to wards, since the overriding goal is for wards with disabilities to be integrated with and receive equal treatment and services consistent with those provided to all wards. Generally, Superintendents continue to be knowledgeable about and cooperative with the goals of the remedial plan. In addition, high-ranking supervisors at all facilities, usually Program Administrators or Treatment Team Supervisors, assist the WDP facility coordinators in procedural and operational matters, and many of these staff should also be commended for their commitment toward making the implementation of the plan filter into the various disciplines and departments. Beyond these staff members, the level of understanding and commitment to WDP Remedial Plan goals and objectives is still sporadic, although gains have been shown in a number of areas. Full cooperation and coordination from all staff has been the major impediment to more significant progress. As will be described below, disability awareness and sensitivity has progressed significantly during the fiscal year, and more staff are becoming better acclimated to the program, and acceptance has increased accordingly. However, many DJJ staff are still not aware of how WDP Remedial Plan requirements relate to their department's activities.

The sections that follow summarize the successful implementation actions taken by the DJJ in some areas, as well as document some areas where no meaningful progress has been made and where more focus is needed to meet the remedial plan's requirements.

Wards with Disabilities Identification and Accommodation

During the third round of visits, the various facilities used different methods and achieved differing results in attempts to identify, classify, and assign appropriate accommodations to wards with disabilities. This was mainly due to the fact that the WIN computerized identification system had not yet been fully implemented at the facilities at the time of the audit (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. A full implementation of WIN system reporting should allow for a more definitive monitoring of the effectiveness of these identification procedures.

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, it is our understanding that the WIN system has been upgraded and installed at all six facilities and that WDP facility coordinators and most other staff members have been trained on how to use the system. However, due to the nature of the auditing process in which facilities are monitored at a particular moment in time during the fiscal year, I have not actually seen the upgraded system in operation at all facilities, nor have I been able to evaluate the veracity and effectiveness of information entered by staff. Therefore, items related to the WIN system

as included in the Auditing Instrument are given a "partially compliant" rating, but this should not be interpreted that DJJ has not performed admirably in bringing about changes to the WIN 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 progress toward this end.

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. As described in the Auditor's preliminary reports, there are many areas that are exemplary in their design and in the appropriate incorporation of accessibility elements into the construction. Examples are the new accessible room and sanitary facilities at the Futch living unit at SYCRCC, the exterior path of travel improvements at O. H. Close, and the accessible showers at Heman G. Stark. It should be noted that the WDP Remedial Plan requires that these more comprehensive architectural modifications only be completed by July, 2008, so many improvements reviewed during the past fiscal year were ahead of schedule, and there are other areas that will be reviewed during the next year of monitoring. These final areas include some of the more detailed items, such as the removal of some fixed seats at dining areas, and the provision of adjustable exam tables at medical examination rooms.

ADA Staff Training

One of the major and most difficult implementation activities of the WDP Remedial Plan is the provision for initial and on-going staff training in the areas of WDP policies and procedures and disability sensitivity training. The WDP Remedial Plan requires that initial staff training be completed by the end of May, 2006 (within 12 months of adoption of the WDP Plan), and that annual training be provided to all staff, as well as to all new hires as part of the Training Center activities. This aspect of the plan was the major topic of discussion at a meeting attended by all parties involved in the *Farrell* matter February 29, 2008. It should be reported that significant strides in training activities have been made during the last half of the fiscal year. All WDP facility coordinators have completed Training for Trainers (called T for T) sessions and are actively involved in training activities at their facilities. The Disabilities Auditor has been provided with numerous training attendance lists for most facilities and was present at one of the training sessions held at Dewitt Nelson YCF, attended by approximately 100 staff members. To date, while the exact figures vary between facilities, a rough accounting shows that approximately 40% of all current staff have been given the training.

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. As described above, training for these SA's has proceeded at an acceptable rate, and these training sessions have helped to increase staff awareness of the requirements of the WDP Remedial Plan. These SA teams are

now set up and 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 WDP facility coordinator.

Educational Issues for Wards with Disabilities

There is overlap between the requirements of the WDP Remedial Plan and Educational Services, particularly in the area of services for wards with disabilities enrolled in special education programs. In their facility reports for this fiscal year, the educational experts have cited improvement on the issue of school participation and the number of hours of instruction for these wards, but they also still cite the need for further improvement at most facilities. Since many wards with disabilities are housed in special treatment or restrictive programs, this situation tends to negatively affect educational services for these wards to a significant degree. I would recommend that remedial strategies developed by the educational experts continue to be implemented to improve the number of hours of direct and integrated instruction for these wards. Monitoring activities still indicated some problems in the formulation of individualized education programs (IEP's). I would recommend particular attention to the requirements of the WDP Remedial Plan, such as the use of staff advocates prior to and during IEP meetings, to help to resolve these issues.

Self and Staff Referrals for Wards with Disabilities

These referrals underwent major changes during the year's audits, with most facilities transitioning from the previous Request for Sick Call (YA 8.229) form to the new "Disability Referral / Evaluation Form" (DJJ 8.288). 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. WDP and Headquarters staff members spent a considerable amount of time during fiscal year in attempts to complete remedial plan items related to the ward self-referral and staff referral process, and their efforts are commendable. The "Disability Referral / Evaluation Form" (DJJ 8.288) was completed and distributed to the facilities on February 25, 2008, and the form is now in use at most facilities. The form has many excellent features, yet it is not yet clear that the form will serve the intended purposes of the remedial plan. First, the form includes Education referrals, and the remedial plan requires the SCT process to refer and assess wards for this purpose. Second, the remedial plan and audit instrument intended that such a form should serve as a basic "sick call" form, and it is unclear if wards will be able to use the new, more complex form effectively. It is recommended that the form remain in use with no revisions throughout the next fiscal year, so that its proper usage and effectiveness can be further monitored and evaluated by the Disabilities Auditor and WDP staff.

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 required studies and activities include:

(1) a special working group to study and provide recommendations for establishing residential programs for wards with developmental disabilities,

(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,
(3) a special working group and study on the effects of and tracking policies for the prescription of certain psychotropic drugs, and
(4) coordination with safety and welfare issues for wards with disabilities, as they would be included in the safety and welfare remedial plan.

The Disabilities Auditor attended a meeting on September 4, 2007, with most of the staff who would be involved in these activities. Subsequent to that meeting, I prepared a memorandum, dated October 17, 2007, describing the discussions of the meeting and recommended follow-up actions, and transmitted the memo to WDP staff on several occasions throughout the year. To date, I have received no substantive information on any progress on these activities. It should be noted that the WDP Remedial Plan requires that the Disabilities Expert be consulted throughout the formulation of these studies and policies. Our interpretation of that requirement would suggest an on-going consultation relationship, and not just a final review and approval/disapproval. Again, it must be stated that the Disabilities Expert is ready and willing to assist in these activities.

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 2007-2008 fiscal year to the eight DJJ correctional facilities and Headquarters by the Disabilities Auditor, Logan Hopper. Facilities are listed in the chart using the following abbreviations:

- DN DeWitt Nelson Youth Correctional Facility
- Ven Ventura Youth Correctional Facility
- Pas El Paso de Robles Youth Correctional Facility
- HS Heman G. Stark Youth Correctional Facility
- Cha N.A. Chaderjian Youth Correctional Facility
- SY Southern Youth Correctional Reception Center and Clinic
- Clo O.H. Close Youth Correctional Facility
- Pre Preston Youth Correctional Facility and Reception Center
- HQ Headquarters

The reports attempted to determine a general level of compliance for the applicable items from the disabilities remedial plan and the disabilities audit instrument, using the following codes:

SC = Substantial Compliance; PC = Partial Compliance; NC = Non-Compliance; NAv = Not Available, -- = Not Applicable.

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

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Headquarters											
I. Directorate											
Maintain a current copy of the Wards With Disabilities Program Remedial Plan in the Director's office.	Verify current copy is retained.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
A. Departmental Ward Disability Coordinator & Functions											
By October 2005, establish and maintain a full-time Departmental Wards with Disabilities Program (WDP) Coordinator and analytical staff to develop, support, lead and manage a quality program.	Verify positions are in place and filled.	--	--	--	--	--	--	--	--	SC	At the present time, Sandi Becker is the full-time Departmental WDP Coordinator, and Maria Correa is currently the full-time WDP Assistant, with other staff being available as needed.
Ensure duty statement encompasses all	Review duty statement.	--	--	--	--	--	--	--	--	SC*	Duty statement for the Departmental WDP Coordinator was presented at the

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Departmental WDP Coordinator duties defined in the WDP Remedial Plan.											latest Headquarters audit
The WDP Coordinator shall perform the oversight functions as set forth in the WDP Remedial Plan.	Review documen-tation maintained by the Departmental WDP Coordinator.	--	--	--	--	--	--	--	--	SC	Sandi Becker is believed to be performing the required oversight functions.
Establish and maintain full-time WDP Coordinators at each facility by Feb., 2006.	Verify positions are in place and filled.	SC*	SC*	SC*	SC*	SC*	SC*	SC*	SC*		Each facility currently has an active WDP Coordinator in place.
The Departmental WDP Coordinator will develop a standardized emergency announcement protocol by December 2005.	Review emergency announcement procedures to ensure procedures are in place to provide the needed assistance for wards w/ disabilities. Determine timeliness of announcement.	--	--	--	--	--	--	--	--	PC	An emergency announcement protocol, TDO #07-94 dated Nov. 27, 2007, was provided to the Auditor by e-mail on Mar. 17, 2008, and in hard copy during the June 3, 2008, headquarters audit. 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. Third, the Auditor has not been able to verify proper training or the readiness for usage at the facilities.
The Departmental WDP Coordinator shall ensure that	Review monthly, quarterly and annual	SC	SC	SC	SC	SC	SC	SC	SC	PC	WDP facility coordinators' monthly reports have been prepared at all

Item	Method	Compliance Rate									Comments / Recommendations
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a WDP report is completed monthly, quarterly and annually for each site.	reports for completeness.										facilities within the last twelve months. Facilities generally use the basic "population" report, as well as the format that includes more information on the services actually provided to wards with disabilities, as well as information on wards with disabilities grievances, disciplinary actions, and those placed in restrictive settings. During the Headquarters audit, the presence of an annual report was questioned. It is assumed that monthly reports are combined to form an overall annual report, although these have not been submitted to the Auditor.
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.	--	--	--	--	--	--	--	--	PC	The Disabilities Auditor attended an initial planning session on September 4, 2007. No "action plan" was provided during the Headquarters audit on June 3, 2008, but a "Proof of Practice" draft of such a plan was recently sent to the Auditor, requesting review by July 7, 2008. That review has not yet been completed. See "Introduction" for a further discussion.
In conjunction with the Health Care Transition Team, the Mental Health and Medical Experts, and	Audit to determine implementation and review documentation to ensure compliance.	--	--	--	--	--	--	--	--	NC	The Disabilities Auditor attended an initial planning session on September 4, 2007. No other consultation has occurred, nor has a draft or approved

Item	Method	Compliance Rate									Comments / Recommendations
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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.											protocol or policy for monitoring psychotropic medications been presented to the Auditor by DJJ. See "Introduction" for a further discussion.
The CYA shall conduct annual compliance reviews of the court-approved Disabilities Program Remedial Plans in all CYA facilities to monitor compliance with the Remedial Plan, to ensure that wards with disabilities are being effectively identified, to ensure that the needs of those wards are being met and to reassess and reevaluate the level of staffing and training needed to comply with the Remedial Plan, commencing in the 2006 calendar year.	Verify completion of annual compliance reviews.	--	--	--	--	--	--	--	--	PC	The DJJ completed its last quarterly report on April 30, 2008. It is believed that this report and other quarterly reports could form a part of the annual report 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 not provided assessments of the level of staffing and training needed to comply with the WDP Remedial Plan. It is believed that "Corrective Action Plans" covering the last fiscal year and the second round of facility audits have been completed for most facilities, but these have not been shared with the Auditor.
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	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	--	--	--	--	--	--	--	--	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.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
of the Expert's report.	the required training.										
Develop the Disability Health Services Referral Form.	Monitor for completion by December 2005.	--	--	--	--	--	--	--	--	PC	It should be acknowledged that the WDP and Headquarters staff have spent a considerable amount of time to complete this item, and their efforts are laudable. 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. The 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.
C. Headquarters Policies											
The CYA shall procure two wheelchair accessible vans to transport wards with disabilities by July 2006.	Review purchase orders (PO) (STD 65) to confirm purchase and within established timeline.	--	--	--	--	--	--	--	--	SC	DJJ has submitted evidence that the two vans have been purchased and that the vans are now located at Preston and Stark. However, documents show that staff have not yet been trained in how to operate the vans, and that they are not currently in use. Since the Auditor has not personally been able to see the vans and verify they meet the intended

Item	Method	Compliance Rate									Comments / Recommendations
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											function, it is recommended that this item not be removed from the audit instrument at this time.
By July 2006, the Department shall develop and maintain system that documents the mental & physical impairments of wards with disabilities and any reasonable accommodations.	Audit to determine implementation within the given timeframe and review documentation to ensure compliance.	--	--	--	--	--	--	--	--	PC	The monthly reports adequately (though not systematically) document mental and physical impairments of wards at an aggregate, but not individual, level. Reasonable accommodations are usually documented by the WDP facility coordinator, but in an informal manner. DJJ has been working on comprehensive documentation through the WIN system upgrades and is believed to be close to completing the task.
The Department shall ensure that wards with disabilities have access equal to non-disabled wards in all levels of care within the youth correctional system.	Review 10% of placements and all level of care for wards with disabilities.	--	--	--	--	--	--	--	--	SC	Reviews of random files did not indicate any specific lack of equal access. It has been previously recommended that the Department prepare a documentation form to aid in assurances of equal access, but this has not yet been accomplished.
All wards under the jurisdiction of the CYA shall be given equal access to all programs, services and activities offered by the Department. Programs, services, and activities shall be offered in the least restrictive environment, with or without accommodations.	Review 10% of placements and access to special programs for wards with disabilities.	--	--	--	--	--	--	--	--	SC	Reviews of random files did not indicate lack of equal access to special programs. It has been recommended that the Department prepare a documentation form to evaluate the least restrictive environment requirement (see item above).
Establish policies to assure that placement of wards with disabilities into restrictive programs is not based either	On-going audit.	--	--	--	--	--	--	--	--	PC	It is recommended that specific policies and procedures be documented in writing to evaluate a ward's (with or without a disability) placement into any

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
directly or indirectly on a ward's physical or mental disability, or on manifestations of that disability.											restrictive program.
By December 2005, the Education Branch shall establish a working committee consisting of the Disability Expert, one Education Expert, the SELPA Director and the Manager of Special Education to study and make recommendations to improve the adult ward's and parents' meaningful participation during IEP meetings, to encourage more active participation, and to provide informational materials for parents and/or surrogates.	Review recommen-dations and develop appropriate implementation plans.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
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.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
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.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
In consultation with the disabilities expert, the CYA will conduct a study regarding the need for a residential program for wards with certain developmental disabilities. The study will commence within 6 months from the date that the Disabilities Remedial Plan is filed with the court.	Review documented study for meeting timeline and evaluate recommen-dations.	--	--	--	--	--	--	--	--	NC	This consultation and the resulting study have not yet occurred.
The visiting facility at Ventura is currently under construction & will be fully operational by 1/06. The new facility at Preston will be fully opera-tional and safe for all wards, visitors and staff by July '06. The CYA will confer with the Disability Expert to explore and implement, as appropriate, interim solutions to address architectural barriers at the existing Preston visiting area until new facility is opened by 7/06.	Visit locations to determine comple-tion/level of oper-ation by estab-lished dates.	--	PC	--	--	--	--	--	NC	--	It has been reported that the new visiting facility at Ventura is now open and in use, after the Auditor's last visit there. However, the Auditor has not been able to verify that the usage is permanent and fully compliant with the WDP Remedial Plan.
The CYA shall conduct a needs assessment and prepare Department wide disability training materials, with the assistance of an outside disability advocacy organization or consultant, in consultation with the Disability Expert, by June, 2006.	Review needs assessment and training materials.	--	--	--	--	--	--	--	--	PC	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 agency be consulted, as required by the remedial plan, to assist in developing the final curriculum for all training modules.
The CYA shall develop a screening tool to assess the	Review screening tool to ensure validation.	--	--	--	--	--	--	--	--	NC	This screening tool is reportedly under development, but not yet completed.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	Ensure that the assessment is completed within the given timeframe.										The Disabilities Expert has not been involved in the development of the screening tool, nor have I reviewed a draft or prototype.
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.	PC	PC	PC	PC	PC	PC	PC	PC	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 40% (see Introduction). It is still recommended that an outside (non-State) disability advocacy agency be consulted, as required by the WDP remedial plan, to assist in developing the final curriculum for all training modules. 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.
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.	--	--	--	--	--	--	--	--	PC	Reviews of random files and interviews indicated several problems in this area at facilities during the last fiscal year. It has been recommended that the Department prepare a documentation form to aid in assurances of equal access. This review did not include fire camps, since they were excluded from the last year's audits, but these will be included during the next fiscal year.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
The CYA shall develop a provisional form that contains a written advisement of ADA Rights Notification in simple English and Spanish by August 2005.	Review form for completion.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
D. Headquarters Programs/Screening											
Maintain a contract for sign language interpreter services, as well as a record of use of this service.	Review contracts (STD 213/210) for sign language interpreter's services.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
The Intake and Court Services Unit staff shall review incoming documentation from the committing courts and counties of all wards for indicators of impairments that may limit a major life activity and require accommodations or program modifications.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	--	--	--	--	--	--	--	--	SC	There were no specific indications that incoming documentation from the courts and counties was not adequately reviewed, although the data records were difficult to follow during the Headquarters audit. It should be noted that records from the courts and county jails are poorly prepared, and that this is beyond DJJ's control; it may be necessary to require better documentation from these parties. I would again recommend additional documentation verifying the extent of review within the Intake and Court Services Unit. (See also item at the top of the next page.)
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.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
When indicators of impairment exist, the Intake and Court Services Unit staff shall complete the disability section on the Referral Document and forward to the designated Reception Center and Clinic.	Sample 10% or 10 ward master files, whichever is greater, reflecting intake for the last quarter. Interview Intake and Court Services Unit staff.	--	--	--	--	--	--	--	--	PC	This was a marginal "SC" compliance item as discussed in last year's annual report. This year's review of intake files indicated that Intake and Court Services Unit staff still had problems in consistently being able to accurately identify known disabilities, or question their presence for future assessment. As with the item two lines above, the fact that records from the courts and county jails are poorly prepared is a contributing factor to this problem, but the Referral Document is still used as an important resource by the clinics, and complete information on this form is important. It may be necessary to require better documentation from these parties.
Facility Administration											
A. Superintendent											
Maintain a current copy of the Wards With Disabilities Program Remedial Plan retained in Superintendent's office.	Verify current copy is retained.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Superintendents shall ensure wards with disabilities are informed, during orientation, of the existence of electronic equipment in libraries, what equipment is available, how and when equipment can be accessed, and where the equipment is located.	Review orientation program for inclusion of information.	PC	PC	SC	PC	PC	PC	PC	PC	--	The three clinics have not instituted the formal orientation program for wards (see below), and the other facilities follow differing informal procedures for relaying this information to wards. Most facilities have prepared their own memo or written information sheet describing these features, but there is no departmental policy. It was not adequately documented nor could it be

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
											determined how wards are provided with information regarding these particular accessible features, except at one facility, where the WDP coordinator kept attendance records with dates of all orientation sessions.
The Superintendent shall report to the Deputy Director, within twenty-four hours, when a ward with a disability that requires accommodation is placed in a restrictive setting, i.e., TD or lockdown.	Interview wards and SAs. Audit TD forms for compliance. Review Special Incident Reports (YA 8.401) related to Administrative Lockdowns.	SC	SC	SC	SC	SC	SC	SC	SC	--	A system of reporting by e-mail is in place at each facility.
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	PC	PC	--	This item was given an "SC" rating at all facilities in last year's annual report. The reason was twofold. First, the "Case Report Transmittal" forms were available in electronic format, but the WDP facility coordinators used other alternate procedures to document accommodations to the Board, and it was felt that they should be given credit for these actions. Second, the Board instituted its own procedures based on the *Armstrong* case to assist in accommodating wards with disabilities, and most of the affected wards were provided with attorneys, thus relieving DJJ from the obligation to provide a Staff Assistant, but these procedures have now been terminated. It was noted in last year's report that the "Case Report Transmittal" forms should be used in the future, when made available

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
											through WIN, to standardize procedures agency-wide. These forms have been revised to provide more details on the specific accommodations required and to document due process, equal access, and the provision of accommodations, as required by the WDP Remedial Plan. However, they have only been available in the last few months, and were not in use during any of the audits. It is believed the consistent use of these forms is crucial to the Board's ability to understand the special needs of wards with disabilities.
B. Facility's Ward Disabilities Coordinator											
Maintain WDP Coordinators at each facility.	Verify positions are in place and filled.	SC	SC	SC	SC	SC	SC	SC	SC	--	Each facility had an active WDP Coordinator in place at the time of each site visit. Since this situation could change at any point in time (e.g., a coordinator could resign or be promoted), it is felt that this item should remain in the audit instrument, despite the two concurrent "SC" compliance ratings (as with the four items directly below).
Ensure duty statement encompasses all facility WDP Coordinator duties as defined in the WDP Remedial Plan.	Review duty statement.	SC	SC	SC	SC	SC	SC	SC	SC	--	Each WDP Coordinator has signed an appropriate duty statement.
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	SC	SC	SC	SC	--	Each WDP Coordinator is believed to be performing the required oversight functions.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	**Ven**	**Pas**	**HS**	**Cha**	**SY**	**Clo**	**Pre**	**HQ**	
Within six months of the court approval and adoption of this plan the facility Ward Disability Program Coordinators will receive a higher level of training provided by qualified trainers/consultants from outside the Department as recommended in Section 5.1 of the Expert's report.	Review outside consultants training material to determine compliance with the requirements in the WDP Remedial Plan. Review and confirm training schedule to ensure all individuals complete the required training.	SC	SC	SC	SC	SC	SC	SC	SC	--	WDP Remedial Plan and general ADA training has been provided to the facility WDP Coordinators, primarily by the Departmental WDP Coordinator, and they have attended additional training at seminars presented by the National Association of ADA Coordinators.
The facility WDP Coordinators shall submit monthly reports to the Department WDP Coordinator.	Review monthly reports.	SC	SC	SC	SC	SC	SC	SC	SC	--	Monthly reports have been prepared in a timely manner by the facility WDP Coordinators, and the expanded report format as recommended by the Auditor has been utilized at most facilities. A short executive summary and some more detailed service-related information would be an excellent addition to this report.
C. Facility's Policies											
Efforts to identify wards with disabilities within youth correctional facilities shall be continuous, and shall include self-referrals, staff-referrals, facility ADA screening and assessment, and special case conferences.	On-going audit.	PC	PC	SC	PC	SC	PC	SC	PC	--	There is still a relatively wide range of compliance related to identification of wards with disabilities among the facilities. This is mainly due to the fact that Headquarters (primarily medical and mental health) have not disseminated comprehensive guidelines for identifications, screenings, and assessments, although there have been some memos for some specific impairments. In general, it is believed that the WDP facility coordinators are using their best efforts to identify affected wards, but clarifications from

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
											Headquarters and cooperation from the various departments are needed to make the proper determinations. Very few special case conferences were held during the fiscal year, and these are not being utilized effectively to assist in assessment efforts.
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	SC	SC	--	There were no documented or known specific instances where a ward's assistive device was taken away due to security concerns.
Wards with hearing disabilities shall be provided use of a Telecommunications Device for the Deaf (TDD).	Interview wards and WDP coordinators to verify presence of operational TDD.	SC	SC	SC	SC	SC	SC	SC	SC	--	TDD's were present at all of the facilities, but were not operational if no deaf wards were present. No wards reported the inability to have an operable TDD available.
Wards with hearing impairments shall have access to at least one facility television located in their assigned living unit that utilizes the closed captioning function at all times while the television is in use.	Interview wards and WDP coordinators to verify presence of operation closed captioning function TV.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Distribute and post reports, brochures, treatment, and education materials in a manner that is accessible to	Conduct site visits to verify presence of accessible posted materials.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
wards with disabilities.											
A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through his or her assigned PA, Casework Specialist or by completing the Referral for Sick Call (RSC) form. A ward may make a self-referral for an accommodation for a documented or perceived impairment through an Education Advisor by completing the Self-Referral to the School Consultation Team (SRSCT) form.	Review submitted RSC (YA 8.229) and SRSCT (YA 7.464) forms and determine appropriateness of disposition. Observe random interviews at intake.	PC	PC	SC	PC	PC	PC	PC	PC	--	This item underwent major changes during the year's audit, transitioning from the previous RSC (YA 8.229) form to the new "Disability Referral/ Evaluation Form" (DJJ 8.288) (see page 10). 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. A "Health Case Services Request Form" was used at some facilities in lieu of the RSC Form YA 8.229, but wards were not typically advised of its proper use. Typically, very little documentation was provided to the Auditor by the Education Department at each site to indicate that the SCT form YA 7.464 and its follow-up forms were being used by wards for self-referrals.
The Principal shall ensure students with disabilities are trained in the proper use of electronic equipment.	Interview wards and Principal for proof of practice.	SC	SC	SC	SC	SC	SC	SC	SC	--	Although wards with physical disabilities who would be most affected by this item were not specifically identified by DJJ, the facilities appeared prepared to provide the necessary and appropriate training, if needed.
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	PC	PC	SC	SC	SC	SC	PC	SC	--	Since the requirement for passing the CAHSEE was deferred for special education students until Dec., 2007, this is the first audit period in which the "waiver request" process has been applicable. As in the past, it was not evident that all wards with disabilities were provided with the accommodations contained in their IEP's, and greater

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
	accord with CDE guidelines.)										documentation of these accommodations should be kept and provided to the Auditor at future audits. Nevertheless, it appeared in the short time that the schools were beginning to re-use the waiver request process that the waiver was granted in most cases.
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.	PC	PC	SC	PC	PC	SC	SC	SC	--	Of the student files reviewed, some did not have had properly prepared graduation plan forms completed within the last year. The degree of problems varied for each facility, as shown in the previous columns in this row. Some files that did have plans did not have all of the necessary information, nor specificity how goals were to be accomplished. Other graduation plans were not being followed once updated, and some graduation plans did not lead toward the graduation goal.
Provide for and implement the four exceptions to the graduation standards for students with disabilities, as listed in the remedial plan.	Review randomly 10 or 10%; whichever is greater, of students with IEP's graduation rates and uses of the exception to the graduation requirements.	SC	SC	SC	SC	SC	SC	SC	SC	--	Some facilities provided lists of students with disabilities graduating in the last year, while others did not. There were no specific indications that any of the four graduation exceptions listed in the remedial plan was denied.
The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities.	Review randomly 10 or 10%; whichever is greater, of access for students with IEP's.	PC	PC	PC	PC	PC	PC	PC	PC	--	All of the facilities showed some improvement from last year, with five receiving a "NC" rating for last year now being rated as "PC". However, based upon the student files reviewed and interviews, there were indications that some wards with disabilities,

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
											particularly those at restricted units, still had limited access to full-day educational programs, vocational programs, and other special educational activities. IEP procedures also improved at all sites, although some special education students were not assessed within the allowed time constraints. A few special education students had outdated IEP's, and IEP forms for minors lacking a parent's or surrogate's signature were still present.
Non-emergency verbal announcements, in living units where wards with hearing and other impairments reside, shall be done on the public address system and by flicking the lights on and off several times to notify wards with disabilities of impending information. Verbal announcements may be effectively communicated in writing, on a chalkboard, or by personal notification.	Review operational procedures. Interview wards with disabilities to determine effectiveness of non-emergency communications.	SC	SC	SC	SC	SC	SC	SC	SC	--	Specific written operational procedures were provided to the Auditor at all facilities. Since few wards with hearing disabilities were present, it was not possible to determine if any significant problems in this area might exist. The flickering 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 emergency protocol is implemented, and until wards with hearing impairments are present to the extent necessary to evaluate the procedures.
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	Interview 10 security personnel and wards yearly for specific inquiry regarding security issues.	PC	PC	PC	PC	PC	PC	PC	PC	--	Interviews and observations indicated ongoing problems in this area. Additional guidelines contained in the Safety and Welfare Plan were adopted during the fiscal year, but a complete review of how these will affect security procedures for wards with disabilities has not been fully analyzed by DJJ, and

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
property.											no specific procedures or policies were provided during the audits.
Prior to placing a ward with a disability into a restricted setting, the Superintendent shall review the referral form and ensure that any accommodation required by a ward has been documented.	Review records of 10 or 10%, whichever is greater, of wards placed in restrictive settings.	SC	SC	SC	SC	SC	SC	SC	SC	--	Lists of wards placed in restricted settings were provided to the Auditor. There were indications that such placements were reviewed as required by the remedial plan, although these procedures will require further review by DJJ and monitoring.
Each Education Specialist that is assigned as a case carrier, or alternate, will discuss the tenets of advocacy with the ward and surrogates prior to the IEP meeting to encourage active participation. During the IEP meeting, the specialist or alternate, will serve as the advocate of the student.	Attend pre-meetings and IEP meetings to determine degree of participation and advocacy roles.	PC	PC	PC	PC	PC	PC	PC	SC	--	This policy is beginning to be implemented, and one of the common activities during the audits was to advise Education staff of ways to document compliance. Many Special Day Class teachers review IEP documents with wards prior to a meeting, but those wards in restrictive units usually had no advance preparation available.
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	PC	SC	SC	SC	PC	PC	SC	--	The degree of training for surrogates varied for each facility, although some training has occurred at all facilities. It is believed that surrogate training has improved dramatically, but those facilities indicated as "PC" had instances where surrogates who signed an IEP were not listed on the attendance lists for the training sessions. An adjunct to this item includes the issue that surrogates are not always provided at IEP meetings, where required.
Reasonable accommodation shall be afforded wards with	Interview wards and WDP coordinators to	PC	PC	SC	SC	PC	PC	SC	PC	--	Procedures for providing the required variety of accommodations and assistive

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
disabilities to ensure equally effective communication with staff, other wards, and the public. Assistive devices that are reasonable, effect-tive, and appropriate to the needs of a ward shall be provided when simple written or oral communi-cation is not effective or as necessary to ensure equal access to the programs and services. (A list of potential devices omitted for brevity)	determine level of availability and accessibility of assistive devices.										devices have not been fully developed at the facilities, or department-wide. Medical issues, including the provisions of glasses, hearing aids, and mobility aids, showed no consistent procedures. The compliance rates usually had more to do with the degree of assistance and cooperation from other departments than the efforts of WDP staff. Better assistance and transfer of necessary information from other departments, as well as specific guidance from Headquarters, is needed.
The Department shall provide reasonable accommodations or modifications for known physical and mental disabilities of qualified wards. Accommodations shall be made to afford equal access to the court, to legal representation, and to health care services for wards with disabilities.	Interview wards with disabilities and WDP coordinators to confirm accommodations.	PC	SC	SC	PC	PC	PC	SC	SC	--	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 be more fully developed at the facilities and department-wide and documented in the updated WIN system.
Qualified sign language interpreters shall be provided as necessary to ensure effective communication and at a minimum for all due process functions, medical consultations, video-conferencing and special programs.	Review record of use logs for qualified interpreters.	--	--	--	PC	PC	--	--	PC	--	There were only two deaf wards present during the audits, and one presented a significant challenge to DJJ during this year. He had an interpreter assigned at most times, but further clarification of the interpreters' duties and more specific guidelines are needed from Head-quarters. Use logs for interpreters were not consistently utilized.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Reasonable accommodations may only be denied if the accommodation 1) poses a direct threat to the Health and Safety of others, 2) constitutes an undue burden, or 3) if there is equally effective means of providing access to a program, service, or activity through an alternative method that is less costly or intrusive. Alternative methods may be used to provide reasonable access in lieu of modifications requested by the ward as long as those methods are equally effective. All denials of specific requests shall be in writing.	Review (written) denied requests for accommoda tion to determine if alternative method provided reasonable access.	SC	SC	SC	SC	PC	SC	SC	SC	--	Refer to two items above for the basic provision of reasonable accommodations. For this specific item, there were few instances encountered where written requests for accommodation were denied in writing.
The Department shall ensure that wards with disabilities have access to all Youth Authority Board (YAB) proceedings. To this end the Department shall provide reasonable accommodations to wards with disabilities preparing for parole and YAB proceedings.	Interview wards with disabilities and IPA's / Casework Specialists to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	Reasonable accommodations are usually commonly provided by the facility WDP Coordinator or a member of the SA team. For further discussion, see page 19.
Departmental staff shall ensure wards with disabilities are provided staff assistance in understanding regulations and procedures related to parole plans & the completion of required forms.	Interview wards with disabilities and Staff Assistants to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	Assistance is adequately provided in parole planning, although the identified Staff Assistants are not usually involved in this process.
Institutional parole staff will provide detailed information regarding the ward's needs	Review sample of Parole Consideration reports for identified	PC	PC	PC	PC	PC	PC	PC	PC	--	While a general degree of information about wards with disabilities needs were included in parole reports, specific

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
and make recommendations to field parole staff regarding referrals to key community agencies and service providers.	wards with disabilities. Interview institutional parole agents / Casework Specialists to ensure compliance.										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. I have recommended that parole reports provide more detailed information on ward's with disabilities specific needs for the continuation of accommodations and special services.
Institutional parole staff shall work collaboratively with field parole staff and Regional Center personnel to coordinate services, as forth in the remedial plan, for individuals with develop-mental disabilities and their families upon release.	Review sample of parole plans for identified wards with developmental disabilities. Interview institutional Parole Agents/Casework Specialist to ensure compliance.	--	--	--	--	--	--	--	--	--	No wards with developmental disabilities were identified as recently paroled.
The IIPA/Casework Specialist shall complete & 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 sched-uling a YAB hearing. PA I/C.S. shall be responsible for requesting accom-modations 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	PC	PC	--	See page 19.
The Department shall ensure that aid is provided to all wards with disabilities who request assistance in	Interview wards with disabilities and SA's to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
requesting accommodations during YAB hearings.											
1. Disciplinary Decision Making System											
To assure a fair and just proceeding, if the rule violation is recorded as a Level 3 (Serious Misconduct), all wards with disabilities who require an accommodation shall be assigned a Staff Assistant (SA) from the facility SA team.	Review DDMS documents concerning wards with disabilities to ensure SA assistance.	SC	SC	SC	SC	SC	SC	SC	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Each facility shall have a SA team with at least one representative from each of the following disciplines: mental health, health care, and education.	Review composition of SA teams.	SC	SC	SC	SC	SC	SC	SC	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Disposition chairperson shall be trained to communicate with wards that have disabilities.	Audit training module and review training record of disposition chairperson for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	Current disposition chairpersons have typically been trained along with the SA team by the Departmental WDP Coordinator, although no specific training module been reviewed and approved by the Auditor. Since disposition chairpersons change frequently, it is recommended that this item not be removed from future audits.
The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe cognitive/emotional disabil-ities & present an overview	Audit training module and review training record of SA for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	The SA team received training from the Departmental WDP Coordinator, although no specific training module been reviewed and approved by the Auditor. Since SA team members change frequently, it is recommended that this item not be removed from

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
of the DDMS process.											future audits.
The facility WDP Coordinators shall review all DDMS/grievance forms at least monthly to identify any patterns of misbehavior that may be related to cognitive and emotional disabilities.	Review monthly audit documents to confirm compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	All facility WDP Coordinators are aware of the requirement and generally review DDMS forms. Documentation has varied, ranging from no written documentation to meeting notes. Further review and refinement of procedures is needed, and further auditing is appropriate.
2. Grievance Procedures											
The SA shall be assigned to each grievance (from filing to resolution) involving a ward with a mental or physical disability who currently requires an accommodation.	Review completed grievance documents (Grievance Form-YA 8.450, Appeal Form-YA 8.451) concerning wards with disabilities to ensure SA assistance through confirmed signature.	PC	PC	PC	PC	PC	PC	PC	PC	--	A number of DJJ 8.450 and 8.451 grievance forms were reviewed at each facility. The new grievance procedures (utilizing a grievance box in lieu of grievance clerks) was not in full operation during the audits. The WDP coordinators at most facilities have 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 with a grievance clerk involved. Also, the updated WIN system will be used to track grievances, and it unclear how this will be accomplished. It is recommended that this item be deferred until the new grievance procedures have taken effect and can be audited and evaaluated.
All grievance respondents shall be trained to communicate with wards	Audit training module and review training record of grievance	PC	PC	PC	PC	PC	PC	PC	PC	--	This is an open-ended item, since a number of staff members may be involved in the initial filing of a

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
that have disabilities.	respondent for compliance.										grievance. Completed staff training at the departmental level would be needed to comply with this requirement. No specific training module related to grievances has been reviewed by the Auditor.
The SA shall complete a course to become a staff assistant that contains modules that define SA roles and responsibilities, describe mental / physical disabilities and present an overview of the grievance process.	Audit training module and review training record of SA for compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
The WDP Coordinator shall review all grievance forms at least monthly to identify any patterns of repetitive involvement that may be related to mental / physical disabilities and refer such cases to the appropriate supervisory staff.	Review monthly audit documents to confirm compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Completed grievance forms should be randomly monitored by the facility WDP Coordinator to determine if indeed disability is an issue, even though the ward filing the grievance may not have specifically cited it.	Included in meetings with WDP Coordinators.	SC	SC	SC	SC	SC	SC	SC	SC	--	All facility WDP Coordinators are aware of the requirement and are reviewing DDMS forms. Documentation has varied, ranging from no written documentation, to meeting notes. Further review and refinement of procedures is needed, and further auditing is appropriate.
The grievance screening process for accommodations, including the medical	Review randomly 10 or 10%, whichever is greater, of	PC	SC	PC	PC	SC	SC	SC	PC	--	Records reviewed during the audits still indicated problems of assuring medical disability issues were resolved in a

Item	Method	Compliance Rate									Comments / Recommendations
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verification process for accommodations, should be completed in a timely manner and interim accommodations shall be provided to the extent necessary.	accommodation related grievances.										timely manner at some facilities.
The Wards Rights Coordinator, within 24 hours of receipt, shall review grievances, with attached documen-tation, 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.	SC	SC	SC	SC	SC	SC	SC	SC	--	No specific issues requesting accommodation unrelated to the medical issues described in the item above were specifically encountered. It is still recommended that procedures to facilitate the Wards Rights Coordinator's review of grievances related to accommodations and discrimination be prepared and implemented.
The Wards Rights Coordinator shall forward to the facility WDP Coordinator or designee all grievances that meet the criteria for review and response within 48 hours of receipt.	Audit grievances from ward with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination to confirm meeting timelines.	SC	SC	SC	SC	SC	SC	SC	SC	--	No specific issues requesting accommodation unrelated to the medical issues described in the item above were specifically encountered. It is still recommended that procedures to facilitate the Wards Rights Coordinator's review of grievances related to accommodations and discrimination be prepared and implemented.
Grievances referred to the CMO when medical verification of a disability or identification of an associated limitation is required and returned to the	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommo-dations or allege	PC	SC	PC	PC	SC	SC	SC	PC	--	Grievances requiring medical verification have exceeded time limits in several cases. It is recommended that procedures to facilitate the medical verification process be prepared and implemented.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
Wards Rights Coordinator are handled within timeframes as defined within the remedial plan.	discrimination to determine compliance of protocol within time constraints.										
If medical verification is not available in the UHR, and medical staff determines that a referral to an expert consultant, external to the department, is required, an appointment shall be scheduled within ten working days to determine whether a disability or any limitations exist. The medical staff, upon receipt of report from an expert consultant, shall note verification of a disability and any limitations that exist on YA grievance form, and in the UHR of a ward.	Review grievances from wards with disabilities (Grievance Form – YA 8.450) that request accommodations or allege discrimination and their UHR to determine compliance of protocol within given time constraints.	PC	SC	PC	PC	SC	SC	SC	PC	--	Grievances requiring medical verification have had some instances where outside assistance from an expert consultant was necessary, but not necessarily the result of a grievance. It is recommended that procedures to facilitate the outside verification process be prepared and implemented.
After consultant verification of a disability, medical staff shall return the grievance, with all required documentation, to the Wards Rights Coordinator. The Wards Rights Coordinator shall forward to the Office of the Superintendent all grievances that meet the criteria for review and response within 48 hours of receipt from Health Care Services staff.	Audit grievances from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrim-ination to determine compliance of protocol within given time constraints.	PC	PC	PC	PC	PC	PC	PC	PC	--	These procedures have not been fully implemented. It is recommended that procedures to facilitate the medical verification process be prepared and implemented.
The Wards Rights Coordinator	Audit grievances	SC	SC	SC	SC	SC	SC	SC	SC	--	It is believed that this procedure is being

Item	Method	Compliance Rate									Comments / Recommendations
		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.	from wards with disabilities (Grievance Form - YA 8.450) that request accommodations or allege discrimination.										handled informally, although no departmental report form has not yet been prepared. WDP facility coordinators are aware of the requirement and are reviewing such grievance forms.
Wards may use the WDP Grievance process to file a grievance based on the denial of a request for a reasonable accommodation during YAB proceedings.	Interview wards with disabilities. Review grievances to determine compliance.	NC	SC	SC	SC	SC	SC	SC	SC	--	There was one instance where a ward had an unresolved grievance relating to this item during the auditing period.
Wards with disabilities shall be granted reasonable accommodations with respect to timeframes, consistent with the Ward Safety and Welfare Plan, for processing of grievances.	Interview wards with disabilities. Review grievances to determine compliance.	--	--	--	--	--	--	--	--	--	There were no indications that a ward had a problem with time lines associated with grievances during the auditing period. A review of the Ward Safety and Welfare does not appear to address this issue, and it is unclear how this item will be handled under the new grievance policy.
D. Programs											
1. Reception Center and Clinic Functions											
As part of the clinic screening and assessment process, all wards shall be screened at the reception centers, and as indicated, throughout their stay in the Department, to determine whether they have a developmental disability which may make them eligible under criteria set	Review screening documents (YA 1.411) in ward field files.	--	NC	--	--	--	NC	--	NC	--	Wards are not formally screened at the reception centers for the presence of a developmental disability, although past screenings (e.g., IQ testing) are reviewed. These procedures do not coincide with WDP Remedial Plan requirements. It is my understanding that meetings have been recently held at headquarters to discuss the issues related to this topic.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
forth in the ADA and/or may make them eligible to receive services from a Regional Center.											
During the initial wards interviews, advise wards of their rights under the ADA and section 504, and receive formal documentation that they have received and understood this advisement.	Observe random interviews at intake facilities.	--	SC	--	--	--	SC	--	SC	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
Assigned Casework Specialists shall refer a ward to a mental health professional on a Mental Health Referral Form when indicators of a mental impairment exist that may limit a major life activity.	Review copies of Mental Health Referral Form for completeness.	--	SC	--	--	--	SC	--	SC	--	Casework Specialists may use various forms, including a "Mental Health Services Referral" form, a "Ward's Request for Reasonable Accom-modation" form, or a "Critical Factors Assessment for Determining Need for Mental Health Evaluation" form, to refer wards to a mental health professional during intake. It is unclear how the newly approved "Disability Referral/ Evaluation Form" (DJJ 8.288) (see page 10) will fit into these processes, since it was not in common use at the clinics during the audits. All reception centers are given an "SC" compliance rating since it was believed that mental health referrals were generally made appropriately, but it should be evident that with the uses of varying forms, standardization and guidance from Headquarters is needed assure long-term compliance. It is recommend that further auditing of this item by the Auditor continue during the next year.

Item	Method	Compliance Rate									Comments / Recommendations
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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	--	--	--	SC	--	SC	--	Casework Specialists use various forms and methods to refer wards to medical professionals during intake. It is unclear how the newly approved "Disability Referral/ Evaluation Form" (DJJ 8.288) (see page 10) will fit into these processes, since it was not in common use at the clinics during the audits. All reception centers are given an "SC" compliance rating since it was believed that medical referrals were generally made appropriately, but it should be evident that standardization and guidance from headquarters is needed assure long-term compliance. It is recommended that further auditing of this item by the Auditor continue during the next year.
Assigned Casework Specialists shall use a Referral to School Consultation Team (SCT) form to refer a ward to an educational professional to verify the existence of a learning impairment that may limit a major life activity.	Review copies of Referral to School Consultation Team (YA 7.464) for completeness.	--	PC	--	--	--	PC	--	PC	--	Casework Specialists use other methods to refer wards with learning disabilities to educational services during intake and at other times, but the RSCT form YA 7.464 form is not used for this purpose, nor is the School Consultation Team (SCT) routinely utilized to document a learning impairment referred during intake. As also discussed in the Education experts' reports, SCT's are not currently operating at an effective level at many facilities.
Licensed mental health professionals and medical personnel shall complete the screening process on a ward within 10 working days of a	Review screening forms for complete-ness and timeliness: MH – SPAN/ YA 8.216; Med – Medical	--	SC	--	--	--	SC	--	PC	--	Based upon records provided to the Auditor, medical and mental health screenings typically occur within 10 days of the referral at most facilities.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
referral from an assigned Casework Specialist.	HX/YA 8.260.										
Within 15 calendar days of completing the Educational Disability Screening process, the education staff shall develop an assessment plan.	Review screening forms for complete-ness and timeliness: Ed – CASAS, CELDT, High Point Testing, HX in file	--	PC	--	--	--	PC	--	SC	--	The initial intake interview includes a checklist for educational needs. Based upon interviews and records review, it appeared that assessment plans were usually developed if indicated by the checklist, but not usually within 15 calendar days.
Within 10 working days of completing the disability screening process, department staff members who are licensed mental health professionals and health professionals and medical personnel shall use standardized psychological test instruments, medical, dental practices to assess wards.	Review appropriate documentation for completeness and timeliness.	--	PC	--	--	--	PC	--	PC	--	It is unclear to what extent psychological testing of all wards is required by this section of the remedial plan. The initial intake interview highlights further needs for psychological assessment, including possible testing, that may be necessary, but this is individualized and not a standard procedure. Further clarification is needed.
Credentialed Education Staff shall complete educational assessment within 50 calendar days.	Review appropriate documentation for completeness and timeliness.	--	SC	--	--	--	SC	--	SC	--	Records provided to the Auditor indicated that a wide variety of educational assessments are either utilized or developed. In some cases, recent assessments from other sources are used to provide interim placement or schedule the IEP. More guidance from Headquarters and standardization is needed.
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	Review random ICR reports for wards with disabilities.	--	PC	--	--	--	SC	--	PC	--	The Initial Case Review (ICR) provides the opportunity for such accommodations, and these appear to be provided at a very general level, but it is unclear that appropriate procedures or documentation have been instituted,

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Supervising Casework Specialist II shall ensure that such accommodations are provided.											particularly with respect to medical accommodations. Since much of this procedure relies on the diligence of the Supervising Casework Specialist II, I would recommend that these procedures be written for future documentation. It is also recommended (as implied by the WDP Remedial Plan) that an actual ICR meeting be held with the ward and all of the various disciplines; this is not occurring at all of the intake facilities, as shown in the columns.
All wards shall complete the orientation process at a reception center that contains a standardized Disability module which shall include: 1) a summary of the main points of the Disability law under Title II of the ADA and IDEA and their relevance to wards, 2) a summary of the main points of the Department Disability Policy as it relates to wards, 3) an explanation of the Disability self-referral process, and 4) the Ward's Rights Handbook section on Disability.	Review orientation program for required components and audit ward-signed orientation forms to confirm participation.	--	PC	--	--	--	PC	--	PC	--	A formal "orientation process", as described in the WDP Remedial Plan (Section III.J.), has been historically presented at only one site, but even that process was not active at the time of the audits. A counselor at the intake living unit usually provides an individual ward or several wards with a general orientation to the WDP program, but no formal "orientation process" is currently provided. A basic "standardized Disability module" has been developed as part of the overall orientation package, but it is not presented on a systematic basis and it needs additional information, particularly with respect to applicable disability law, the IDEA, and the referral process. I would recommend that the Departmental WDP Coordinator assist in coordinating and supplementing these past efforts, and possibly even present the first few orientations, to effect implementation of this provision.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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	--	--	--	PC	--	PC	--	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 were provided to the Auditor.
2. Residential Programs											
For each special program or activity, evaluate eligibility criteria to assure that wards with disabilities are not excluded when they can perform the essential functions of the activity.	On-going audit, based on detailed factors listed in the plan. Visit special program locations yearly.	SC	PC	SC	SC	PC	SC	--	PC	--	Visits to unique programs and interviews with wards and program directors gave only a few specific indications (as evidenced by the columns to the left) that wards with disabilities were not included on an equal basis in special programs. However, for some programs, there was 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 many of these programs.
Staff shall refer wards to Health Care Services and the Education Department for screening when information	Review submitted SRSC (YA 7.464) and SCT Referral (YA 8.229) forms and	PC	PC	PC	PC	PC	PC	PC	PC	--	Staff generally used various forms and methods, some written and some e-mailed, to refer wards to Health Care Services and the Education Department

Item	Method	Compliance Rate									Comments / Recommendations
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is observed or received that indicates the presence of a physical or mental impairment that has not been documented and verified.	determines appropriateness of disposition.										for screening. It is unclear how the newly approved "Disability Referral/ Evaluation Form" (DJJ 8.288) (see page 10) will fit into these processes, since it was not in common use at the clinics during the audits. All facilities are given a "PC" compliance rating since procedures are not standardized and at most facilities, the number of referrals was much less than would be expected. There were instances where wards were referred to various service components (education, mental health, etc.), but referrals were informal and did not generally follow the time lines or procedures described in the WDP Remedial Plan. Many of the referrals actually came from WDP facility coordinator . Guidance and training is needed from Headquarters to demonstrate appropriate use of these forms consistent with the WDP Remedial Plan. The updates to the WIN system should help to track future staff referrals.
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	Audit case conference forms (ICP) for wards with disabilities to ensure implementation and timeliness.	PC	PC	PC	PC	PC	PC	PC	PC	--	Very few or special case conference forms or reports were provided to show compliance. While few referrals were reported, it is believed that the facility WDP Coordinators (not the Treatment Team Supervisors / Supervising Casework Specialists) are beginning to monitor the timely resolution of screening, although the exact time limits could not be verified.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
assigned PA /Casework Specialist conducts a special case conference.											
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 accom-modations required; (7) Need for a Staff Assistant; (8) Level of care designation; (9) Classification code.	Review documentation for completeness of information.	PC	PC	PC	PC	PC	PC	PC	PC	PC	DJJ has worked steadily to upgrade its computerized ward record-keeping system, referred to as the WIN system. The system should be available for use during the next round of audits, 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 lauded for their willingness to work with the WDP coordinators and include WDP-specific data in the new system.
The Program Manager shall ensure that the presentation, the curriculum, and any supplemental materials used for individual and small group counseling, large group meetings, and resource groups are modified to ensure equal access to the information by wards with disabilities.	Review modified materials.	SC	SC	SC	SC	SC	SC	SC	SC	--	While only some specific procedures for modifying materials were provided to the Auditor at some facilities, there were no indications that wards with disabilities did not have equal access to informational materials.

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The Program Manager shall ensure that a Staff Assistant (SA) is assigned to a ward with a disability when individualized assistance in the completion of mandated or necessary functions.	Review list of SA and assignments. Conduct interviews with SA & wards with disabilities to determine effectiveness.	SC	SC	SC	SC	SC	SC	SC	SC	--	The facility WDP Coordinator (not the Program Manager) typically reviews the need for individualized assistance. The SA teams have been set up at each facility, and accommodations are typically provided.
The facilities shall ensure equal access to services, such as medical and religious, and activities, such as visiting and recreation, to wards with disabilities as to those provided to wards without disabilities.	Interview wards with disabilities to determine access and participation.	SC	SC	SC	SC	SC	SC	SC	SC	--	There were no indications that wards with a disability did not have equal access to the non-educational services as listed .
3. Developmental Disabilities											
No outward signs of identification or labeling will be posted for wards involved in the developmental disabilities program.	Tour facilities to ensure compliance.	SC	SC	SC	SC	SC	SC	SC	SC	--	No such signs of identification were encountered.
Services will be provided to all wards identified as being developmentally disabled or who have been determined to need supportive services similar to wards with developmental disabilities, irrespective of age of onset.	Review departmental list of DD wards, program placement (YA 1.503) and ICP.	--	--	--	--	--	--	--	--	--	No wards were specifically identified by the DJJ or listed on YA 1.503 forms as being developmentally disabled, although it is unclear how and to what extent such determinations would be made. (See also third item on page 13 and second item on page 14.
4. Removal of Architectural Barriers											
The Department committed to the renovation of one room at each facility, as a minimum, to	Monitor the project completion timeline and visit each	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
ensure the provision of accessible housing for wards with disabilities. The total completion of this project is scheduled for June 30, 2006.	institution upon completion to ensure compliance with accessibility criteria.										FUTURE AUDITS. (All facilities have one accessible room.)
The Department committed, at a minimum, to have one fully accessible shower and/or lavatory area at each facility. Each of these fully accessible shower and/or lavatory areas must be in close proximity to the renovated accessible cells due to be completed by June 30, 2006. Presently, the schedule includes nine areas to be completed in FY 2005/06 and eight areas in FY 2006/07.	Monitor the project timeline and visit each facility area upon completion to ensure compliance with accessibility criteria.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS. (All facilities have one accessible shower / lavatory area.)
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	SC	SC	--	The compliance rating shown indicates the general degree of compliance only for those items scheduled to be completed during FY 2005/06. Items to be completed by the end of FY 2008/09 are mostly completed, but there are still a few items remaining (such as removed seats at dining halls and adjustable exam tables).
The Department committed to analyze 3000 additional barriers identified in the report prepared by Access Unlimited and provides a	Review, approve and submit required report.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.

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		DN	Ven	Pas	HS	Cha	SY	Clo	Pre	HQ	
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.											
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.	--	--	--	--	--	--	--	--	--	ITEM HAS RECEIVED TWO CONSECUTIVE "SC" RATINGS AND HAS BEEN REMOVED FROM FUTURE AUDITS.
The second category of projects, which involve projects that will require substantial funding, will be completed by Sept. 30, 2008	Audit second category projects for compliance of completion within defined timeline.	--	--	--	--	--	--	--	--	--	Since the required critical barrier removal completion date of September 30, 2008, has not yet arrived, site visits only provided a general review of certain areas of future barrier removal. Most of these items have been completed, but there are still a few items remaining (such as removed seats at dining halls and adjustable exam tables).

California Department of Corrections: Division of Juvenile Justice

Sex Behavior Treatment Program

Audit 3

August, 2008

Prepared by
Barbara Schwartz, Ph.D.

This report is based in part on interviews of staff and SBTP participants whose confidentiality whenever possible is being respected. In many cases it reflects their perceptions of situations which may be more complicated than their reports indicate.

O.H. CLOSE YOUTH CORRECTIONAL FACILITY: Site Visit, February 21, 2008 (Resubmitted)

Administrative Meeting

Heather Bowlds, Ph.D. (Psychologist)
Annette Herring (Senior Classification Officer)
Cathleen Beltz (Office of the Special Master)
Barbara Schwartz Ph.D. (Farrell Expert)
Rachel Stern (CDCR Legal)
Fred Martin Ph. D (Central Office)

Dr. Bowlds and Senior Classification Officer Annette Herring had done an impressive job in organizing evidence of compliance with the plan. They have organized the files so that they are readable and auditable. Upon opening the main file one can instantly tell where in the program the youth is and what he needs to accomplish. The manner in which the staff at Close has organized the material can serve as an example for the rest of the units. At this time the WIN was not operational. I also met with Superintendent Marc-Aurele.

Group Observation

I observed Dr. Bowlds leading the Healthy Sexuality class with seven youths. Initially some were much more talkative than others, but over the course of the 90 minutes all but one of the participants voluntarily participated. The young men were excited about being able to talk about their sexuality in an open and forthright manner. The topic dealt with the different realms of sexuality, including sexual preference and identity, gender roles, touch and sensuality, among other things. The participants were so enthusiastic that they requested that the group be extended another hour. One young man stated ―This is going to be a great group!" However, the class was given without the use of the overhead that was prepared to illustrate the realms of sexuality and how they interact. Apparently an overhead projector was not available. Instead a youth drew the concept without understanding the point of how the realms interact. The pedagogy behind the curriculum is crucial. This material must be offered exactly as it was prepared to be offered. I did speak with Superintendent Marc-Aurele, who promised to acquire an overhead projector for the class.

Interviews

Youth 1:

Youth has been in OH Close SBTP since February 2007. He is now at stage 4. He describes one of his thinking errors as “anger.” A high risk situation is when he sees something laying around that does not belong to him; there is a risk that he will take it. He uses self talk (“it is not worth it”) to prevent himself from engaging in the high risk behavior. When asked if he was familiar with why a youth could be expelled from the program, he stated that he believed reasons included refusal of the program, refusal to engage in treatment, failure to internalize the treatment, and many other reasons. He believes that program staff go out of their way to help youth. This has been good for him because his own father is in prison and he has little family contact. He feels that staff care about him.

Youth 2:

Youth is at stage 9 in the SBTP. Some of his thinking errors include thoughts that staff are “mean” or “out to get” him (he believes that actually, staff are kind and want to help, but he sometimes does not recognize that). He is able to use interventions, but did not specify. High risk situations include drugs/alcohol, temptation to manipulate others, and a sense of entitlement and power and control over others. He knows of youth who have been thrown out of the program for fighting, doing drugs, and for sexually acting out.

Youth 3

Youth is at stage 5 in the SBTP. High risk situations include anger and opportunities to manipulate others. When faced with high risk situations, he “asks for help,” “cools down,” deep breathes, and does positive self-talk. He really likes staff on the unit and believes that most staff care about the youth.

Youth 4

Youth is at stage 4. His thinking errors include thinking people are staring at him. When that happens, he tries to ignore it. He has not yet gotten to the stage at which high risk situations are identified.

ISSUES

- The other facilities should learn from Close as to how to organize their files and present evidence of compliance with the plan.

- In order to effectively pilot the Healthy Living curriculum, it must be implemented exactly as directed by Dr. Cellini, and this includes the use of overhead projectors.
- It would be helpful in evaluating the program staff to view their resumes in order to give DJJ recognition for the quality of staff that are being recruited.
- In monitoring Chaderjian, Southern, and Stark I will be looking closely to see that the required amount of treatment is being implemented. I am anxious to credit the program with the work that is being done but can only do that if there is concrete evidence demonstrating this.
- I am also looking forward to reviewing the new policies which were referenced in the meeting.

PRESTON YOUTH CORRECTIONAL FACILITY: Site Visit, April 28, 2008

Administrative Meeting:

Erin Peele (Central Office)
Paul Woodward (Central Office)
Ramona Beresford-Howe (Preston SBTP MH clinician)
Peter Shumsky (Preston Senior MH Clinician)
Tim Mahoney (Preston Superintendent)
Laurie Akang (Central Office)
Steve Ragan (Preston SBTP YCC)
Barbara Schwartz, Ph.D. (*Farrell* expert)
Cathleen Beltz (Office of the Special Master)

On the above date attorney Cathleen Beltz and I met in the Visiting Room with the above staff. All of the treatment activities that were observed that day were held in this space.

Preston's ―Informal" Sex Behavior Treatment Program (SBTP) was implemented in mid-2007. Preston had been authorized one clinician (Dr. Ramona Beresford-Howe) and one YCC (Steve Ragan) position for the informal/outpatient SBTP program based on projected needs. If the positions were not assigned, the facility would have lost the authorization to fill them the following fiscal year. Preston was also authorized one clerical position for the SBTP, which remains vacant. Preston's informal program relies on the partially developed SBTP curriculum. Youth in the program are selected from DJJ's SBTP waiting list.

On the date of the site visit, Preston's SBTP had 34 youth enrolled. Many youth in the program have mental health diagnoses in addition to requiring sexual behavior treatment, and many are currently receiving treatment in Preston's Intensive Treatment Program, Specialized Counseling Program, or Intensive Behavior Treatment Program. Four youth were participating in the Healthy Living Program. Dr. Beresford-Howe and Mr. Ragan note the complexities in providing sexual behavior treatment to youth with significant mental health diagnoses. Since the program began, three youth have transferred to an inpatient SBTP program. Transfer summaries were created for one of the three. For two transferees, emails were forwarded to appropriate clinical staff at receiving facilities. Only one of the three transferred had made it through the program's first stage. This is due in part to the difficulty of providing informal sexual behavior treatment to mentally ill youth. Dr. Beresford-Howe and Dr. Shumsky note that some of Preston's SBTP youth may never be eligible for an inpatient SBTP.

One youth was receiving individual therapy because the staff feels that he is more antisocial than the rest of the young men who are participating. He is given written assignments which are reviewed by the staff, and he is credited with having completed the stages.

SBTP staff are concerned that youth participation in the program remain confidential. Consequently, the superintendent has agreed to allow the ―sensitive needs groups" to meet in the visiting hall, away from housing units and other youth. At the time of the visit, a group was held in the visitor's hall. It is unclear exactly who (youth workers, other staff, etc.) have access to this area of the facility during SBTP groups, but Dr. Beresford-Howe and YCC Ragan were hopeful that the venue would serve to better protect youths' identities. However, uniformed staff repeatedly interrupted the group to use the vending machines. Additionally, the staff noted that the participants themselves violate confidentiality.

Dr. Beresford-Howe developed an assessment/intake tool (based on J-SOAP and other evidence based tools) that she tailored specifically to the needs of Preston's youth. Dr. Beresford-Howe and YCC Ragan identify youth in need of sexual behavior treatment (based on commitment offense, parole board orders, and SORD scores). For youth requiring treatment, YCC Ragan records information about each youth and creates a list of youth who would benefit from Preston's informal program. The list is updated every two days.

Dr. Beresford-Howe runs the program consistent with the stages identified in the current SBTP curriculum. She pulls topics from various modules beginning with the introductory module, which become the small group topics. Groups consist of 2-5 youth. Staff state that resource groups are offered to each youth once per week for 1-1.5 hrs, not including prep, documentation, or debriefing time. Groups include Assault Cycle, Anger Management and Confidentiality. YCC Ragan completes ―weekly reports" containing information about the groups conducted, interviews completed, case notes entered, and daily activities.

This was the first time I was able to utilize the WIN System since it became operational. It greatly simplified monitoring participation.

Group Observations

Healthy Living: The group consisted of four youths and was taught by Dr. Beresford-Howe. An overhead projector was used. Dr. Beresford-Howe related well to the participants. Placement in Healthy Living is determined by the SORD score. (See below for recommendation.) All of the youths participated to some extent. One group member dealt with some emotionally charged material related to his family.

Core Group: As mentioned above, the Core Group was held in the Visiting Room. The environment was less than optimal although it is utilized to prevent identification of the youths charged with sex offenses by the general population. However, the air conditioning was so loud that it was difficult to hear. Additionally, on several occasions uniformed staff walked through the room to use the vending machines. The group has six members, but only four showed up. One group member was excused as he was the young person mentioned above who was dealing with some significant family issues. The group was run by Dr. Beresford-Howe while YCC Ragan sat outside of the circle and took notes. The group was told that an Informed Consent form was being presented to them, but what was presented was not an Informed Consent form but rather an overview of treatment. This form does not satisfy informed consent requirements. It does not identify the person consenting, the reason for the treatment, or an expiration date; it also does not provide alternative treatment options. Confidentiality, other than as related to psychological evaluations, was not accurately or thoroughly explained. For instance, no information was presented on how a youth could disclose additional offenses without receiving additional charges and whether anything they said could be used in a WIC 1800 or adult civil commitment procedure. This reflects the ongoing issue of a lack of policies and related forms which would address these crucial ethical issues and which have been repeatedly requested. I am concerned that SBTP psychologists in particular could run afoul of their licensing board if these issues are not adequately addressed by DJJ.

Case review

Youth 1

Date	**Core**	**Resource**	**Individual**	**Family**	**Large Group**
4/24/08	**165 minutes**		**60 minutes**		
Average for 1 week of treatment	**165 minutes**				

This week was this youth’s first group. He is very worried about being identified as a sex offender. His offense is rape by force which he claims was consenting sex with his girl friend. He is not familiar with basic terms of treatment. He does feel that the staff are “very good,” “considerate of our feelings,” and that they care about the youths.

Youth 2

Date	Core	Resource	Individual	Family	Large Group
4/1/08	**60**				
4/2/08		**75**			
4/23/08	**60**				
Average for 4 weeks of treatment	**30 minutes**	**19 minutes**			

This individual has been in the program for 7 months and participates in a group that, according to him, meets on Wednesdays or Thursdays. He is scheduled to be released in 2011. He molested two of his sisters in 2003. He was initially placed in four different community based treatment programs for youths with sexually inappropriate behavior but remained in denial. He has a number of mental health issues and is on psychiatric medication. While he has just finished Stage 1, he has little understanding of high risk situations, saying that his only high risk would be to work in a kindergarten. He also stated that he was molested by his father and his brother but intends to live with them upon release.

Youth 3

No groups

This individual has been the center of disagreements between staff members as to what the best housing assignment should be. It was apparently agreed upon at a case conference on March 12, 2008 that he should be assigned to general population rather than Sequoia, although a month previously he had attacked a staff member. Dr. Beresford-Howe stated that this young man has received individual rather than group treatment as the staff determined that he should not be mixed with the other youth in the program. Therefore, as of 4/10/08 they have given him all of the paperwork to do through Stage 6. Although they do not think that he will be able to progress through this stage on his own, they nevertheless are intending to let him work as far as he can go individually. He was not available to be interviewed.

Youth 4

Date	Healthy Living	Resource	Individual	Family	Large Group
3/28/08	**120**				
4/8/08	**90**				
4/22/08	**85**				
4/24/08	**165**				
Average for 4 weeks of treatment	**115**				

This individual has participated in a number of sessions of Healthy Living. He could not be interviewed because he became very upset in Healthy Living regarding family issues.

ISSUES

- The core group is using the old SBTP curriculum which is basically unusable because it refers to handouts which do not exist, because it is based on material for which no copyright releases or references were obtained, and because it fails to include any experiential exercises.
- Healthy Living.
  - Youths are placed in Healthy Living based on their SORD scores. This is not the way the process was intended to work. In this situation all of the youths identified as suitable for the SBTP could be taking this as a resource group and the rest of the youths with sexually inappropriate conduct but who will not need to participate in the outpatient SBTP should be taking it.
  - It was very important that the Healthy Living curriculum be offered in a consistent way including following the time frame set by Dr. Cellini. Otherwise it is impossible to know how long it will take to deliver the program. This was not done at Preston; the time allotted varied widely.
- At Preston as at the other facilities, groups do not meet on a set day for a set period of time. They might run 60 minutes one day and two and a half hours the next day. This teaches youths that in the community they need not be bound by a set time or bring up their issues in a timely manner because the group will just run on and on. This will not be the case in the community.
- A youth is being excluded from group because of a unilateral decision by staff. Therefore he is being treated individually and being allowed to complete assignments on his own and reviewed by the YCC. At the very least this arrangement should have been brought before the SBTP Task Force, and this was not done. There is a world of difference between processing material in a group and

processing it in an individual session. This young man should be prioritized for a move to a residential program Because offering a youth only individual therapy is a radical departure from the model, this decision should have been reviewed by the Program Coordinator, if not by the full Sex Behavior Task Force. The Task Force would also be in position to advise whether this youth could fit in with another program.

- There is a problem with space. While participants in this program need to avoid identification, the current arrangement in the Visiting Room is hampered by an extremely loud air conditioner and staff walking through the room to access the vending machines.
- Youth were presented with a form that supposedly outlined issues regarding informed consent and confidentiality. However, this form and the accompanying group discussion did not address issues of major concern, such as how to disclose unreported crimes and the future use of disclosures during treatment. DJJ has no adequate mechanism in place for youth to provide informed consent to treatment.

CHADERJIAN YOUTH CORRECTIONAL FACILITY: Site Visit, April 29, 2008

Chaderjian was visited a second time this spring in order to allow more time to review the overall program. (See February, 2008 report for initial findings).

Administrative Meeting:

Alejandro Gonzalez, CWS in SBTP
Chris Edwards, CWS Feather
Grace Dah, CWS Feather
Scott Miller, Program Administrator
Mary Duncan, SCWS
Krys Hunter, Ph.D. Psychologist,
G.L. Kirkwood, Ph.D. Psych
Rick Flynn, Prog. Admin MH Programs
Paul Woodward, Prog. Admin.
Erin Peele, P.A. II
Rachel Stern
Eric Kunkel, Ph.D. Chief Psychologist
Barbara Schwartz, Ph.D. (*Farrell* expert)
Cathleen Beltz (Office of the Special Master)

It was reported that the piloting of the Healthy Living curriculum is nearly complete. It was reported at this meeting that a temporary change in the way shifts and posts are handled has caused what is hopefully a temporary problem with the program. Ms. Beltz and I were told at the meeting that staffing decisions are governed by a “shift and bid” process, rather than the previous “post and bid” process. Under “post and bid,” staff selected the shift and hall for themselves. Now, reportedly staff can select shift and days off, but the hall assignment is made by facility administration. Anticipating a physical move for the SBTP from Feather Hall, it is my understanding that Superintendent Joan Loucraft did her best to select staff for the positions on the SBTP Unit who would be most amenable to working with youth with this type of problem. These individuals were then placed in the unit to which the program was to move. However, there has been a significant delay in this move, leaving Feather Hall with staff who may not be particularly interested in working with this population. In fact, one or two staff members (conflicting reports) have repeatedly requested to be moved off of this Unit for personal reasons, but this has not been done. It is recommended that the system devise some way of dealing with staff who may have been sexually assaulted and may have significant difficulty being exposed to discussions of sexual assault. While staff may have been victims of other types of crimes and would be expected to deal with perpetrators of a variety of crimes, there would little exposure to extended discussion of these offenses outside of the SBTP. Though it may pose administrative difficulties to devise a method to avoid assigning certain staff to SBTP populations, it is important to staff and to youth in these populations that staff be able to work with a population which may reactivate trauma. While anyone working for DJJ may have at one time been a victim of a crime, sexual offenses are particularly traumatizing, and it is hoped that there could be a system devised to allow vulnerable staff to avoid having to be exposed to traumatic material. Perhaps the best possible method would be to solicit volunteers to work with these youth.

There was a team meeting off-site during which SBTP staff were provided training including what to expect from SBTP youth and core concepts about youth treatment. Staff will be trained in the Boesky Suicide Prevention Program, and some staff may be going to a California conference on sex offender treatment. Staff also participated in the J-SOAP training.

Staff Interviews

The staff whom I interviewed continue to feel “marginalized.” This is important to note as it reflects an issue with the service delivery system. They indicated that the first team meeting with the new staff was postponed four or five times. They feel that the staffing ratio between the SBTP and the other treatment units is not equitable. They also stated that they were under the assumption that additional professional staff had been originally allocated to the SBTP but then given to other units. Forms such as those used for case conferences continue to lack a space for the psychologists to sign off on and while they can sign off on a blank space, the design of the form reinforces a feeling that their opinions are not being considered. This could be easily remedied by redesign of the form to reflect the opinion of all team members. They consequently feel that their opinions are extraneous. They are additionally under the assumption that while other treatment units will have Case Work Specialists (MSW level) providing treatment, the SBTP will have Case Managers (BA level). Whether this assumption is correct remains unclear.

The staff that I interviewed voiced concerns for special needs youths including those who speak only Spanish. No interpreters are being provided other than a parole agent. The staff believe that being a parole agent and being involved in the therapy process represents a conflict of interest. There is a YCC who is Spanish-speaking and has specialized training in working with youths with inappropriate sexual behavior issues. Assigning this individual would solve several problems at once. It would not only provide an interpreter but also a staff member interested in working with this population. DJJ's rebuttal of this issue indicated that there is a Spanish-speaking YCC on Pajaro Hall, but this is not the SBTP housing unit. The fact that in the past there was an interpreter does not address the current issue. They reiterated that there is at least one staff member who is actively trying to be removed as working with this population may be activating personal issues. They commented that there is at least one very motivated and interested YCC but he is ridiculed and ostracized by other staff members. In addition, staff repeatedly stated that although they have requested that a 504 plan be developed for a learning disabled youth on multiple occasions, this has not been done. DJJ should assess whether a problem in the 504 referral process, or an isolated occurrence led to this result.

The staff are also frustrated as they do not know who is responsible for the SBTP at Chad. The staff have a variety of additional duties, including operating a program addressing sexual behavior problems in youth in the Intensive Treatment Program and providing individual treatment as well. They also indicated that they had not yet been trained on how to use the WIN system. In its comments to a draft of this report in October 2008, DJJ management stated that all staff have been trained on the WIN system. This may have occurred since the interview with these staff members.

The staff stated that the security staff continue to use the placement of youths on suicide watch as “a punishment.” This necessitates the involvement of the psychologists during their off hours. A new policy has been developed to address the issue of suicide watch but was probably not in place when this staff was interviewed.

Currently psychological staff are being required to do WIC 1800 evaluations on their own patients. This issue should be solved by the new policy.

One staff member indicated that he or she has decided to make a major change in the treatment model without consultation with the rest of the program. Specifically, the staff member refuses to incorporate relapse prevention plans into his or her administering of the program. This is not acceptable and must be remedied by the development of an SBTP organizational chart, uniform curriculum, and accompanying training.

There is also a problem with duplication of the group notes wherein the YCC writes one set of notes and the psychologist writes another. Multiple sets of notes may differ in content and are stored in different locations. This can raise a particularly difficult problem where, for example, a youth attempts suicide after making veiled comments in group therapy that are inconsistently documented.

Group Observation

A group conducted by Dr. Kirkwood was observed and focused primarily on substance abuse issues. It was attended by a YCC who contributed in a way that suggested that he could have benefited from more training in group dynamics.

Case Reviews

Youth 1

Treatment provided over the past month included:

Date	Core	Resource	Individual	Family	Large Group
3/24/08		80 minutes (Victim Awareness Presentation)			
4/2/08	60				
4/13/08		60			
4/14/08	120				
4/18/08					
4/18/08			X-no time indicated		
4/20/08		60			
4/23/08	120				
4/23/08			X-no time indicated		
4/27/08		60			
Average for 4 weeks of treatment	50 minutes per week	36 minutes per week		This youth's family had multiple phone contacts with DJJ.	

Not available for interview.

Youth 2

Date	Core	Resource	Individual	Family	Large Group

4/2/08					**60 minutes**
4/1/08			**60 minutes**		
4/8/08			**60 minutes**		
4/15/08			**60 minutes**		
4/22/08	**100 minutes**		**60 minutes**		
4/29/08			**60 minutes**		
Average for 4 weeks of treatment	**25 minutes**		**75 minutes**		**12 minutes**

This youth stated that he has graduated from school and spends his days sleeping. He will be released in three months. He also indicated that he has finished Stage 10 in the SBTP. He has completed Criminal Thinking, Interpersonal Relations, Anger Management, Stress Management, and Victim Awareness. Each of these psycho-educational classes met once a week. He also stated that large groups meet for 60 minutes once a week and that he meets with his case worker for 15-20 minutes, as opposed to the above record.

Youth 3

Date	**Core**	**Resource**	**Individual**	**Family**	**Large Group**
4/2/08				**Contact-no time recorded**	**No time recorded**
4/10/08	**80 minutes**				
4/17/08	**70 minutes**				
4/18/08			**60 minutes**		
4/19/08			**60 minutes**		
4/25/08	**60 minutes**	**60 minutes**	**60 minutes**		
Average for 4 weeks of treatment	**53 minutes**	**15 minutes**	**45 minutes**		

This youth was just transferred at the end of February. He stated that he attends Core Group 1.5 to 2 hours a week on Thursdays. He also is reportedly enrolled in two resource groups (Anger Management and Victim Awareness), which meet for 1-1.5 hours a week. He also stated

that when he needs to he meets with his caseworker for 15 to 30 minutes a week. He is on Stage 4 and misses his third period in school each week to come to treatment.

Youth 4

Date	Core	Resource	Individual	Family	Large Group
4/2/08					60 minutes
4/5/08		60 minutes			
4/14/08	75				
4/17/08		60 minutes	60 minutes		
4/19/08					No time recorded
4/21/08	60 minutes				
4/26/08					No time recorded
4/28/08	60 minutes				
Average for 4 weeks of treatment	49 minutes	30 minutes	15 minutes		

This youth has been at Chad since March, 2007 and is currently on Stage 10. He stated that he has learned about Relapse Prevention and was able to identify relevant risk situations and give relevant interventions. He reported that he attends core group once a week for an hour on Mondays and has one resource group (Victim Awareness) once a week for an hour. He also stated that he meets with his caseworker each week for 30 to 90 minutes and that they mainly discuss what the caseworker did over the weekend.

Youth 5

Interviewed in lieu of Case 1. This youth reported that he has been at Chad for two years. He stated that he attends core group for 1.5 to 2 hours per week on Thursdays. He stated that he is on stage 6 and has completed all of the classes. He meets with his caseworker once a week for about 20 minutes. He was able to identify some risk situations but was unable to give realistic interventions.

ISSUES

- Currently a major concern is that in anticipation of the move of the unit, line staff were selected and placed in the unit to which the program was to be moved. However, the move has not occurred, and the program must deal with line staff who are reportedly not

particularly interested in working with this population, including at least one who is actively trying to have himself removed from the unit.

- It is reported that line staff continue to use suicide watches as punishment. This is not only an abuse of the department's effort to prevent self-abusive and suicidal behavior but also requires the psychological staff to come in during their off-hours to do evaluations. While this may be necessary in mental health emergencies, it is seen as harassment of the mental health staff as well as the youth when it is being used as punishment.
- Psychological staff continue to feel ―marginalized." They believe that the administration thinks that Youth Counselors should be providing the treatment. They also feel that they are being asked to do tasks that compromise their therapeutic relationships, such as doing WIC 1800s. Psychologists do not sign off on the treatment planning forms and thus feel that their opinions do not matter.
- The psychological staff are confused about organizational issues, including who is in charge of the SBTP at Chad.
- The staff needs to be clear on what parts of the SBTP can be changed without approval of Dr. Martin or the SBTP Task Force.
- The staff was more proactive on providing documentation than they had been in the past.
- Staff is still not providing the required number of treatment hours.

SOUTHERN RECEPTION CENTER: Site Visit, May 21, 2008:

Administrative Meeting

T. Bonzon (Supervising Casework Specialist)
R. Uliana, Ph.D. (Psychologist)
D. Leong, Ph.D. (Psychologist)
R. Ma, Ph.D. (Psychologist)
F. Martin, Ph.D. (Psychologist)
L. Allen, R.N. (Central Office)
P. Woodward, Ph.D. (Psychologist)
L. Cowen (Program Administrator)
I. Nazarette (Central Office)
J. Blackwell (Central Office)
G. Freeman, Ph.D. (Psychologist)
D. Finks (Senior Youth Correctional Counselor)
M. DuBow, Psy. D. (Psychologist)
C. Beltz, J.D. (Attorney, Office of the Special Master)

Staff reported that there are plans to move into a new building equipped with two group rooms, one conference room, office space, and two interview rooms. Dr. Leong has instituted many aspects of the Good Lives model which focuses on developing positive goals and doing community service. The youth have been involved in a Victim Outreach Project which has brought speakers into the institution. They have raised money for a variety of charitable organizations including Smile Train which funds cleft palate surgery, Operation Gratitude, Foster Grandparent Appreciation Day, Children's Hospital, and making ―pain dolls." The staff have also initiated mock parole boards and youth are presenting their Relapse Prevention Plans to the large community group.

The staff have been very active in training and in providing training to other agencies. For example, staff have presented their Survivors Groups at the CCUSO conference, the Successfully Dressed Program at a national conference on sexual addiction, overviews of the SBTP to DelAmo Hospital, and a presentation on deviant fantasies at the American Society for Philosophy, Counseling and Psychotherapy. The staff have also received training in the Static-99 and JSORRAT as well as more generic training in issues such as Motivational Interviewing.

The staff is excited about the quality of the new YCCs; many of the former staff retired, and new staff who are enthusiastic about participating in the SBTP have been brought in. These staff have participated in team training.

Five youths were referred for the 1800 process. They were primarily referred to obtain more time for treatment or for lack of treatment progress. One was continuing to expose himself to staff. One had been collecting sexually explicit pictures. One was recommended but then became more motivated. Several have accepted the extra time in order to complete the program and have their juvenile records sealed.

One youth was terminated as the staff felt that he was too immature to handle the program. The youth agreed to be placed on the waiting list and will be placed in the program when he is more mature.

The facility has 3 psychologists based on funding and population projections for FY 08/09.

Group Observations

I observed a presentation of Healthy Living. The class is in its eleventh week and only recently acquired an overhead projector. The group was reviewing what they had learned in the first six weeks of the class. The staff member attempted to engage the students in a review of the material; however, the approach to the review could have been more structured, for instance, by using questionnaires or a game format. In addition, by simply questioning the students about what the curriculum covered, only what was remembered was presented. Many of the group participants had taken Sex Education in school and reported that they did not feel that they had learned much in the first six classes.

A core group was observed. This group usually has six members, but eight youths were present. One individual has been in DJJ for five years for molesting his sister when he was 12 years of age. Another group member recently had his sentence extended through an 1800 process. He reported that he was moved from a Stage 8 back to 2 and is now on Stage 4. Another young man reported that he was convicted of rape and feels that he has gained insight into his attitudes towards women and is now on Stage 9. I.S. has been incarcerated for 5.5 years for three molestations and two rapes. He has gone through the 1800 process, and his sentence has been extended for two years. S.W. is on Stage 6 and will be released soon. J.Z. was transferred from Paso Robles where he stated that he was on Stage 6. I was curious about this as I have been repeatedly told that there is not a SBTP at Paso Robles. He has been placed on Stage 3 in the current group. He was reluctant to talk and stated that he did not know why he is in the group. C.V. is on Stage 6. He is now 18, and his crime was committed when he was 9; if this is true, these facts raise questions as to why he is even in the treatment program. C.B. is in the process of undergoing an 1800 and is on Stage 4. He molested two nephews when he was 12. He recently had a photo album confiscated. A good deal of time was devoted to talking about their jobs and about the parole issues of a youth in another group.

Staff Interview

The staff interviewed was concerned that the census is dropping to 36 youth and that the program will lose staff because she feels that it is not considered to be a mental health program. She was encouraged by the fact that the DA of Los Angeles County has been very supportive of the program. This staff member feels that the administration has been very supportive, especially considering that some of the restorative justice program have required waivers of the rules in order to do fund raising with the staff.

Case Reviews

Youth 1

Date	Core	Resource	Individual	Family	Large Group
3/14/08			30		60
3/24/08	180				
4/4/08	180				
4/11/08	180				
4/14/08		Music Therapy			
4/18/08	180				
4/22/08		Good Lives Group			
4/23/08		X (Name not			60

		indicated)			
4/26/08	**180**				
Average for 4 weeks of therapy	**225 minutes**				**30 minutes**

Youth has been in the program for nearly 2 years and is beginning stage 5. He has not been held under section 1800, but “has heard they like to do them at SRC.” His high risk situations are “when using drugs.” He uses self talk as interventions. He has core group on Fridays for 3 hours. He completed Anger Management. He likes treatment and unit staff. His commitment offense was forcible rape. Youth reports he ran away from a group home and went to a party, took ecstasy, was angry at his mom and “took it out on [his] victim to get his power back.” He claims also to have another victim (17 years old). The next night he was reported and arrested. He thinks the program is really for pedophiles instead of youth with his commitment offense.

Youth 2

Date	**Core**	**Resource**	**Individual**	**Family**	**Large Group**
4/17/08			**30**		
4/18/08					**60**
4/22/08	**180**				**X (No time)**
4/24/08	**180**	**90 (Healthy Living)**			
4/25/08		**Healthy Living-no time** **Good Lives (no time)**			
5/2/08		**Emotional Maturity (60)**			
5/7/08	**180**				
5/12/08		**Healthy Living (no time)**			**60**
5/14/08	**180**		**30**		
Average for 4 weeks of therapy	**180 minutes**				

This young man reported that he has molested five children and was arrested in 2004. He had been in two group homes and assaulted other adolescents in these placements when he was about 15. He is currently on Stage 4 and is dealing with his own victim issues. He stated that he will be released in three years. This is a highly narcissistic individual who stated that he plans to go to Stanford, Harvard, Yale, or the University of Southern California and get a Ph.D. in physics, a J.D., and an M.D. The staff should be helping this young man make more realistic plans for his future.

Youth 3

Date	Core	Resource	Individual	Family	Large Group
4/17/08		**Emotional Maturity (60) Music Therapy (No time)**			**X (No time)**
4/18/08	**X (No time)**	**120 (Survivors' Group)**			**60**
4/22/08					
4/24/08		**90 (Healthy Living)**			
4/25/08		**Healthy Living-(no time) Good Lives (no time)**			
4/26/08		**120 (Survivors' Group)**			
5/2/08	**180**	**Emotional Maturity (60)**			
5/9/08			**20**		
5/10/08		**150 (Survivors' Group)**			
5/21/08	**X (No time)**				
Average for 4 weeks of therapy					

This youth stated that he dropped out of the Emotional Maturity class because he did not get along with some of the other participants. He stated that he has been at this facility for two months. He molested relatives when he 15. Currently he is on Stage 4 where he has been for about a year. He stated that he wants to go to college, get an M.A. degree, and work either as a painter or doing yard work. He stated that he has learned why what he did to his victims was wrong. He was able to identify several triggers including people ―hollering” at him and ―pushing” him around.

Youth 4

Date	Core	Resource	Individual	Family	Large Group
4/18/08					**60**
4/22/08		**Good Lives (No time)**			
4/23/08		**Music Therapy (No time)**			
4/29/08	**195**				
5/8/08	**180**				
Total	**188 minutes**				

This young man stated that he has been incarcerated since 2005 and expects to be released in December, 2008 or January, 2009. He is currently on Stage 6 or 7 and is working on his Relapse Prevention Plan. He has been involved in a number of charitable projects, including Operation Gratitude, Angel Tree, and Smile Train. He molested his 7 year old sister when he was 15. In the future he hopes to become a public speaker and educate the public on sex offenders and sexual addiction.

Youth 5

This youth was interviewed due to his unusual background. According to him (and his story was not verified through the official record due to lack of time), when he was nine, he molested his two year old brother. He stated that he confessed this to his mother's boyfriend, who reported him to the police. He stated that his mother is mentally ill and physically abused him. When she learned of the molestation, his mother threw him out of the house, and for a while he lived under a bridge. She also called the police threatening to kill him. He stated that he spent the next two years in juvenile hall, and the staff there became his family. Although placed in a group home, he kept running away to return to juvenile hall. Eventually he was sentenced to DJJ. Since being in the institution he has repeatedly had his sentence extended in six-month increments due to lack of treatment progress in the SBTP. However, if what this youth is reporting is correct, it is highly questionable

whether he should ever have been in treatment in the first place. He participates in a group that meets two to three hours on Monday and is currently on Stage 6. If the above history is accurate, this case points to the need to accurately assess which youth should be in this program and which should not be in the SBTP.

ISSUES

- The staff have been involved in a number of interesting activities based upon the Good Lives model and Restorative Justice. This should be incorporated into the overall model.
- The staff have been able to develop expertise which they are now presenting on a national level.
- The lack of a uniform curriculum is continuing to prevent overall consistency. Without new outpatient and residential curriculum, staff rely on outdated and incomplete curriculum, which is implemented inconsistently within and among facilities.
- The required number of treatment hours is not being provided. Although there is an improvement in the number of core treatment hours, resource group hours were either not being provided or not being documented.
- Healthy Living has been piloted but not with an overhead projector, which was an important part of the program.
- The staff appears to have unrealistic views about how much time is needed for treatment and which youths are actually in need of treatment. If the information provided by Case 6 is correct, it is questionable whether this individual should ever have been in treatment for his sexual behavior in the first place, much less having had his sentence extended repeatedly because of lack of treatment progress.

H. G. STARK YOUTH CORRECTIONAL FACILITY: Site Visit, May 22, 2008

Administrative Meeting

L. Allen, R.N. (Central Office)
I. Ward, M.D. (Psychiatrist)
C. Beltz, J.D. (Office of the Special Master)
B Schwartz, Ph.D. (Farrell Expert)
J. Close (CMO)
L. Poncin, Ph.D. (Psychologist)
B. Shapiro (CWS)
D. Harris (CWS)
T. Clipps, Ph.D. (Psychologist)

Y-J Chang Ph.D. (Psychologist)
F. Martin, Ph.D. (Psychologist)
P. Woodward, Ph.D. (Central Office)
J. Hetherton (SCWS)
R. Martinez (Superintendent)
G. Castellanos (TTS)
E. Mock (Program Administrator)
M. Lassiter (Central Office)

Stark has had some staffing changes. The facility uses the shift and bid process: the staff now choose the days off, and the administrators choose the location. Because 60%-70% of the staff are new, the older staff stated that they ―now have people who want to work with these youth.” However, the Mental Health staff have not had input into whom is assigned to the Unit. The staff reported that the violence in the institution has decreased, and there have been very few grievances other than over food. The staff reported that the superintendent is very supportive of the program. Dr. Ward, a psychiatrist, has been assigned to work with the program on a half-time basis.

The program is facing a move, and the staff are considering separating ―the predators” from the less aggressive youths to help keep them safe from the more aggressive peers. This should be approached with caution.

Some creative special programs including a theater project and an art program coordinated by Pitzer College is in place. The staff stated that currently six resource groups are being offered. The youth also participated in a Victim’s Awareness Week which included a number of different activities. The following resource groups are being offered:

1. Interpersonal Relations
2. Stress Management
3. Criminal Thinking
4. Anger Management
5. Human Sexuality
6. Victim Awareness

There are also case work groups which cover such topics as Criminal Thinking, Anger Management, Victim Impact, Impulse Control, and pre-parole issues.

Staff have received a variety of special training, including training on the JSORRAT, Static-99, Motivational Interviewing, Anger Replacement Training, and mental health issues. Staff have been participating in two-hour meetings every month.

The parole board has improved in terms of accepting treatment team recommendations.

Group Observations

Core Group: I observed a core group led by Dr. Clipps. The youth were working on self esteem issues. Initially there was little group interaction although the therapist related well to each of the members. One individual talked about his relationship with his mother and how she labeled and stereotyped others. He then saw how he was doing the same thing with his sister's boyfriend. He also obtained some valuable insight into the dynamic of his offense.

Healthy Living: I observed the Healthy Living curriculum being piloted by a staff member and a recently hired YC who had worked with the parole department. The group was on session 9 although they had just obtained the overhead projector. The piloting of the Healthy Living curriculum required consistent use of an overhead projector with which to deliver the transparencies. The staff member has a very good relationship with the young men, although it did not appear that the group leaders had reviewed the material before the session. There was an extended discussion of statutory rape.

Case Reviews

Youth 1

Date	Core	Resource	Individual	Family	Large Group
3/04/08	95				
3/11/08	95				
3/13/08		100			
3/18/08	90				
3/26/08			30		
3/27/08		45			
3/31/08			30		
4/03/08		60			
Total	190/4=47 minutes	205/4=51 minutes	60/4=15 minutes		

The youth has been in this SBTP for 8 months and is nearing completion of stage 1. He was previously “thrown out” after one year for “talking during group.” He has been in DJJ for four years. In March, the youth was written up for exposing himself to female staff. His commitment offense was lewd conduct with a child under 14 (youth was 17). Youth has not been held under section 1800. Youth attends for one hour each week both a cycle group and a recovery group facilitated by clinicians. Twice per month for one hour, he attends YCC-facilitated groups.

Youth 2

Date	Core	Resource	Individual	Family	Large Group
3/05/08		95			
3/06/08	60				
3/08/08	60				
3/10/08		50			
3/13/08	100				
3/17/08			35		
3/18/08		80			
3/27/08	75				
3/29/08		50			
4/05/08			25		
Total	74 minutes	69 minutes	15		

Youth has been in DJJ since 2003, and in SBTP at Stark since 2007. He was kicked out of Stark SCP for fighting. Youth has received two years of time added to his sentence (for fighting). Youth is at level 3 in the program, but does not feel that it helps him. He prefers it “calm” on the unit, not to have to “fight, treatment-wise,” and not to have to do “work.” He is in group with a clinician once or twice per week (“when it happens” – the clinician was on leave during or leading up to our site visit, so her groups were cancelled) and also a group with a YCC once or twice per week. His high risk situations include negative peers and drugs. Youth’s commitment offense was rape by force and fear. He says he and some friends went to a “cool 31 year old lady’s house who let us kick it.” At first she was flirting with him, but then told him he was moving too fast. He had “distorted thoughts” then, and she “froze up” so he ended up “taking advantage of her.”

Youth 3

Date	Core	Resource	Individual	Family	Large Group

3/01/08		**90 (Small group)**	**25**		
3/05/08	**100**				
3/06/08	**135**	**35 (Small group)**			
3/11/08	**85**				
3/17/08		**70**			
3/18/08	**85**				
3/25/08		**90**			
3/29/08		**50**			
4/01/08		**60 (Small group)**	**30**		
Total	**101**	**98**	**27**		

Youth has been in the SBTP for eight or nine months and is at stage 4 of the program. He is not familiar with his high risk situations**.** Youth reports that he spends three hours per week in groups (1.5 hours with clinician and 1.5 hours with a YCC). Youth has not been held on section 1800. His commitment offense was that he and several friends were “feeling each other up and videotaped it.” He says he is in the program for a past offense (section 288(a)).

Case 4

Date	**Core**	**Resource**	**Individual**	**Family**	**Large Group**
3/07/08			**20**		
3/11/08		**90**			
3/12/08	**120**				
3/19/08		**60 (Small group)**			
3/26/08	**90**		**43, 46**		
4/07/08		**90 (Small group)**			
Total	**101**	**99**	**36**		

Youth is being considered for program completion. He has received time credits and worked through all stages of the program. He helps the Spanish youth translate. He recites his “external” (substance abuse, negative peers, porn) and “internal” high risk situations (objectifying people, powerlessness, and anger) and his interventions (staying away from drug dealers). His commitment offense was molesting his sister over three years “with force and hostility.” His treatment team is recommending him for parole. He is not held on section 1800, and youth reports receiving four hours of group per week.

Youth 5

Date	Core	Resource	Individual	Family	Large Group
3/07/08			30		
3/09/08		X (Small group) No time			
3/17/08			10		
3/23/08		X (Small group)-20 X (Small group)-60	10		
3/24/08		90			
3/25/08		80, (Small group)-61			
3/30/08		61 (Anger Management)			
4/01/08	75				
Average	75	80	13		

This youth stated that he recently arrived at this facility. He stated that he is scheduled to participate in a group run by Dr. Clipps which is held for 1 to 2 hours a weeks and that he is in a Dysfunctional Families group. This group was not listed as one operated by the SBTP. He indicated that he feels that the facility is safe but is uncomfortable about talking about his issues.

Youth 6

Date	Core	Resource	Individual	Family	Large Group
2/27/08		120	15		
3/07/08			20		
3/11/08		90 (Resource Group)			
3/12/08	120				
3/19/08		60 (Small group)			
3/26/08		90	43, 45		
Total	120	90	30		

This young man was originally admitted to DJJ in 2002 and has been paroled and readmitted on multiple occasions. He reported that he attends a core group for 90 minutes a week and another one for 75 minutes. He also stated that there are different participants in each of these groups. He commended the staff for being caring and helpful but stated that this rehabilitation is being interfered with by the racial tension at this facility.

ISSUES

- The SBTP at Stark is set up so that the youth will receive a large number of treatment hours. However, there are a number of problems in moving from the plan to actuality. The psychology staff is not clear on how the groups should be set up. The model calls for core groups and several types of resource groups. At Stark there are Relapse Prevention groups and Cycle groups that are operated by psychologists, and there are resource groups and ―small groups” offered by case workers and YCCs. Some of these are apparently resource groups. It is not clear what the purpose of the ―small groups” is. Thus there is a very basic misunderstanding of the model. It was reported that there are also large community groups, but there were no notes on these groups.
- The groups are not being held on a basis regular enough to meet the requirements of the plan. Staff frequently cancel groups, and there do not appear to be co-leaders who could staff these groups in their absence. In its October 2008 comments to a draft version of this report, DJJ identifies additional reasons for group cancellations: codes, lack of security staff, and miscellaneous events such as victims awareness weeks, TB testing, flu vaccinations, graduations, and exams. Many of these reasons are unacceptable causes for cancellation, and staffing and programming schedules must not conflict with youths' treatment hours.
- There are inconsistencies among the WIN system notes, medical notes, and group notes. See discussion of documentation problems at Stark on grid, below.
- There were only two references to resource groups in the WIN records reviewed. One youth attended one session of Anger Management and another attended one session of an unnamed resource group. All youths in the program should be participating in resource groups, and this means that staff will have to continue to develop new groups. The groups could be larger and could last longer.
- Healthy Living began to be piloted without the overhead projector that was a vital part of the program.
- It is interesting that at Stark the driving force behind the program are caseworkers and youth counselors rather than psychologists. This may explain why the latter are confused about how their work fits into the model.
- Stark staff have developed an impressive collection of experiential exercises. However, it is important that copyright issues be resolved around the use of these materials.
- The staff is considering separating the ―predators” from the ―nonpredators.” This can be valuable but can also involve numerous logistical problems. It implies that there are equal numbers in each group. It also discounts the benefits that can come from

heterogeneous placements. Isolating the “predators” may exaggerate these tendencies. It is also not clear what the definition of “predator” is.

ADMINISTRATION

I met with Dr. Martin and Ms. Allen who are working on the policies and procedures. They have developed a very complete table of contents.

ISSUES

- The finalizing of the policies and procedures will contribute to unifying the various programs.
- However, this will provide the structure rather than the content of the program. In the years since the Consent Decree was signed, the treatment of juveniles with problematic sexual behavior has transformed from an adaptation of the treatment of adult sex offenders to its own unique approach which incorporates a number of developing methodologies, including Dialectic Behavioral Therapy, brain-based treatments based on findings from developmental psychopathology and traumatology, and treatments for a variety of co-morbid disorders (such as Reactive Attachment Disorders, Post Traumatic Stress Disorder, Attention Deficit/Hyperactivity Disorder, and Asperger’s Syndrome). These treatments are incorporated into the treatments for sexually inappropriate youth rather than offered as adjunct approaches. The curriculum for the SBTP needs to reflect evidence-based therapies.
- Twice in the past DJJ (or CYA depending upon the timing) has retained an expert to help develop a state-of-the-art curriculum. Twice a variety of issues have interfered with this project. The current incomplete residential and outpatient curricula lack necessary homework paperwork, experiential exercises and have a variety of problems with the copyright laws. New curricula based on the latest approaches is absolutely essential.
- The administration needs to ensure that all of the sites fully understand the mandates of the court relating to treatment times and follow these until the plan can be amended.
- A risk evaluation procedure which is not dependent upon instruments with questionable validity for this population needs to be developed in conjunction with the mental health assessment batteries. Mandated tools can be incorporated into this protocol but their limitations should be fully recognized.
- Training issues will have to await the development of the curriculum.
- Staff should understand that significant issues such as whether individual treatment is substituted for group therapy or whether major components of a cognitive behavioral program are to be abandoned must be reviewed by the Program Administrator and hopefully the Sex Offender Task Force.

CONCLUSION

- There has been significant improvement in the amount of treatment that is being acknowledged as needed to conform to the Remedial Plan's requirements. However, there are still problems in actually providing these hours, such as the assignment of psychologists to other tasks during group hours, difficulty releasing youth to attend treatment, vacations, and sick leave. This could be addressed by assigning and training co-therapists, including caseworkers and YCCs, who could ensure that the groups meet.
- A problem that I have addressed repeatedly and which continues to be an issue is the timing of group therapies. Group therapy should be offered at the same time every week and run for exactly the same amount of time each session.

APPENDIX A—O.H. CLOSE (Previously submitted)

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: O.H. CLOSE SITE VISIT, FEBRUARY 21, 2008

Standard	Title	Description	Audit Criteria	Compliance Rating
1***[1]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: NA** Administrative Task
2***	Treatment Model	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	1. Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs	Compliance Measure: 95% of groups scheduled to be held with the exception of security cancellations. **Rating: NA**

[1] *** Priority criteria

		Specific treatment programs for the sub population.	participants. 2. The expert will attend at least two groups at each facility during each audit period. 3. The expert will interview administration, staff and participants at each facility during each audit period.	At this time there are no special needs groups. However, the program appears willing to accommodate special needs participants should the need arise.
3***	Screening & Assessment	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	1. Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools. 2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established	Compliance Measure: Approved/Not approved **Rating: NA** Administrative task Compliance Measure: 95% **Rating: NA** No established protocol.

			protocol.	
4***	Multi-modal Treatment Model-*Residential Component*	The treatment program provides a multi-modal, multi-disciplinary and offense -specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF.	1. *The expert will review 10% of files for the presence and appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week.	Compliance Measure: 95% **Rating:75%** I reviewed one file as an example, and Ms. Beltz reviewed *four* youth files (10 percent of program participants) with the assistance of the SBTP's Supervising Casework Specialist. Youth files reviewed include DJJ # 90951 (Youth ―A") DJJ #89660 (Youth ―B") DJJ #91816 (Youth ―C") DJJ # 90404 (Youth ―D") The SCWS reports that youth receive a total of four hours per week of core group time, with one hour reserved for prep time and follow-up. The monitor reviewed notes for 3-4 weeks prior to the February site visit. Three of four files reviewed contained notes reflecting 180 minutes of core group per week. Youth B's file reflected 3 hours of core group for two weeks

				prior to the site visit, but nothing was noted for the week of February 4, 2008. The SCWS stated that they continue to have a problem providing all required group time when staff are on vacation or leave. Often, other staff will fill in, but not always. When no replacement staff is available, group must be cancelled.
			2. *The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week.	Compliance Measure: 95% **Rating: Partial** Documentation of individual therapy/time with treatment staff continues to be sporadic. For example, a clinician may note ―Youth seen," but not indicate for how long. The SCWS reports that staff are still not aware of the expectation that all time spent with youth be documented. Despite poor documentation, the SCWS is confident that youth receive at least three hours' treatment time per week (including time with both

				custody and treatment staff). None of the files reviewed reflect three hours per week. Youth D appears to have received 20 minutes' individual time with a YCC, twice in a two week period. Notes are incomplete for other files reviewed. The rating is —Partial" because the participants are receiving individual counseling, but it is not being documented in a uniform manner.
			3. * The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a ten-week schedule. The expert will review resource group schedule and lists of participants.	Compliance Measure: 95% **Rating: 95%** Following the last site visit, the facility began to maintain a binder with lists of groups, schedules, and youth enrolled. Three of the four youth are enrolled in at least one resource group. The SCWS reports that all youth who are not currently enrolled are waiting for a ten-week group to begin. The SCWS reports that all SBTP youth are scheduled

				for or attending at least one or two groups at all times.
			4. * The expert will review 10% records for the presence and appropriateness of special resource group notes documenting that at least two different special resource groups offered on a ten week schedule	Compliance Measure: 95% **Rating: Could not evaluate as the staff is confused about the concept.** There still appears to be some question among staff regarding what constitutes a resource group versus a "special resource group."
			5. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Measure: Present/Not present **Rating: Partially present** Since the last site visit, SBTP staff have been instructed to note specifically when youth families are contacted (dates and times) as well as the youths' program stages when family contact is initiated. Contact and attempts to contact are noted on a "SOTP Parent Assessment Form" that is copied and maintained in youth files. The SCWS reports continued difficulty

				in motivating some families to be involved with youths' treatment. Below are the findings for the four files reviewed: *Youth A:* Notes reflect that family contact was initiated at stage three in 8/07, and youth was assessed for appropriateness of family involvement. The determination was made that family involvement was not appropriate. *Youth B:* Assessment for family involvement was conducted at stage 3 in 2/08. *Youth C:* Family involvement assessment was conducted at stage 3 in 8/07. Since then, the youth has had face-to-face therapy sessions with his family monthly. *Youth D:* Was assessed in 8/07 at stage 3, but no additional notes about family contact.
			6. The expert will review for presence and appropriateness relevant documentation of meetings with family	Compliance Measure: Present/not present **Rating: Present**

			members. 7. * The expert will review 10% of records for presence and appropriateness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	Compliance Goal: 95% **Rating: NA** No maintenance groups exist at this time.
5	Multi-model Treatment Model-*Outpatient Component*	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	1. *The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week. 2. *The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks	Compliance Goal: 95% **Rating: NA** Outpatient component has not been established at this time. Compliance Goal: 95% **Rating: NA**

			3. *The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule. 4. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 5. The expert will review for presence and appropriateness relevant documentation of meetings with family members 6. * The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.	Compliance Goal: 95% **Rating: NA** Compliance Goal: 95% **Rating: NA**
6	Milieu Therapy in Residential Treatment	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are	1. * The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held	Compliance Goal: 95% **Rating: 95%** All files reviewed reflect four hours per week of large

		provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	per week for a total of four hours per week. 2. * The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program. 3. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.	group time. Compliance Goal: 95% **Rating: 0%** No documentation.
7	Individuation of treatment	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	1. Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided.	Compliance Goal: 95% **Rating: 95%** The program is individualized through the use of the Achievement Matrix, which tracks progress in the program, and through the Parole Readiness Form and Quarterly Reports. Youths are referred for specialized services such as co-morbid mental health treatment,

			2. Expert will review rosters of specialized resource groups and other therapeutic experiences.	including psychopharmacological treatment. Compliance Measure: Present/not present **Rating: Partially present** Currently there are no specialized resource groups, but there are lists maintained of youth who are on psychiatric medication. Thus, there is partial compliance with this requirement.
8	Treatment Plans with Objective Goals	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	1. Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants.	Compliance Measure:95% **Rating: 100%** For each of the four files reviewed, the identified treatment issues are the same. The SBTP appears to use sex offense boiler plate language for each youth in the program, including goals of ~~u~~understanding their sexual history, the sexual assault cycle, relapse prevention, and reducing the risk of reoffending.” This language is plugged into

				youth files at the time of commitment. Case management conferences are held at least quarterly. Individualized goals are documented in the Achievement Matrix.
			2. Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	Compliance Measure: 95% **Rating: 50%** None of the files reviewed contained notes about specific interventions that are provided to youth to assist in meeting specific behavioral goals. Likely, this is because goals notes are not specific. However, it is now easy to see where in the treatment program the participants are and thus what specific goals they have accomplished and need to accomplish. By including reference to specific goals in treatment notes, compliance can be improved.
9	Victim Outreach	The treatment program coordinates with treatment programs and therapists of individual victims as well as	1. The expert will review the file of correspondence with community therapists.	Compliance Measure: Present/not present **Rating: Partial**

		agencies that address sexual abuse in the community to combat the problem of sexual assault.	2. The expert will review documentation of outreach to victims' agencies.	A committee of program participants has been formed to work on Restorative Justice issues. This is a first step in addressing this goal. Compliance Measure: Present/not present **Rating: Partial** Some outreach is occurring, but it is not being documented.
10	Staff Qualifications	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	1. Expert will review the number and professional qualifications of SBTP staff.	Compliance Measure: 100% **Rating: Because staff CVs are not provided, this cannot be qualitatively measured.** However, there has been significant improvement in that two new psychologists and a case work specialist have been hired, all of whom reportedly have sex offender treatment experience of some type. Ms. Beltz interviewed one staff member. This YCC is new to DJJ (prior occupation was not custody

				related). He was trained as a YCO and is currently a YCC on the SBTP, where he has been for approximately one year. His goal is to stay in the SBTP. He self describes as motivated to provide treatment to youth and wants to become a supervising casework specialist one day. He has an AA degree in Criminal Justice and is currently a Junior in a ―Human Services" program. He plans to obtain his masters degree within the next four years. Training specific to the SBTP includes what he describes as 6 days of SORD training.
11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: 75%** A number of staff were sent to the Association for the Treatment of Sexual Abusers Conference which was held in San Diego this past November. Additionally, staff have recently received training in

				Motivational Interviewing, Static-99, and Suicide Prevention.
12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. * The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating: 95%** A log of supervision meetings was reviewed.
13	Multi-disciplinary team reviews	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	1. * The expert will review minutes of the multi-disciplinary teams.	Compliance Measure: 95% **Rating: 95%** Quarterly reviews are held with a multi-disciplinary staff.
14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	Compliance Goal: 100% **Rating: NA** Administrative task Compliance Goal: 100% **Rating: NA**

15	Program Completion	Completion of the program reflects the completion of competency-based goals.	1. The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Measure: 95% **Rating: NA** It is difficult to access the files of program completers as these youths have often left DJJ and their files have been archived. I will work with the staff to determine what would be the most efficient way to access this information.
16	Suspension/Termination From SPTP	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	1. The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination. 2. Audit will review 20% of records of terminated or suspended participants to insure they comply with policy. 3. The expert will review the written policy on suspension and termination to ensure that they are adequate.	Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**

17	Pre-release	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	1. The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release 2. The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.	Compliance Measure: 95% **Rating: 50%** I was assured that pre-release planning is being done but saw no documentation. Compliance Measure: 95% **Rating: No documentation**
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision	1. * The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract. 2. The expert will review documentation that the SBTP	Compliance Measure: 95% **Rating: Not reviewed** Compliance Measure: Present/Not present

			has been involved in the training of parole personnel.	**Rating: Not reviewed**
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	1. The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	Compliance Measure: Present/not present **Rating: NA** Administrative task
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract 2. The expert will review all prepared materials to ensure that they are appropriate.	Compliance Measure: In compliance/Not in compliance **Rating: NA** Administrative task
21	SBTP Program Coordinator	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	1. The expert will evaluate whether this position has been filled.	Compliance Measure: Achieved/Not achieved **Rating: NA** Administrative task
22.	Vocational Training	The CYA will make	1. The expert will evaluate	Compliance Measure:

		vocational opportunities available for youths with sexual behavior.	vocational training opportunities for youth with sexual behavior.	Present/not present **Rating: Present** Vocational training is provided on an individual basis.
23.	Physical Facilities and Resources	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	1. * The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.	Compliance Measure: Present/not present **Rating: Present** The physical plant at Close is adequate for the treatment program.
24	Behavioral Management System	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors.	1. The expert will review 10% of all records for documentation which supports the use of such a system. 2. The expert will review 10% of files containing disciplinary reports for documentation which supports use of such a system. 3. The expert will review the behavioral management plan itself to insure that it is appropriate.	Compliance Measure: 95% **Rating: NA** No documentation Compliance Measure: 95% **Rating: NA** No documentation **Rating: 95%** Behavioral rating system was provided and appears to

				be appropriate, but no documentation of utilization was provided.
26.	Healthy Sexuality Programs for all wards	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA.	1. The expert will review records which document existence of such programs. 2. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	Compliance Measure: Present/not present **Rating: Present** The Healthy Living curriculum is being piloted. I observed the program being presented to a group of youth who were very excited about the program. The curriculum package is well done.
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior. 2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present/not present **Rating: NA** Administrative task Compliance Measure: Present /not present **Rating: NA** Administrative task

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
* In addition to review records, the expert will directly observe these activities and facilities.

APPENDIX B—PRESTON

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: PRESTON SITE VISIT, APRIL 28, 2008

Standard	Title	Description	Audit Criteria	Compliance Rating
1***[2]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: NA** Administrative task.
2***	Treatment Model	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	1. Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs participants.	Compliance Measure: 95% **Rating: Deferred** It is premature to ascertain rates of compliance since this is a very new program. The staff does appear to be offering Healthy Living and a core group, the latter of which just began. The participants are primarily special needs individuals with multiple mental health needs. They are not

[2] *** Priority criteria

			2. The expert will attend at least two groups at each facility during each audit period. 3. The expert will interview administration, staff and participants at each facility during each audit period.	providing group therapy to one youth who does have an Axis 1 diagnosis. (See comments.)
3***	Screening & Assessment	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	1. Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools. 2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	Compliance Measure: Approved/Not approved **Rating: NA** Administrative task Compliance Measure: 95% **Rating: NA**
4***	Multi-modal Treatment Model-*Residential Component*	The treatment program provides a multi-modal, multi-disciplinary and offense -	1. *The expert will review 10% of files for the presence and	Compliance Measure: 95% **Rating: NA**

		specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF.	appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week. 2. *The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week. 3. * The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a ten-week schedule. The expert will review resource group schedule and lists of participants. 4. * The expert will review 10% records for the presence and appropriateness of special resource group notes	Preston is not a Residential Program. Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**

			documenting that at least two different special resource groups offered on a ten week schedule 5. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 6. The expert will review for presence and appropriateness relevant documentation of meetings with family members. 7. * The expert will review 10% of records for presence and appropriateness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	 Compliance Measure: Present/Not present **Rating: NA** Compliance Measure: Present/Not present **Rating: NA** Compliance Measure: 95% **Rating: NA**
5	Multi-model Treatment Model-*Outpatient Component*	The treatment program provides a multi-modal, multi-disciplinary and offense-	1. *The expert will review 10% of records for presence and adequacy of group	Compliance Measure: 95% **Rating: 50%**

		specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	notes documenting individual progress in at least two hours of group therapy per week. 2. *The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks 3. *The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule. 4. The expert will review documentation reflecting an	None of the records reviewed indicated the required two hours a week of group therapy, although they did reflect that group therapy was being offered between 60 and 165 hours over the month. Thus, I am assigning a rating of 50%. Compliance Measure: 95% **Rating: 50%** One youth is receiving individual SBTP-focused individual therapy. All cases documented case conferences. All of the youths had generic contact with staff. Compliance Measure: 95% **Rating: 75%** In this situation, Healthy Living can be counted as resource group. Three of the four individuals were receiving this course. Compliance Measure: 95% **Rating: NA**

			effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 5. The expert will review for presence and appropriateness relevant documentation of meetings with family members 6. * The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.	None of the participants have reached these stages.
6	Milieu Therapy in Residential Treatment	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	1. The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week. 2. * The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the	Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**

			operation of the residential treatment program. 3. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.	
7	Individuation of treatment	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	1. Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided. 2. Expert will review rosters of specialized resource groups and other therapeutic experiences.	Compliance Measure: 95% **Rating: 95%** All cases reviewed are receiving specialized mental health services. Compliance Measure: Present/not present **Rating: Not present.**
8	Treatment Plans with Objective Goals	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	1. Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants.	Compliance Measure: 95% **Rating: 25%** Matrix was being used. Some credit can be given for the presence in case conference notes of goals related to SBTP, though these were very general.

			2. Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	Compliance Measure: 95% **Rating: 25%.** Some credit can be given for case conference documentation of progress towards general goals.
9	Victim Outreach	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	1. The expert will review the file of correspondence with community therapists. 2. The expert will review documentation of outreach to victims' agencies.	Compliance Measure: Present/not present **Rating: Not present.** This would not be expected in so new a program. Compliance Measure: Present/not present **Rating: Not present.** This would not be expected in so new a program.
10	Staff Qualifications	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	1. Expert will review the number and professional qualifications of SBTP staff.	Compliance Measure: 100% **Rating: 100%** Staff appear to be qualified.

11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: Not evaluated.**
12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating: Not evaluated.**
13	Multi-disciplinary team reviews	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	1. * The expert will review minutes of the multi-disciplinary teams.	Compliance Measure: 95% **Rating: 100%** Case conferences were adequately documented for all youths assessed.
14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	Compliance Measure: 100% **Rating: NA** Administrative task Compliance Measure: 100% **Rating: NA**

15	Program Completion	Completion of the program reflects the completion of competency-based goals.	1. The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Measure: 95% **Rating: NA** No program completers.
16	Suspension/Termination From SPTP	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	1. The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination. 2. Audit will review 20% of records of terminated or suspended participants to insure they comply with policy. 3. The expert will review the written policy on suspension and termination to ensure that they are adequate.	Compliance Measure: 95% **Rating: NA** No suspensions or terminations. Compliance Measure: 95% **Rating: NA**

17	Pre-release	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	1. The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release 2. The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.	Compliance Measure: 95% **Rating: NA** No participants are at this stage. Compliance Measure: 95% **Rating: NA**
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision	1. The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract. 2. The expert will review documentation that the SBTP has been involved in	Compliance Measure: 95% **Rating: Not reviewed** Compliance Measure: Present/Not present **Rating: Not reviewed**

			the training of parole personnel.	
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	1. The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	Compliance Measure: Present/not present **Rating: NA** Administrative task
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract 2. The expert will review all prepared materials to ensure that they are appropriate.	Compliance Measure: In compliance/Not in compliance **Rating: NA** Administrative task
21	SBTP Program Coordinator	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	1. The expert will evaluate whether this position has been filled.	Compliance Measure: Achieved/Not achieved **Rating: NA** Administrative task
22.	Vocational Training	The CYA will make	1. The expert will evaluate	Compliance Measure:

		vocational opportunities available for youths with sexual behavior.	vocational training opportunities for youth with sexual behavior.	Present/not present **Rating: Not assessed**
23.	Physical Facilities and Resources	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	1. * The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.	Compliance Measure: Present/not present **Rating: Not present** Although the facility is attempting to meet this need, there is currently no appropriate group space which can meet the needs for confidentiality.
24	Behavioral Management System	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors.	1. The expert will review 10% of all records for documentation which supports the use of such a system. 2. The expert will review 10% of files containing disciplinary reports for documentation which supports use of such a system. 3. The expert will review the behavioral management plan itself to insure that it is appropriate.	Compliance Measure: 95% **Rating: NA** No documentation Compliance Measure: 95% **Rating: NA** No documentation **Rating: 95%** Behavioral rating system was provided and appears to

				be appropriate, but no documentation of utilization was provided.
26.	Healthy Sexuality Programs for all wards	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA.	1. The expert will review records which document existence of such programs. 2. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	Compliance Measure: Present/Not present **Rating: Present** Healthy Sexuality is being offered.
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior. 2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present/not present **Rating: NA** Administrative task Compliance Measure: Present/not present **Rating: NA**

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
*In addition to review records, the expert will directly observe these activities and facilities.

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: CHADERJIAN SITE VISIT, APRIL 29, 2008

Standard	**Title**	**Description**	**Audit Criteria**	**Compliance Rating**
1***[3]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: NA** Administrative Task
2***	Treatment Model	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	1. Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs participants.	Compliance Measure: 95% of groups scheduled to be held are held with the exception of security cancellations. **Rating: 50%** Specific treatment programs for youth with special needs (low functioning, Spanish-speaking only). There is a primarily Spanish-speaking group, and DJJ hopes to have an interpreter soon. Previously, a Spanish-speaking YCC facilitated, but the group is currently led by an English-speaking facilitator with translation assistance from Spanish-

[3] *** Priority criteria

			2. The expert will attend at least two groups at each facility during each audit period. 3. The expert will interview administration, staff and participants at each facility during each audit period.	speaking youth and Spanish-speaking CWS. There is one hearing impaired youth in another group, and group is held when the interpreter is available. Youth uses sign language and fully participates. Although these specialized groups are held, there is insufficient documentation to conclude that they are held for 3 hours a week, since the regular groups do not meet this requirement.
3***	Screening & Assessment	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the	1. Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and	Compliance Measure: Approved/Not approved **Rating: NA** Administrative Task

		assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	assessment tools. 2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	Compliance Measure: 95% **Rating: NA** No established protocol.

| 4*** | Multi-modal Treatment Model-*Residential Component* | The treatment program provides a multi-modal, multi-disciplinary and offense - specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF. | 1. *The expert will review 10% of files for the presence and appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week.

2. *The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week.

3. * The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a ten- | Compliance Measure: 95%
Rating: 60%

Staff report that youth are receiving 2 hours as opposed to the required 3 hours a week of small group.

Compliance Measure: 95%
Rating: 20%

Youth reported that they meet with the YCC usually for about 20 minutes a week. YCCs are recording 60 minutes a week, but their notes do not reflect discussions that would take that amount of time or discussions that follow a treatment plan. (For example, one note stated simply that youth told the YCC that he worked in the bakery.)

Compliance Measure: 95%
Rating: 80%

Groups: Stress Management, Victims Awareness, Anger |

			week schedule. The expert will review resource group schedule and lists of participants. 4. * The expert will review 10% records for the presence and appropriateness of special resource group notes documenting that at least two different special resource groups offered on a ten week schedule 5. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 6. The expert will review for presence and appropriateness relevant documentation of	Management, Interpersonal Skills, Addictive Behaviors, Human Sexuality, Criminal Thinking (= 7) Compliance Measure: 95% **Rating: 95%** There is a survivors group and a group for youth with substance abuse problems. Compliance Measure: Present/Not present **Rating: Present** Efforts consistently made to contact family are noted in the ITI (casework notes in WIN). Ward Phone Log (WIN palette) and case notes detail the contents of the calls. Families of two youth are actively involved in treatment on ongoing basis. Compliance Measure: Present/Not present **Rating: Partially present**

			meetings with family members	A log of one youth was provided (in the ITI) which documented 27 family phone calls in a three-month period. (This was not a randomly selected record.)
			7. * The expert will review 10% of records for presence and appropriateness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	Compliance Measure: 95% **Rating: NA** Formerly, when youth have left SBTP to return to the general population, this was viewed by the parole board as a treatment failure instead of as having –graduated." Clinicians are attempting to be more active in communication with the parole board that youth returning to the GP are successes. There are no maintenance groups.
5	Multi-model Treatment Model-*Outpatient Component*	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This	1. *The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week.	Compliance Measure: 95% **Rating: NA** Not an outpatient program.

		program will be provided at all facilities to medium risk youths with sexual behavior.	2. *The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks	Compliance Measure: 95% **Rating: NA**
			3. *The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule.	Compliance Measure: 95% **Rating: NA**
			4. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Measure: 95% **Rating: NA**
			5. The expert will review for presence and appropriateness relevant documentation of meetings with family members	
			6. * The expert will review 10%	

			of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.	
6	Milieu Therapy in Residential Treatment	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	1. * The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week. 2. * The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program.	Compliance Measure: 95% **Rating: 25%** Minutes are documented in case notes. Every morning before school, during lunch hour, and on Wednesday afternoons, large groups are held. Sometimes youth will share where they are in the program and where they are going. School movement is sometimes delayed in order to include more issues. This is not uniformly documented in the WIN System, nor was this reported by youths. Compliance Measure: 95% **Rating:** No documentation. The facility is working on creating a ward council on the hall. Activities include

			3. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.	victims' week, victims' council, and a grievance council that helps youth mediate with staff.
7	Individuation of treatment	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	1. Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided. 2. Expert will review rosters of specialized resource groups and other therapeutic experiences.	Compliance Measure: 95% **Rating: 100%** Youths with mental health needs are being seen by the MH Department and the psychiatrist. Compliance Measure: Present/not present **Rating: Not Present** Rosters not provided, although staff stated that these groups exist.
8	Treatment Plans with Objective Goals***	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	1. Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated	Compliance Measure: 95% **Rating: 50%** The matrix has been

			quarterly for all participants.	implemented as of approximately the first of April. Quarterly reviews, ICPs, and ITIs also respond to these criteria. All of the reviewed files have quarterly reviews, but SBTP goals are generic.
			2. Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	Compliance Measure: 95% **Rating: 50%** Because the matrix has just been implemented, responses to identified needs will be review in next audit.
9	Victim Outreach	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	1. The expert will review the file of correspondence with community therapists. 2. The expert will review documentation of outreach to victims' agencies.	Compliance Measure: Present/not present **Rating: Present** Presumably, correspondence was involved in setting up the panel described below. Compliance Measure: Present/not present **Rating: Present** On 4/14-4/18, a panel of speakers/victims presented to the youth. Youth spent at least two sessions thereafter

				processing the panel experience. Several restorative justice activities are also occurring, including a ―run" and art projects sponsored by staff with proceeds going to victims' groups.
10	Staff Qualifications	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	1. Expert will review the number and professional qualifications of SBTP staff.	Compliance Measure: 100% **Rating: Deferred** The psychological staff is well qualified. However, because the selected YCC staff are currently on another unit, evaluation of this item will be postponed until the planned move is accomplished.
11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: 75%** One clinician or staff person will attend the CCOSO conference. Staff have had a variety of special trainings. The team also had a one-day training. However, an overall training plan for the SBTP has not been implemented.

12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. * The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating: 35%** A team meeting was held off-site, and other staff manned the unit. It was reported that "almost weekly" there is a smaller meeting with the clinicians and the CWS to share information and then communicate with line staff. Professional staff feels that there is not good communication with the line staff. No log was provided.
13	Multi-disciplinary team reviews	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	1. * The expert will review minutes of the multi-disciplinary teams.	Compliance Measure: 95% **Rating: 100%** These reviews were all present.
14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these	Compliance Measure: 100% **Rating: NA** Administrative Task Compliance Measure: 100% **Rating: NA**

		the limits of confidentiality, informed consent to treatment and their due process rights.	policies.	
15	Program Completion	Completion of the program reflects the completion of competency-based goals.	1. The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Measure: 95% **Rating: 20%** Two youth have completed the program. YCs receive stage work when youth complete. Case notes document the stages. 1) B, A: Youth already completed the program, and the file was kept elsewhere. Staff was confident that they had noted in the youth file that he had completed all stages of the SBTP. 2) J, K: ~~"~~Has completed 1-9 and working on stage 10" (also, continues to attend groups, etc.). 3) H ~~"~~continuing on to stage 10." However, I have not seen case notes that reflect completion of goals, and I would be very skeptical that the current line staff could

				accurately critique these assignments. Also, the matrix has just been adopted.
16	Suspension/Termination From SPTP	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	1. The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination. 2. Audit will review 20% of records of terminated or suspended participants to insure they comply with policy. 3. The expert will review the written policy on suspension and termination to ensure that they are adequate.	Compliance Measure: 95% **Rating: 0%** No such documentation exists. Compliance Measure: 95% **Rating: 100%** Youth ―L” is in the process of being terminated. He has struggled to leave the unit and has asked the PB to be removed. He has victimized youth on the SBTP. A behavioral contract was developed, and he will be monitored and reevaluated for return to SBTP in 90 days. **Rating: NA** Administrative task

17	Pre-release	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	1. The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release 2. The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.	Compliance Measure: 95% **Rating: 65%** Process was described, but documentation was not provided. Compliance Measure: 95% **Rating: 65%** **17.1 and 2**: ―PCH" Report (parole consideration hearing) and ―life plan" for youth prerelease. Also, YC prepares the report that identifies whether youth have appropriate placement upon release. If not, a sex offender group home is requested. One youth was paroled last week and had been accepted into a group home. Clinicians encouraged youth to contact the homes, and he is making other community contacts including with CalWORKs. See copy of PCH and parole

				plan with evaluation of placement/residence appropriateness as well as details of support group and services youth are expected to receive. This includes family counseling through EFFORT, but the counseling is not sex-offender specific. The PCH and parole plan goes out 60 days prior to parole, and the field agent has 35 days to generate parole plans (pre-release package) to send back to the institution. Then board dates are set. Two parole plans were provided. Both documented details of release and treatment plans. One appeared to reflect transitional planning, the other evaluated the youth's progress in treatment but did not reflect careful release planning.
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an	1. * The expert will review monthly reports from community vendors to insure that they are in compliance	Compliance Measure: 95% **Rating: Not reviewed**

		extension of treatment and informed supervision	with provisions of the contract. 2. The expert will review documentation that the SBTP has been involved in the training of parole personnel.	 Compliance Measure: Present/Not present **Rating: Not reviewed**
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	1. The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	Compliance Measure: Present/not present **Rating: NA** Administrative task
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract 2. The expert will review all prepared materials to ensure that they are appropriate.	Compliance Measure: In compliance/Not in compliance **Rating: NA** Administrative task
21	SBTP Program Coordinator	CYA will retain a full time	1. The expert will evaluate	Compliance Measure:

		program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	whether this position has been filled.	Achieved/Not achieved **Rating: NA** Administrative task
22.	Vocational Training	The CYA will make vocational opportunities available for youths with sexual behavior.	1. The expert will evaluate vocational training opportunities for youth with sexual behavior.	Compliance Measure: Present/not present **Rating: Present** Several programs are offered, increasing since the DeWitt closure.
23.	Physical Facilities and Resources	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	1. * The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.	Compliance Measure: Present/not present **Rating: Not present** At the present time, the space is inadequate to provide for the treatment program. A new space has been designated but is not ready.
24	Behavioral Management System	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors.	1. The expert will review 10% of all records for documentation which supports the use of such a system. 2. The expert will review 10% of files containing disciplinary reports for	Compliance Measure: 95% **Rating: NA** No documentation Compliance Measure: 95% **Rating: NA**

			documentation which supports use of such a system. 3. The expert will review the behavioral management plan itself to insure that it is appropriate.	No documentation **Rating: 95%** Behavioral rating system was provided and appears to be appropriate, but no documentation of utilization was provided.
26.	Healthy Sexuality Programs for all wards	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA.	1. The expert will review records which document existence of such programs. 2. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	Compliance Measure: Present/Not present **Rating: Present** I observed this program being piloted at Chad in February. I have also reviewed the curriculum and find it to be acceptable.
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior.	Compliance Measure: Present/not present **Rating: NA** Administrative task

			2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present /not present **Rating: NA** Administrative task

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
* In addition to review records, the expert will directly observe these activities and facilities.

APPENDIX D—SOUTHERN RECEPTION CENTER

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: SRC SITE VISIT, MAY 21, 2008

Standard	**Title**	**Description**	**Audit Criteria**	**Compliance Rating**
1***[4]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: NA** Administrative task
2***	Treatment Model	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	1. Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs participants.	Compliance Goal: 95% of groups scheduled to be held are held with the exception of security cancellations. **Rating: 50%** There have been such groups in the past, but there are none currently.

[4] *** Priority criteria

			2. The expert will attend at least two groups at each facility during each audit period. 3. The expert will interview administration, staff and participants at each facility during each audit period.	SBTP staff report that in the past, groups have been held specifically for English language learners, the hearing impaired, and for low cognitive functioning youth. Currently, no such groups are being provided; however, youth with the above mentioned special needs are accommodated on the unit by custody and clinical staff, and they receive individual care as needed. There was previously a small Spanish-speaking group, and they work with their peers at this time. Youth are allowed to write in Spanish.
3***	Screening & Assessment	Appropriate screening and	1. Expert will review the	Compliance Measure:

		assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools. 2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	Approved/Not approved **Rating: NA** Administrative task Compliance Measure: 95% **Rating: 50%** Although all of the records reviewed had SORD scores, compliance with this goal requires that an appropriate assessment protocol be established.
4***	Multi-modal Treatment Model-*Residential Component*	The treatment program provides a multi-modal, multi-disciplinary and offense - specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF.	1. *The expert will review 10% of files for the presence and appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week.	Compliance Measure: 95% **Rating: 60%** SRC has a ―Core Group Therapy" binder that includes tabs for each YCC and weekly sign-in sheets for each youth on each counselor's caseload. In addition to sign-in sheets, clinicians log WIN notes following each group. From youth files reviewed, three of the five youth files/group tracking sheets reflect youth attendance at

				three hours of core group per week. For one youth, the YCC was absent and the group was cancelled. For the second youth, groups were held for less than the required three hours per week.
			2. The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week.	Compliance Measure: 95% **Rating:** Lack of documentation.
			3. * The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a ten-week schedule. The expert will review resource group schedule and lists of participants.	Compliance Measure: 95% **Rating: 90%** An ―SBTP Treatment Matrix" was provided for each youth. Matrices indicate SRC has eight groups, but staff are still unclear as to the definitions of resource groups and specialized groups. In the files reviewed, 80% of the youth were involved in some kind of resource

				group. Additionally, the program offers a group for youths who are survivors of sexual assault.
			4. * The expert will review 10% records for the presence and appropriateness of special resource group notes documenting that at least two different special resource groups offered on a ten week schedule	Compliance Measure: 95% **Rating: 50%**
			5. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Measure: Present/Not present **Rating: Partially present** Efforts to contact family documented in the matrices were provided for each youth file reviewed. Not all attempts at contacting family members were successful, and not all stages have been documented (because some youth progressed beyond stage 3 by the time the SBTP matrices were implemented).

			6. The expert will review for presence and appropriateness relevant documentation of meetings with family members.	Compliance Measure: Present/Not present **Rating: Partially present.** One file documents two meetings between a SBTP youth and his mother since April 2008. The youth is at stage five.
			7. * The expert will review 10% of records for presence and appropriateness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	Compliance Measure: 95% **Rating: NA** No maintenance groups exist.
5	Multi-model Treatment Model-*Outpatient Component*	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	1. *The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week. 2. *The expert will review 10% of records for the presence and adequacy of	Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**

			individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks	
			3. *The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule.	Compliance Measure: 95% **Rating: NA**
			4. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.	Compliance Measure: 95% **Rating: NA**
			5. The expert will review for presence and appropriateness relevant documentation of meetings with family members	
			6. The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups	

			conducted for all wards having completed Stage 10.	
6	Milieu Therapy in Residential Treatment	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	1. * The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week. 2. * The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program. 3. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the	Compliance Measure: 95% **Rating: 30%** Large groups have been documented as occurring but not at the required level. Compliance Measure: 95% **Rating: 50%** It would appear that youths are involved in a variety of community activities, often aimed at charitable endeavors. This is to be commended, but it is difficult to ascertain to what degree the youth are directing this and other community activities due to the lack of documentation. Minutes should be kept of each of these activities.

			functioning of the TC.	
7	Individuation of treatment	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	1. Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided. 2. Expert will review rosters of specialized resource groups and other therapeutic experiences.	Compliance Measure: 95% **Rating: 95%** Youth with special needs, such as need for mental health care, are referred for this treatment. Compliance Measure: Present/not present **Rating: Present** The health record documents mental health and psychiatric care.
8	Treatment Plans with Objective Goals	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	1. Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants. 2. Expert will review those same clinical records for	Compliance Measure: 95% **Rating: 95%** All five files reviewed contain Identified Treatment Issues from date of arrival and were evaluated regularly at case conferences. The Treatment Matrix has been implemented. Compliance Measure: 95% **Rating: 95%**

			evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	The various treatment review forms indicate that this factor is complied with.
9	Victim Outreach	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	1. The expert will review the file of correspondence with community therapists. 2. The expert will review documentation of outreach to victims' agencies.	Compliance Measure: Present/not present **Rating: Partially present** Relevant activities are being conducted, but there is no documentation. Compliance Measure: Present/not present **Rating: Present** There have been victim-centered activities which obviously involved outreach to victim groups.
10	Staff Qualifications	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	1. Expert will review the number and professional qualifications of SBTP staff.	Compliance Measure: 100% **Rating: 50%** Psychological staff are well qualified. It is difficult to ascertain the qualifications of other staff as I have been unable to access their CVs.

11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: 50%** The psychological staff have been attending training in assessment, Motivational Interviewing, and Aggression Replacement. However, orientation and ongoing training in the SBTP has not been developed.
12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. * The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating: 95%** Weekly clinical meetings including clinicians and Senior Psychs, SCWSs, and SYCCs are held. They discuss and identify unit issues, progress in treatment, custody staff guidance into clinical issues, discharge planning, and service projects. Documentation of the supervision meetings is a sign-in sheet that is signed weekly by all those in attendance. The Senior Psych is also available to meet with them individually.

				The Senior Psych has been here for five months.
13	Multi-disciplinary team reviews	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	1. * The expert will review minutes of the multi-disciplinary teams.	Compliance Measure: 95% **Rating: 95%** Quarterly reviews of various types document multidisciplinary reviews.
14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	Compliance Measure: 100% **Rating: NA** Administrative task Compliance Measure: 100% **Rating: NA**
15	Program Completion	Completion of the program reflects the completion of competency-based goals.	1. The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Measure: 95% **Rating:** Documentation not provided.
16	Suspension/Termination From SPTP	Suspension or termination for the SBTP are based on	1. The expert will review 10 % of clinical records for	Compliance Measure: 95% **Rating: 0%**

		written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	documents reflecting program participants' understanding of program rules related to suspension and termination. 2. Audit will review 20% of records of terminated or suspended participants to insure they comply with policy. 3. The expert will review the written policy on suspension and termination to ensure that they are adequate.	There is no documentation of this being done. Compliance Measure: 95% **Rating:** Records of terminated youths not provided. Comment: Written policy being developed by administration.

17	Pre-release	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	1. The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release 2. The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.	Compliance Measure: 95% **Rating: 0%** Prerelease program not being done Compliance Measure: 95% **Rating:** Documentation not provided.
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision	1. The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract. 2. The expert will review documentation that the SBTP has been involved in	Compliance Measure: 95% **Rating: Not reviewed** Compliance Measure: Present/Not present **Rating: Not reviewed**

			the training of parole personnel.	
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	1. The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	Compliance Measure: Present/not present **Rating: NA** Administrative task
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract 2. The expert will review all prepared materials to ensure that they are appropriate.	Compliance Measure: In compliance/Not in compliance **Rating: NA** Administrative task
21	SBTP Program Coordinator	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	1. The expert will evaluate whether this position has been filled.	Compliance Measure: Achieved/Not achieved **Rating: NA** Administrative Task
22.	Vocational Training	The CYA will make	1. The expert will evaluate	Compliance Measure:

		vocational opportunities available for youths with sexual behavior.	vocational training opportunities for youth with sexual behavior.	Present/not present **Rating: Not evaluated at this time**
23.	Physical Facilities and Resources	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	1. The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.	Compliance Measure: Present/not present **Rating: Present** Physical facilities are currently usable, and expanded space will soon be available.
24	Behavioral Management System	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors.	1. The expert will review 10% of all records for documentation which supports the use of such a system. 2. The expert will review 10% of files containing disciplinary reports for documentation which supports use of such a system. 3. The expert will review the behavioral management plan itself to insure that it is appropriate.	Compliance Measure: 95% **Rating: NA** No documentation Compliance Measure: 95% **Rating: NA** No documentation **Rating: 95%** Behavioral rating system was provided and appears to be appropriate, but no documentation of utilization was provided.

26.	Healthy Sexuality Programs for all wards	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA.	1. The expert will review records which document existence of such programs. 2. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	Compliance Measure: Present/Not present **Rating: Present** Comment: Healthy Living was observed, and curriculum has been reviewed.
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior. 2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present/not present **Rating: NA** Administrative task Compliance Measure: Present /not present **Rating: NA**

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
* In addition to review records, the expert will directly observe these activities and facilities.

APPENDIX E—STARK

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: STARK SITE VISIT, MAY 22, 2008

Standard	Title	Description	Audit Criteria	Compliance Rating

1***[5]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: NA** Administrative task
2***	Treatment Model	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior.	1. Expert will review group notes that document the existence of therapy groups directed at different risk levels and special needs participants. 2. The expert will attend at least two groups at each	Compliance Measure: 95% **Rating: 75%** Staff report that 95% of scheduled groups are held, with the exception of security cancellations. At the time of the audit, Stark staff were still unclear about the definitions of resource and specialized groups. The facility continues to offer a Spanish language group as an accommodation for the ELL students. However, there is no interpreter. There is one hearing impaired youth, for whom the facility provides an interpreter. He also uses hearing aids.

[5] *** Priority criteria

			facility during each audit period. 3. The expert will interview administration, staff and participants at each facility during each audit period.	
3***	Screening & Assessment	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	1. Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools. 2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	Compliance Measure: Approved/Not approved **Rating: NA** Administrative task Compliance Measure: 95% **Rating: 50%** Although all of the records which were reviewed had SORD scores, compliance with this goal requires that an appropriate assessment protocol be established.
4***	Multi-modal Treatment Model-*Residential Component*	The treatment program provides a multi-modal, multi-disciplinary and offense - specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The	1. *The expert will review 10% of files for the presence and appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week.	Compliance Measure: 95% **Rating: 40%** Staff stated that Stark youth attend two groups per week with a clinician. The reviewed records indicate that the six youth whose

		residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF.		records were reviewed were receiving 86 rather than 180 minutes of core therapy per week, and some youths received only one core group in a month's period of time. Since groups are not identified as core groups but are called Relapse Prevention Group and Cycle Group, it is difficult to determine how each should be classified. Staff stated that there are ten types of resource groups run specifically as part of the SBTP. They are: • Stress Management • Victim Impact • Anger Management • Interpersonal Skills • Addictive Behavior • Human Sexuality • Criminal Thinking • Impulse Control • Pre-parole • Self Esteem However, rosters were only provided for six groups. In the group notes, resource groups are also recorded as ―small groups."

				Additionally, some of the "small groups" are not resource groups. Each psychologist has a caseload. Staff stated that each youth has two groups per week for 90 minutes, each facilitated by clinicians, two groups per week with a YCC for two hours each, and one resource group for one hour a week, by a YCC (on a ten-week schedule). Counting the Cycle group, resource groups, and small groups, the youth whose records were reviewed received 86 minutes of these types of groups per week. There is also a large group with a SYCC once per week for one hour.
			2. *The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and	Compliance Measure: 95% **Rating: 20%** When youth request individual therapy, staff will see them. If the youth wants individual therapy instead of groups, it is not allowed.

			individuals sessions with treatment staff for at least three hours a week.	There is no set schedule every week, but youth have time with clinicians and caseloads. The reviewed records showed an average of 23 minutes a week of individual sessions.
			3. * The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a ten-week schedule. The expert will review resource group schedule and lists of participants.	Compliance Measure: 95% **Rating: 80%** Resource groups include: Interpersonal Skills Anger Management Stress Management Criminal Thinking Human Sexuality Addictive Behavior However, there were only two references to resource groups in the reviewed records. One youth had one session of Anger Management, and one record referenced one session of a ―resource group.”
			4. * The expert will review 10% records for the presence and appropriateness of special	Compliance Measure: 95% **Rating: NA** See ―Core” groups. Each

			resource group notes documenting that at least two different special resource groups offered on a ten week schedule 5. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 6. The expert will review for presence and appropriateness relevant documentation of meetings with family members.	clinician holds nine groups per week, but staff are still confused about the difference between resource and specialized resource groups. Compliance Measure: Present/Not present **Rating: Partially present** Staff report that family contact is being made, but this is not always documented on the achievement matrix. I reviewed one youth file that showed 10 family contact attempts in four months. (Staff will begin to document family contacts at the various stages on the ~~–a~~achievement matrix" developed by DJJ central office and place in youth files in May 2008). Compliance Measure: Present/Not present **Rating: NA** Families are still unwilling to come to the facility for

			7. The expert will review 10% of records for presence and appropriateness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.	group meetings. Compliance Measure: 95% **Rating: NA**
5	Multi-model Treatment Model-*Outpatient Component*	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	1. *The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week. 2. *The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every two weeks	Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**

			3. *The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule. 4. The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine. 5. The expert will review for presence and appropriateness relevant documentation of meetings with family members 6. * The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.	Compliance Measure: 95% **Rating: NA** Compliance Measure: 95% **Rating: NA**
6	Milieu Therapy in Residential Treatment	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy	1. The expert will review for presence and adequacy the notes of residential large group minutes documenting	Compliance Measure: 95% **Rating: 20%** Staff state that large groups

		model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others.	that such two groups are held per week for a total of four hours per week. 2. * The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program. 3. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.	are held once a week for an hour, no documentation was provided. Compliance Measure: 95% **Rating: NA** Youth do appear to be involved in various projects, but no documentation was provided.
7	Individuation of treatment	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	1. Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided. 2. Expert will review rosters of specialized resource groups and other therapeutic experiences.	Compliance Measure: 95% **Rating: 95%** Youths appear to be referred to mental health services when deemed necessary. Compliance Measure: Present/not present **Rating: Partially present**

				Individuals in need of mental health services including psychopharmacological treatment are referred to the Mental Health Department.
8	Treatment Plans with Objective Goals	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	1. Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants. 2. Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.	Compliance Measure: 95% **Rating: 95%** The Achievement Matrix has been implemented and was provided for all youth being reviewed. Compliance Measure: 95% **Rating: 95%** The Achievement Matrix is being used.
9	Victim Outreach	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	1. The expert will review the file of correspondence with community therapists. 2. The expert will review documentation of outreach to victims' agencies.	Compliance Measure: Present/not present **Rating: Not Present** No documentation was provided. Compliance Measure: Present/not present **Rating:**

				No documentation was provided.
10	Staff Qualifications	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	1. Expert will review the number and professional qualifications of SBTP staff.	Compliance Measure: 100% **Rating: Deferred.** While the psychological staff are all well qualified, lack of documentation of the background of the case work and youth counselor staff prevents meaningful assessment of this item.
11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: 50%** The psychological staff have been attending training in assessment, Motivational Interviewing, and Aggression Replacement. However, orientation and ongoing training in the SBTP has not been developed.
12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating:50%** Staff report that Stark continues to hold once

				monthly (two-hour) staff meetings and weekly clinical meetings. Log not provided.
13	Multi-disciplinary team reviews	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	1. The expert will review minutes of the multi-disciplinary teams.	Compliance Measure: 95% **Rating:95%** Staff report that Stark holds four- to eight-hour meetings attended by the entire treatment team and conducts training, discusses staffing of cases, and addresses any operational issues.
14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	Compliance Measure: 100% **Rating: NA** Administrative task Compliance Measure: 100% **Rating: NA**

15	Program Completion	Completion of the program reflects the completion of competency-based goals.	1. The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.	Compliance Measure: 95% **Rating: Deferred** Documentation not provided
16	Suspension/Termination From SPTP	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place.	1. The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination. 2. Audit will review 20% of records of terminated or suspended participants to insure they comply with policy. 3. The expert will review the written policy on suspension and termination to ensure that they are adequate.	Compliance Measure: 95% **Rating: Deferred** Documentation not provided Compliance Measure: 95% **Rating: Deferred** Documentation not provided
17	Pre-release	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will	1. The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been	Compliance Measure: 95% **Rating: Deferred** Documentation not provided

		be made by the SBYP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	evaluated and that the pre-release package was complete at the time of release 2. The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.	 Compliance Measure: 95% **Rating: Deferred** Documentation not provided
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision	1. The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract. 2. The expert will review documentation that the SBTP has been involved in the training of parole personnel.	Compliance Measure: 95% **Rating: Not reviewed** Compliance Measure: Present/Not present **Rating: Not reviewed**
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in treatment	1. The expert will review written proposal for the evaluation project and compliance with agreed	Compliance Measure: Present/not present **Rating: NA**

		and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	Administrative task
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract 2. The expert will review all prepared materials to ensure that they are appropriate.	Compliance Measure: In compliance/Not in compliance **Rating: NA** Administrative task
21	SBTP Program Coordinator	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	1. The expert will evaluate whether this position has been filled.	Compliance Measure: Achieved/Not achieved **Rating: NA** Administrative task
22.	Vocational Training	The CYA will make vocational opportunities available for youths with sexual behavior.	1. The expert will evaluate vocational training opportunities for youth with sexual behavior.	Compliance Measure: Present/not present **Rating: Present** Youths in the SBTP are offered opportunities for vocational training.

23.	Physical Facilities and Resources	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	1. The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.	Compliance Measure: Present/not present **Rating: Partially present.** Currently there are problems with the adequacy of the physical facilities. For example, Healthy Living was offered in a very crowded room. However, the program is moving, and facilities will be more adequate at that time.
24	Behavioral Management System	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors.	1. The expert will review 10% of all records for documentation which supports the use of such a system. 2. The expert will review 10% of files containing disciplinary reports for documentation which supports use of such a system. 3. The expert will review the behavioral management plan itself to insure that it is appropriate.	Compliance Measure: 95% **Rating: NA** No documentation Compliance Measure: 95% **Rating: NA** No documentation **Rating: 95%** Behavioral rating system was provided and appears to be appropriate, but no documentation of utilization

				was provided.
26.	Healthy Sexuality Programs for all wards	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA.	1. The expert will review records which document existence of such programs. 2. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	Compliance Measure: Present/Not present **Rating: Present**
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior. 2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present/not present **Rating: NA** Administrative task Compliance Measure: Present /not present **Rating: NA**

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
* In addition to review records, the expert will directly observe these activities and facilities.

APPENDIX F—ADMINISTRATION

SEXUAL BEHAVIOR REMEDIAL PLAN AUDIT/COMPLIANCE INSTRUMENT: ADMINISTRATION

Standard	Title	Description	Audit Criteria	Rating

1***[6]	Policies and Procedures Which Establish and Govern the Administration of the Sexual Behavior Treatment Program	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the Sexual Behavior Treatment Program	1. The expert will review the Program Manual and all policies and procedures to insure adequacy.	Compliance Measure: Approved/Disapproved **Rating: Deferred** Ms. Allen and Dr. Martin have provided me with a table of contents for the policies and procedures. The next step is the development of the policies themselves.
3***	Screening & Assessment	Appropriate screening and assessment tools are used to evaluate risk and treatment needs initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	1. Expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools.	Compliance Measure: Approved/Not approved **Rating: Not approved.** I do not approve of use of the JSORRAT or the Static-99 to assess risk with SBTP participants. I do approve of the J-SOAP. The SBTP is still using the SORD. Staff have been trained in the JSORRAT and the Static-99. These two assessments have been ―mandated" by the California Sex Offender Management Task Force. However, neither of these

[6] *** Priority criteria

			2. The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.	assessments has proven validity with youthful offenders. The administration also needs to develop an assessment protocol for treatment planning and monitoring. Compliance Measure: 95% **Rating: 50%** Although all of the records reviewed had SORD scores, compliance with this goal requires that an appropriate assessment protocol be established.
11	Staff Training	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	1. Expert will review training records of the SBTP staff.	Compliance Measure: 95% **Rating: 50%** Administrative staff will need to develop an orientation to the SBTP model and coordinate training.
12	Staff Supervision	The program provides regularly scheduled supervision for all staff working directly with wards.	1. * The expert will review a log of supervision meetings	Compliance Measure: 95% **Rating:**

14	Ethics	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	1. The expert will review written procedures regarding confidentiality and informed consent. 2. Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	Compliance Measure: 100% **Rating: 0%** Administrative staff needs to develop policies and procedures around these issues. This has not been done, although Dr. Arguello indicated that this issue is being addressed as part of the development of the Mental Health policy. Compliance Measure: 100% **Rating: 0%** See above.
18	Aftercare	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision	1. The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract. 2. The expert will review documentation that the SBTP has been involved in the training of parole personnel.	Compliance Measure: 95% **Rating: Not reviewed** Compliance Measure: Present/Not present **Rating: Not reviewed**
19	Program Evaluation	CYA will conduct an evaluation of the SBTP which	1. The expert will review written proposal for the	Compliance Measure: Present/not present

		will assess basic demographic factors, progress in treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables.	evaluation project and compliance with agreed upon deadlines 2. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	**Rating: Not present** A program evaluation proposal has not been developed.
20	Program Materials	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive.	1. Audit will review written contract with publisher for compliance with contract	Compliance Measure: In compliance/Not in compliance **Rating: Deferred** Dr. Cellini has presented DJJ with the Healthy Living curriculum, which DJJ is now piloting. At the time of this audit, there was an arrangement with Dr. Cellini to complete the residential and outpatient curricula. This arrangement has dissolved. During the time it has taken for DJJ to decide on a treatment model, the field has changed significantly, and a new treatment model

			2. The expert will review all prepared materials to ensure that they are appropriate.	is necessary.
21	SBTP Program Coordinator	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP	1. The expert will evaluate whether this position has been filled.	Compliance Measure: Achieved/Not achieved **Rating: Achieved**
27.	Training of Adjunct Staff to understand the treatment needs of Youths with Sexual Behavior problems.	SPTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	1. The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior. 2. The expert will review the content of training materials to insure that quality training is being provided is suitable.	Compliance Measure: Present/not present **Rating: Not present** This will depend upon the development of the treatment model. Compliance Measure: Present /not present **Rating: Not present** See above.

The California Youth Authority Sexual Behavior Treatment Program Audit Tool
* In addition to review records, the expert will directly observe these activities and facilities.