SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

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

NINTH REPORT OF SPECIAL MASTER

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

TABLE OF CONTENTS

I. INTRODUCTION 1

II. *FARRELL* EXPERTS' PRIORITES 1

III. STATUS UPDATE ON RESET DEADLINES 2

IV. MEDICAL CARE 2

A. Inclusion of Facility Compliance Scores 2

B. Achievements Since The Last Report 4

C. Areas for Improvement 6

V. SAFETY AND WELFARE 8

A. Monitors' Report on Safety and Welfare Standards/Criteria Items 8

B. Development of DJJ's Integrated Behavior Treatment Model 8

1. Remedial Plan Requirements 9

2. Chronology 13

VI. CONCLUSION 18

APPENDICES

Appendix A: Experts' Priorities for Fiscal ear 2008-2009

Appendix B: OSM Monitors Fletcher and Schwartz, *Status of Items with Modified Deadlines* (May 2009)

Attachment 1: Attachment 1, "Time Add Tracking System," provided as DJJ Proof of Practice #303, December 5, 2008

Appendix C: LaMarre and Goldenson, *Second Report of Consent Decree By the Experts* (February 2009)

Appendix D: OSM Monitors Fletcher and Schwartz, *Safety and Welfare Remedial Plan Audit Items: Report of Findings* (June 2009)

Attachment 1: Draft Court Compliance organization chart, undated (provided in approximately January 2009)

Attachment 2: PPP&R organization chart, January 26, 2009

Attachment 3: Document entitled "Policy Dashboard: As of 3/11/09"

Attachment 4: Draft Project Charter: Comprehensive Classification System, February 25, 2009

Attachment 5: "Program Service Day Policy" (PoP 37 , April , 2009)

Attachment 6: "Program Service Day Standards," May 11, 2009 (PoP 402, May 15, 2009)

Attachment 7: Project schedule listing, e.g., chartered projects and minor projects, undated (PoP #362, March 12, 2009)

Attachment 8: Memorandum of Sandra Youngen to superintendents, November 25, 2008 (PoP #305, December 5, 2008)

Attachment 9: "Program Credits Handout for DJJ Youth," March 2009

Attachment 10: Memorandum of Pamela Shintaku to Sandra Youngen and Bernard Warner, March 10, 2009

Attachment 11: Memorandum of Sandra Youngen to superintendents, January 8, 2009

Attachment 12: Memorandum of Sandra Youngen to facility staff, June 3, 2008

Attachment 13: Youth Incentive Program "Pyramid," March 3, 2009

Attachment 14: Memorandum from Jeff Plunkett, Major, Division of Juvenile Facilities, February 4, 2008

Attachment 15: Sample Quarterly Statistical Report pages

Attachment 16: Sample Daily Operations Report

Attachment 17: "Outline of the Sa2-12 PbS to QSR/CompStat on Safety Issues" and "PbS Source Document uide: Incident Report Form" (PoP 3 9, March 11, 2009)

Attachment 18: E-mail of Barry Krisberg to various, May 7, 2009

Attachment 19: Bid #6000000077 – Normative Culture (cover page only)

Attachment 20: Excerpt from draft Behavior Treatment Program Operations Guide (Sample BTP Facility Schedule), August 7, 2008

Attachment 21: DJJ Intake and Court Services, Juvenile Hall Orientation Log, January to March 2009

Attachment 22: DJJ, New Commitment Orientation (Power Point slides), undated (provided March 12, 2009)

Attachment 23: Orientation handouts, undated (provided March 12, 2009)

Attachment 24: Youth Grievance System Handout for DJJ Youth, July 2008

Attachment 25: Youth Grievance Clerk Duty Statement, undated

Attachment 26: Memorandum of Sandra Youngen to Superintendents and Ward Incentive Coordinators, May 23, 2007

Attachment 27: Memorandum of Jim Cripe to Doug Ugarkovich, November 13, 2008

Attachment 28: Memorandum of Lisa Goodwill to Jan Krueger, June 11, 2008

Attachment 29: State of California Purchase Order #61613, May 23, 2007

Attachment 30: State of California Purchase Order #61614, May 23, 2007

Attachment 31: Memorandum, Jim Cripe to Principals, October 8, 2008

Attachment 32: Department of Corrections and Rehabilitation Operations Manual § 101120.11 (2007)

Attachment 33: Duty statement for Religious Programs Coordinator (PoP #177, January 24, 2008)

Attachment 34: Religious Services/Programs Sign Up and Attendance Roster, January 2003

Appendix E: Donna Brorby, facsimile of email, *IBTM -- experts' high level issues* (March 3, 2008)

Appendix F: Excerpt from Barry Krisberg, *revised informal report on January 2009 central office site visit (summary)* (April 10, 2009)

I. INTRODUCTION

This report attaches the medical experts' second annual report and a report on the safety and welfare issues monitored by the special master's office. It also attaches a summary of priorities designated by the experts in each remedial area and an update on the compliance status of certain standards and criteria items for which the Court reset deadlines this year.

The special master has not yet received the comprehensive reports of the safety and welfare and mental health experts that she expected to file with this report, though she and the parties have received numerous informal site visit reports from these experts. She now expects to file the experts' comprehensive reports with her next report, which will also likely include comprehensive reports in the areas of education and disability.

II. *FARRELL* EXPERTS' PRIORITIES

Between December 2008 and February 2009, the *Farrell* experts identified priority areas for fiscal year 2008-2009 and provided this information to DJJ leadership.[1] This was done at the request of then-new Chief of Court Compliance Michael Brady. Except in the area of wards with disabilities, where the expert relied on his dashboard submission and his conversation with Mr. Brady about it, these priorities are not identical but are closely related to the items on the "key indicators" portion of the "dashboard."[2] The office of the special master will focus future reports on DJJ compliance with priority requirements, as experts provide their findings in these areas. The priorities are attached as Appendix A.

[1] E-mail of Zack Schwartz to Michael Brady, February 16, 2009.
[2] At the request of the Court, the parties crafted a "dashboard" with the help of the experts to depict compliance status in identified priority areas. DJJ provides an update for each Case Management Conference.

III. STATUS UPDATE ON RESET DEADLINES

On February 20, 2009 and March 27, 2009, the Court adopted DJJ's proposed modifications of certain *Farrell* deadlines.[3] A number of those deadlines have passed. A status update regarding some of those items is attached as Appendix B.

IV. MEDICAL CARE

The medical experts conducted their second round of site visits from September 2007 to June 2008.[4] Their comprehensive report was completed in February 2009 and is attached as Appendix C. The experts' executive summary and the recommendation section at the close of the report are brief and summarize the experts' findings and recommendations for the current fiscal year. The medical experts have reviewed and approve our summary of their report.

A. Inclusion of Facility Compliance Scores

This is the first *Farrell* medical report to include compliance scores for each facility.[5] During the previous round of site visits, the experts were "field- testing" the medical audit instrument.[6] The compliance scores range from 61% to 81% overall and are a starting point for measuring further progress.[7] To put these scores in context, 85% is a benchmark for compliance, though the percentage score is not itself necessary or sufficient for compliance.[8]

---

[3] Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2.
[4] Appendix C (Goldenson/LaMarre second report), p. 3.
[5] *See ibid.*
[6] Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 3.
[7] *Id.*, p. 41, n.1.
[8] Health Services Remedial Plan Health Care Audit Instrument, p. 3.

Table I: Compliance Scores by Facility and Aspect of Care (%)[9]

	Chaderjian	Close	Preston	Stark	SYCRCC	Ventura
Facility Leadership, etc.	55	67	NR	33	43	63
Medical Reception	42	NA	72	43	63	69
Intrasystem Transfer	56	80	56	54	59	83
Nursing Sick Call	NR	55	51	48	60	62
Medical Care	65	97	83	71	69	81
Chronic Disease Management	60	87	82	53	51	77
Infection Control	38	50	100	71	63	50
Pharmacy Services	100	100	67	93	100	92
Medication Administration: Process	60	92	92	66	75	77
Medication Administration: Records	80	75	87	75	88	84
Urgent/Emergent Care	60	54	88	81	70	75
Outpatient Housing Unit	73	73	NR	NA	63	NR
Health Records	0	25	25	50	100	25
Preventive Services	79	76	96	85	88	88
Consultations	38	80	91	74	98	84
Peer Review	60	60	20	0	67	40
Credentialing	88	88	71	71	67	88
Quality Management	50	50	50	50	63	38
Total (%)	61	81	77	64	72	76

The compliance scores reveal several areas of strength for DJJ health services. During the monitoring period, DJJ hired a statewide Pharmacy Services Manager, who implemented standardized pharmacy practices at the facilities.[10] Under this leadership, pharmacy services received the highest scores of any aspect of care during this round.[11] Preventive services, which had not been implemented at any facility as of the previous report, are at or near compliance at all facilities.[12] The medication administration process

[9] "NR" indicates that the item was not rated, and "NA" denotes "not applicable."
[10] Appendix C (Goldenson/LaMarre second report), p. 16.
[11] All facilities but Preston had pharmacy services scores above 90%. *See* Table I, above.
[12] *See* Table I, above; Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 31. Preventive services include lifestyle changes (e.g., assistance in weight loss), screening for disease (e.g., annual TB skin test) and mental health conditions, immunizations, and health education or counseling. Health Care Services Remedial Plan, pp. 34-36. In the area of preventive care, the medical experts continue to recommend that DJJ develop a statewide program to address obesity in the DJJ population.

also improved, drawing high scores at several facilities that had received poor qualitative evaluations in the previous report.[13]

Table II: Average Compliance Scores

Aspect of Care	Score (%)
Pharmacy Services	92
Preventive Services	85
Medication Administration: Records	82
Credentialing	79
Medical Care	78
Consultations	78
Medication Administration: Process	77
Urgent/Emergent Care	71
Outpatient Housing Unit	70
Chronic Disease Management	68
Intrasystem Transfer	65
Infection Control	62
Medical Reception	58
Facility Leadership, etc.	52
Quality Management	50
Nursing Sick Call	45
Peer Review	41
Health Records	38

B. Achievements Since the Last Report

DJJ has addressed or begun to address most of the recommendations the experts made in their last report.[14] With the completion of the Peer Review, Credentialing and Organizational Structure policies, the division now has a complete set of initial medical policies.[15] Although the Clinical Records Administrator position remains vacant, DJJ has one contractor and one employee working to develop health records and a health records

[13] *See* Appendix C (Goldenson/LaMarre second report), p. 4; Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 26.
[14] *See* Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 34.
[15] Appendix C (Goldenson/LaMarre second report), pp. 12-13. Twenty-nine of the 32 key policies were written as of the previous experts' report. Fifth Report of the Special Master (October 2007), p. 23.

management program.[16] The pharmacy manager has begun to collect data on purchasing practices, which may be used to evaluate its cost-effectiveness.[17] Cooperation among medical and custody staff has improved at all facilities, although some youth still miss medical appointments because staff are not available to escort them.[18]

DJJ issued final organization charts which establish a model for health care delivery, supervision, and oversight.[19] There are certain conflicts between the requirements of the remedial plan and the current charts.[20] DJJ and the medical experts have agreed to plan modifications that will resolve these conflicts.[21]

Central office has implemented an internal auditing process ("Quality Management Plan") for medical care.[22] A team at each facility will evaluate emergency medical care plus two aspects of care from the remedial plan each quarter and will develop corrective action plans.[23] The former Director of Nurses similarly developed and implemented a Nursing Services Quality Management Plan.[24] She independently checked the results of the facility evaluations and instructed Supervising Nurses as to how to improve their audits.[25] The general Quality Management Plan does not include external review, does not provide for each aspect of care to be evaluated annually (instead, two aspects of care will be evaluated each quarter), and does not encourage

[16] Seventh Report of the Special Master (March 2008), p. 10; Appendix C (Goldenson/LaMarre second report), pp. 14-15.
[17] Appendix C (Goldenson/LaMarre second report), p. 16.
[18] *Id.*, pp. 4,
[19] *Id.*, pp. 7-8.
[20] *Id.*, p. 8.
[21] *Id.*, p. 7; e-mail of Rachel Stern to special master, et al., April 24, 2009 (proposing modifications to remedial plans); e-mail of Madie LaMarre to Rachel Stern, et al., May 4, 2009 (indicating that experts support proposal to modify plan requirements regarding Medical Director and Public Health Nurse).
[22] Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 33; Appendix C (Goldenson/LaMarre second report), pp. 4, 13.
[23] Appendix C (Goldenson/LaMarre second report), p. 13.
[24] *Id.*, p. 10.
[25] *Ibid.*

facilities to study problems unique to their facility.[26] The experts therefore rated the Quality Management Plan as partially compliant, indicating that more work is required in this area.[27]

A previous report noted that youth in DJJ who require health care services for serious medical problems faced an unacceptable risk of receiving substandard care.[28] The medical experts generally did not observe the same problems during this round.[29] This was evidenced by relatively high scores on chart reviews of medical care.[30] They attribute this change to the drop in population and the fact that new physician hires and attrition have increased the proportion of good doctors in the system.[31] This proportion will be important for DJJ to maintain as it adjusts its health services staffing levels to its smaller population.[32]

C. Areas for Improvement

Medical reception remains weak.[33] At most facilities, the experts noted, clinicians "did not consistently perform and document adequate history and physical examinations, identify medical conditions and develop appropriate treatment plans for each active medical problem. This is particularly disturbing because DJJ adolescents and young adults are by and large a medically healthy population and the failure to adequately address the medical conditions they do have is a serious concern."[34]

---

[26] *Id.*, pp. 4, 13.
[27] *Id.*, p. 13.
[28] Fifth Report of the Special Master (October 2007), pp. 23-24.
[29] E-mail of Madie LaMarre to Zack Schwartz, May 1, 2009.
[30] *See* Table I, above.
[31] E-mail of Madie LaMarre to Zack Schwartz, May 1, 2009.
[32] *Ibid.*
[33] *See* Table II, above; Appendix C (Goldenson/LaMarre second report), p. 4.
[34] Appendix C (Goldenson/LaMarre second report), p. 4.

DJJ still has trouble retaining key central office medical staff. Previous reports have noted "poor morale among health care services headquarters staff leading to attrition by transfers and resignations," as well as a high level of vacancies among this group.[35] The Director of Nurses (Cathy Ruebusch, RN) resigned in August 2008, after serving slightly more than a year.[36] During this brief time, she showed an ability to identify problems in DJJ's nursing system and develop solutions. In addition to work on quality management, described above, she developed and implemented physical assessment training for nurses and identified problems in the division of supervisorial responsibility for nursing services.[37] She ultimately resigned because of a perceived lack of resources and support.[38]

The medical experts have urged DJJ to adjust facility staffing to appropriate levels.[39] DJJ has continued to increase health care staffing even as it loses youth.[40] As a result, clinician-to-patient ratios are sometimes excessive.[41] Such inefficiency is perpetuated by weaknesses in nursing sick call.[42] DJJ lacks standardized procedures that would guide nurses' care of minor issues and establish which conditions and complaints must be referred to a physician.[43] Currently, youth see physicians for minor complaints that could be handled by a nurse, such as athlete's foot, acne, and mild headaches.[44] The medical experts consider the development of standardized nursing procedures a top

[35] *See* Third Report of the Special Master (September/November 2006), p. 14; Seventh Report of the Special Master (March 2008), p. 9.
[36] Appendix C (Goldenson/LaMarre second report), pp. 7, 10-11. Ms. Ruebusch was hired in May 2007. Fifth Report of the Special Master (October 2007), Appendix C (Goldenson/LaMarre first report), p. 8.
[37] Appendix C (Goldenson/LaMarre second report), pp. 10-11.
[38] *Id.*, pp. 7, 10-11.
[39] E-mail of Madie LaMarre to Michael Brady, January 23, 2009.
[40] Appendix C (Goldenson/LaMarre second report), p. 4.
[41] *Id.*, p. 35.
[42] Nursing sick call compliance scores were among the lowest this round. *See* Table II, above.
[43] Health Services Remedial Plan, p. 17; Appendix C (Goldenson/LaMarre second report), pp. 5, 36, 39.
[44] Appendix C (Goldenson/LaMarre second report), pp. 5, 36.

priority.[45] They have also urged DJJ to evaluate resource use and staff productivity.[46] Without data on health care resource needs, which DJJ is currently unable to provide, it will not be able to adjust staff levels effectively.[47]

V. SAFETY AND WELFARE

A. Monitors' Report on Safety and Welfare Standards/Criteria Items

The special master is assigned to monitor certain items of the Safety and Welfare Remedial Plan. Monitors Aubra Fletcher and Zack Schwartz conducted a round of site visits to monitor these items between October 2008 and March 2009. A report of their findings has been provided to the safety and welfare expert and is attached as Appendix D. The safety and welfare expert is completing a round of monitoring and will be providing a comprehensive report on the state of compliance with the safety and welfare remedial plan in the near future. The special master will reserve comment on matters discussed in the reports for her next report.

B. Development Of DJJ's Integrated Behavior Treatment Model

The pivotal issue before the *Farrell* parties at this time is the development of the integrated behavior treatment model (IBTM) that is promised and required by the safety and welfare and mental health plans. The IBTM will serve as the overarching paradigm for the treatment of youth twenty-four hours a day, seven days a week. DJJ has been pursuing a particular vision of a model since at least 2006, when the safety and welfare plan was completed and filed.[48] The *Farrell* safety and welfare and mental health experts

[45] E-mail of Madie LaMarre to Michael Brady, January 23, 2009; Appendix C (Goldenson/LaMarre second report), p. 36.
[46] Appendix C (Goldenson/LaMarre second report), p. 10.
[47] *Id.*, pp. 10, 16.
[48] DJJ's risk/needs and IBTM consultant Orbis Partners, Inc. has provided an articulation of that vision. *See* pp. 16-17, *infra*.

have envisioned something different for just as long. Both (or all) visions are embedded in the plan. The experts felt constrained to reserve judgment and give DJJ time to work with its chosen consultants and develop its chosen model, on the grounds that DJJ was acting within its discretion under the remedial plans. They warned DJJ that they thought DJJ would fail to develop and implement the model it envisioned, and now they feel that subsequent developments have proven them right. Plaintiff has brought these concerns to the Court's attention, and the Court has scheduled a hearing for July 2, 2009.[49]

1. Remedial Plan Requirements

In the January 31, 2005 Stipulation Regarding California Youth Authority Remedial Efforts, the Safety and Welfare Remedial Plan, and the Mental Health Remedial Plan, DJJ committed to reform its system from a punitive to a rehabilitative model.[50] The plans refer to the new model to be developed as the Integrated Behavior Treatment Model or "IBTM."[51] The IBTM is to "provide[] the central guiding vision uniting screening, assessment, case planning, treatment/rehabilitation, transition, and aftercare."[52] Its concepts will be "used across all parts of the agency – including the core treatment program, special treatment programs, academic and vocational education, work, recreation, mental health, and parole."[53] Because all staff will be trained on and follow the model, the IBTM will "not only structure[] the environment to help promote success in changing behavior, it [will] also create[] a common vocabulary for all parts of the agency and facilitate[] continuity of treatment/rehabilitation when youth move

[49] Order, June 2009.
[50] For the remedial plan revisions that relate to that commitment, see Safety and Welfare Remedial Plan, pp. 33-43 and Mental Health Remedial Plan, pp. 3-5, 21-23.
[51] *See, e.g.*, Mental Health Remedial Plan, pp. 21-23.
[52] Safety and Welfare Remedial Plan, p. 34.
[53] *Ibid.*

between facilities and living units."[54] The IBTM will encompass most aspects of life in DJJ, including the incentive and disciplinary systems.[55] It will provide the framework for all staff interactions with youth and their families.[56] The IBTM's treatment/rehabilitation philosophy and interventions are to be based on cognitive-behavioral treatment.[57]

The safety and welfare and mental health remedial plans require DJJ to adapt the Washington State Juvenile Rehabilitation Administration's Integrated Treatment Model ("Washington ITM" or "Washington model") in crafting its IBTM. The Mental Health Remedial Plan states that DJJ will develop a treatment model "based on" the Washington ITM.[58] The safety and welfare plan requires DJJ to "consult with experts in cognitive-behavioral treatment for juvenile offenders to adapt the Washington [ITM] to the needs of DJJ with specific emphasis on modifications needed for" older youth, gang-involved youth, youth with racist attitudes and behaviors, and "[a]ny other area DJJ deems necessary."[59] It states that DJJ will "modify and tailor" Washington's ITM training materials, implementation plan, and other documentation to meet DJJ's needs.[60] The

---

[54] *Ibid.* The mental health plan similarly states: "Using an IBTM throughout DJJ will provide a common language and approach for understanding and changing youth behavior. It will simplify staff training and ease staff movement between units. System-wide adoption of an IBTM will facilitate continuity of care for youth moving between programs and living units." Mental Health Remedial Plan, p. 21. This language from the two plans invokes a core feature of the Washington ITM. *See* Juvenile Rehabilitation Administration Integrated Treatment Model Design Report, September 2002, pp. 13-53, available at http://www1.dshs.wa.gov/jra/ITM.shtml (describing how staff can understand a youth's problematic behavior, create conditions to change it, and build skills that youth will continue to use in the community) [hereinafter "ITM Design Report"].

[55] Safety and Welfare Remedial Plan, p. 54 ("Positive incentives and negative sanctions are an integral part of the integrated treatment model . . . .").

[56] Mental Health Remedial Plan, p. 21 ("The IBTM will also require that all DJJ personnel . . . are therapeutic/rehabilitative in their interactions with youth and families . . . . All direct care staff will be trained on the IBTM and able to work with youth on emotional regulation, interpersonal effectiveness, distress tolerance, behavior analysis and, as the need arises, aggression and self-harm behavior.").

[57] Safety and Welfare Remedial Plan, p. 34.

[58] Mental Health Remedial Plan, pp. 22; *see also id.*, pp. 21-23.

[59] *Id.*, 41; *see also id.*, p. 33 ("This section defines the components of a rehabilitative model and outlines a well documented and successful approach used by one state [Washington] that DJJ will adapt to meet its needs.").

[60] *Id.*, p. 34.

plan refers to the Washington ITM not because it is the only successful system in the United States, but because it is "the most fully documented" of several successful state systems.[61]

The safety and welfare plan also requires DJJ to develop a treatment/rehabilitation model directed at reducing recidivism by using risk/needs assessment, case management, and research-based rehabilitative programs targeting identified risks and needs.[62] It requires that DJJ develop a "comprehensive system . . . to accurately assess the risks and needs of the youths and match rehabilitation/treatment services to meet their needs, while building on and developing strengths and protective factors."[63] In context, the risks, needs, strengths, and protective factors referred to are primarily those related to the risk that a particular youth will repeat criminal conduct.[64] Risk/needs assessment "identifies issues to be prioritized for behavioral analysis and treatment/rehabilitation interventions."[65] Periodic reassessment of risks and needs measure a youth's progress in treatment and the effectiveness of the treatment programs.[66]

The kind of individualized recidivism-focused risk/needs assessment and related case management described by these provisions of the safety and welfare plan is not part

[61] *Ibid.* ("[T]he concepts behind the treatment model in states with successful rehabilitative programs are more or less the same. As the state with the most fully documented model, the [ITM] developed by the Washington State is used to illustrate these concepts."). In his comments on a draft of this memorandum, Dr. Trupin points out that these successful/effective programs have developed rehabilitation/treatment program content and interventions that are adhered to with fidelity by staff and that effectively improve skills while the youth is incarcerated. These skills are required for youth to function safely and maturely when they return to their communities and families. Washington's extensive documentation makes it the most clearly and completely articulated and manualized model available.
[62] Safety and Welfare Remedial Plan, pp. 4-5, 35-38; *see also* Mental Health Remedial Plan, p. 5.
[63] Safety and Welfare Remedial Plan, p. 4.
[64] *See id.*, pp. 4-5.
[65] *Id.,* p. 35.
[66] *Id.*

of the Washington ITM.[67] The safety and welfare plan also requires DJJ to include "normative culture" in its IBTM,[68] another component not mentioned in the Washington ITM description. The remedial plans do not indicate the extent to which these components are consistent, inconsistent, complementary, or redundant of the Washington ITM or precisely how DJJ should integrate them with an adaption of the Washington model.

The Safety and Welfare Remedial Plan required DJJ to complete a detailed description of its proposed IBTM and an accompanying manual by November 15, 2008.[69] DJJ was to convert facilities to a rehabilitative model between January 2007 and January 2010, beginning before and finishing after it created the written description and manual of the IBTM.[70] Three facilities were to complete conversion to the rehabilitative model before the description and manual for the IBTM would be written. DJJ was to issue a request for proposals for a risk needs assessment tool in October 2006, consult with experts to develop its IBTM by July 2007, complete the IBTM description and manual by mid-November 2008, complete training in risk/needs assessment by February 2009, complete training in treatment plan development and the IBTM by August 2009, and complete training in motivational interviewing, normative peer culture, interactive

[67] *See* ITM Design Report, *supra* note 54. Washington JRA has not been using risk/needs assessment. *E.g.*, statements of Orbis associate David Robinson during teleconference with DJJ and *Farrell* mental health experts, October 15, 2008. The Washington model does rely heavily on behavior analysis-based assessment, however. *See* ITM Design Report, *supra* note 54. An emphasis is on all youth mastering skills (*e.g.*, self-regulation, distress tolerance, etc.) that most youth who enter juvenile corrections facilities lack and that experts believe commonly are a cause of criminal behavior is central to the Washington ITM. This is part of what DJJ is to adapt to its population and needs, integrated with normative peer culture and with risk/needs assessment and case management directed at recidivism.

[68] Safety and Welfare Remedial Plan, p. 42.

[69] Safety and Welfare Remedial Plan, p. 41; Safety and Welfare Remedial Plan Standards and Criteria, item 4.3. The Court has not modified the deadline for this item. *See* Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2. The special master anticipates that DJJ will propose a new deadline.

[70] Safety and Welfare Remedial Plan Standards and Criteria, items 6.b-c.

journaling and other unnamed key components of the IBTM by dates to be set in a training schedule.[71]

2. Chronology

DJJ issued its request for proposals for "Integrated Behavior Treatment Model: Risk Needs Assessment, Interventions and Training" in April 2007 and entered into a contract with the winning bidder, Orbis Partners, Inc., two months later.[72] Since then, it has developed and begun to use risk/needs assessment and case management focused on factors assessed as related to youths' risk to recidivate.[73] DJJ has trained some staff members in risk/needs assessment, treatment planning, the principles of cognitive behavioral treatment, motivational interviewing, as well as conflict resolution and crisis management.[74] All of this was pursuant to and consistent with several provisions of the safety and welfare remedial plan.[75]

It was not, however, sequenced or undertaken in consultation with the safety and welfare and mental health experts. DJJ did not consult the court experts before it issued the request for proposals that resulted in the contract with Orbis Partners, Inc. ("Orbis"). The experts would have advised separate contracts for risk/needs assessment and for treatment programming, for example, because the best potential treatment program contractors would not bid on a contract requiring development of a risk/needs assessment

[71] Safety and Welfare Remedial Plan Standards and Criteria, items 5.3, 5.4, and 6.7. DJJ has regularly provided schedules for trainings, but this documentation does not indicate when all staff requiring the training will have received it.
[72] Seventh Report of the Special Master (March 2008), p. 18 n.66.
[73] *E.g.*, statements of staff to Barry Krisberg during central office site visit, January 14, 2009; the special master observed an initial case management conference at the Stark facility in April 2009.
[74] *See* Appendix D (Fletcher and Schwartz, Safety and Welfare Remedial Plan Audit Items: Report of Findings, June 2009), pp. 29-33.
[75] *See id.*

tool.[76] In the experts' view, Orbis' particular expertise was in risk/needs assessment and not in treatment model development or treatment programming.[77] Compounding its error, DJJ resisted the requests of the safety and welfare and mental health experts to consult with DJJ and Orbis as they commenced their work together in 2007.[78] It did not arrange for the experts and Orbis to meet until April 2008, when it presented the model it was developing with DJJ to the experts and a conference room full of DJJ management staff.[79] That meeting was not a forum for the experts and the Orbis principals to engage in a high-level discussion of the model.[80] The approach Orbis presented then – based on risk/needs assessment, case management, and cognitive behavioral treatment programs targeting risks and needs assessed as related to recidivism – is the approach that DJJ has pursued and is proffering now.[81] The experts' seriously questioned whether this approach was appropriate for confined youth, as opposed to youth being treated in a community setting, where it has proven effective.[82] They pursued their questions and concerns that the approach would not work for DJJ during a series of five lengthy telephone conferences with DJJ and Orbis between August 2008 and February 2009.[83]

---

[76] Statements of Eric Trupin and Barry Krisberg to special master during teleconference, June 2007; *see also* Reporter's Transcript of Proceedings, Order to Show Cause hearing, May 9, 2008, at 749:5-750:15 [hereinafter "RT, May 9, 2008"].

[77] Statements of Eric Trupin and Barry Krisberg to special master during teleconference, June 2007.

[78] In November 2007, DJJ advised the special master and experts that Orbis was still working on a timetable for "deliverables" and not available to meet with the experts. *See* Sixth Report of the Special Master (January 2008), Appendix A (Trupin/Lee report), Attachment 1 (Trupin/Lee report on standards and criteria items), p. 2.

[79] RT, May 9, 2008, at 705:21-706:20, 745:21-747:24.

[80] RT, May 9, 2008, at 705:21-706:20.

[81] Declaration of Michael K. Brady In Support of Defendant's Brief Concerning the Integrated Treatment Model, ¶ 12 and Appendix B.

[82] Letter of special master to Monica Anderson, May 6, 2008, admitted as Exhibit E, RT, May 9, 2008, 699:2-28; *see also* RT, May 9, 2008, 705:21-706:20, 745:21-747:24.

[83] The special master's office prepared minutes and summaries of teleconferences held on August 22, 2008, September 8, 2008, September 17, 2008, October 15, 2008, and February 5, 2009 and provided them to the parties and experts by e-mails dated September 5, 2008, September 11, 2008, September 21, 2008, November 25, 2008, and February 10, 2009, respectively. Those minutes and summaries contributed to the basis for the special master's summary of the history and the experts' positions sent to the parties and

By October 2008, the safety and welfare and mental health experts and DJJ reached an understanding that the DJJ/Orbis approach was within DJJ's discretion under the remedial plans but was not the approach that the experts favored.[84] Though some of the experts' concerns had been resolved, they strongly recommended that DJJ closely adapt the Washington model, which the safety and welfare plan required DJJ to adapt without specifying how closely. They reiterated that the Washington model had already been developed and proven effective in an institutional juvenile corrections setting. It would be relatively easy to closely adapt and adopt it because Washington had documented ("manualized") it.[85] The experts explained that, though a risk/needs and case management approach directed at recidivism might be equally good in theory, it would be much harder for DJJ and Orbis to succeed in the development and implementation of a model that was new and untested in an institutional setting.[86] That would involve designing and implementing components for the model to change and manage the institutional environment and staff and youth culture and behavior. Given the challenges reflected in the slow pace of reform through October 2008, they strongly advised DJJ to take the easier, and better documented, path.[87] With the support of its Orbis Partners, Inc. consultants, DJJ promised to meet the challenges identified by the experts and remained firmly committed to the path they had been pursuing for two years.[88]

---

experts on March 3, 2009. A copy of the text of the March 3, 2009 e-mail is attached hereto as Appendix E. The safety and welfare expert delegated his role in the discussions to the mental health experts for the September 17, 2008 and October 15, 2008 teleconferences.

[84] Statements of Eric Trupin and Terry Lee during teleconference with DJJ and Orbis, October 15, 2008.

[85] *Id.*

[86] *Id.*

[87] *Id.*

[88] Statements of Bernie Warner, Amy Seidlitz and David Robinson during teleconference with experts, October 15, 2008.

In February 2009, DJJ and the safety and welfare and mental health experts were locked in the same impasse. The experts concluded that DJJ had not progressed in the development of its treatment model to meet the concerns that they had expressed in October.[89] DJJ did not appear to understand what would be necessary to complete the model on which it was working and to implement it.[90] The experts informed DJJ that they would bring their concerns to the Court unless DJJ provided them with a written description of an IBTM that they believed met the requirements of the remedial plans.[91]

DJJ responded by dedicating staff to write a comprehensive description with the assistance of a consultant recommended by the safety and welfare expert.[92] The DJJ IBTM team started work in early April, and DJJ projected that a draft written description would be produced within 30 days.[93] The mental health experts informed DJJ that they believed that the team would be incomplete if it did not include an expert in the Washington JRA model.[94] DJJ added a Washington consultant recommended by the mental health experts, and he began work with the IBTM team at the end of April.[95] DJJ instructed the consultants that DJJ was engaging them to help prepare the best possible written draft of what DJJ envisioned as its model, for purposes of putting DJJ's approach in writing for the safety and welfare and mental health experts' and plaintiff's counsels'

[89] *See, e.g.*, Appendix E (Donna Brorby, facsimile of e-mail, *IBTM -- experts' high level issues*, March 3, 2008).
[90] *See, id.,* ¶ 3.
[91] *See id.*
[92] Statements of DJJ management during meeting with OSM and plaintiff's counsel, March 25, 2009; statements of Michael Brady during telephone conference, week of April 13, 2009. Dr. Angela Wolf, recommended by Dr. Krisberg, began working with DJJ on the IBTM draft in early April 2009. Statements of Dr. Angela Wolf and Michael Brady during court compliance task force meeting, April 2, 2009.
[93] Statements of DJJ management during meeting with OSM and plaintiff's counsel, March 25, 2009; statements of Michael Brady during telephone conference, week of April 13, 2009.
[94] Statements of Michael Brady and Angela Wolf to the special master, May 2009.
[95] The availability of the consultant, Dr. Henry Schmidt, was limited by his full-time job commitment. Statements of DJJ staff during *Farrell* Task Force meeting April 30, 2009.

review and input.[96] If the consultants disagreed and could not convince DJJ to modify the draft to something that they would support, then the consultants would so inform the safety and welfare and mental health experts and the parties.

Under the compulsion of the Court's scheduling order that required it to file a draft of the IBTM description by June 1 or an explanation for failing to meet that deadline,[97] DJJ filed (1) notes reflecting the meetings and work of the dedicated IBTM work group that had been working with the expert-designated consultants to put DJJ's model in writing and (2) a document prepared by DJJ's Orbis consultants to explain the model as DJJ and Orbis Partners, Inc. had conceived it.[98] The Orbis-prepared document reflects the model that DJJ and Orbis have been working on together for two years.[99] It does not, however, reflect an understanding of and response to the concerns that the *Farrell* safety and welfare and mental health experts have repeatedly raised.[100] The work group notes reflect that the group was far from being able to outline a model at the

[96] Statements of Michael Brady to special master, May 2009. The special master supported Mr. Brady's plan for writing the description, based on credible representations by DJJ's mental health leadership that DJJ's IBTM manager had a more complete and better IBTM in mind than had been put on paper, and based on the utility of having a full description for the experts' consideration.

[97] Order, May 4, 2009.

[98] Declaration of Michael K. Brady In Support of Defendant's Brief Concerning the Integrated Treatment Model, ¶¶ 11-12 and appendices A and B. What DJJ filed was very different from what DJJ's consultants and most of the DJJ work group had expected to file as of May 17, 2009. One of DJJ's consultants, Dr. Wolf, expected to complete a draft based on a ten-page document created by the work group during the period May 20-25. DJJ's IBTM manager informed the group that she would keep the responsibility to produce the draft, rather than turn it over to Dr. Wolf on May 19. Rather than building upon the 10-page document, the IBTM manager submitted the Orbis description as the draft to the work group on the evening of May 23.

[99] The special master infers this from Chief Deputy Secretary Bernard Warner's statements during the October 15, 2008 and February 5, 2009 teleconferences of the safety and welfare and mental health experts, special master, and DJJ staff.

[100] Statements of Barry Krisberg, Eric Trupin, Terry Lee, and Barbara Schwartz to the special master, et al. during teleconference, June 5, 2009. The experts will explicate their views during the upcoming hearing. Dr. Krisberg's opinions based on an April 2009 informal report are attached hereto as Appendix F (Excerpt from Barry Krisberg, revised informal report on January 2009 central office site visit (summary), submitted April 10, 2009). Dr. Krisberg provided the draft of this report to the parties in February 2009, and provided the April 10, 2009 version after the period for comments expired. DJJ's June 1, 2009 filing has not changed his views, though he is preparing a revised report that reflects his consideration of the June 1 IBTM documents. Statements of Barry Krisberg to special master during teleconference, June 9, 2009.

end of May, apparently because of the attachment of some within DJJ to the model as they and DJJ's Orbis consultants have conceived it for two years. The parties seem to be at impasse now as they prepare for the hearing set for July 2.

V. CONCLUSION

The special master respectfully submits this report.

Dated: June 12, 2009

_____

Donna Brorby
Special Master

Appendix A
Experts' Priorities for Fiscal Year 2008-2009

Between December 2008 and February 2009, the *Farrell* experts identified priority areas for fiscal year 2008-2009 and provided this information to DJJ leadership.[1] The priorities are listed by subject area below.

A. Education Priorities

1. Fill vacant leadership positions as noted on the DJJ organizational chart.
2. Provide access to a 240-minute school day for all eligible students.
3. Increase vocational enrollment.
4. Provide a full and meaningful school day for restricted units.
5. Adjust to downsizing; evaluate and recompute all educational staff allocations.
6. Establish a reliable interface between the WIN system and special education data-collection systems.
7. Assure that IEP progress benchmarks and transition plans are completed and reviewed as required under IDEA.
8. Fill the vacant Superintendent of Education position as quickly as possible to provide the much needed leadership necessary to manage the educational program statewide.
9. Fill vacant central office education positions noted on the organizational chart to provide direction, support and monitoring of the education program.

In providing this list of priorities, the education experts reiterated the importance of the remedial requirements identified by them for inclusion in the "key indicators" section of the dashboard.

B. Health Care Services Priorities

1. Develop and implement standardized nursing protocols and related training program.
2. Develop and implement standardized health record manual that contains policies and procedures and related health record and ancillary forms. Provide training to the field.

[1] *See, e.g.*, e-mail of Zack Schwartz to Michael Brady, February 16, 2009; memorandum of Tom O'Rourke and Robert Gordon to Monica Anderson, June 26, 2008; statements of Logan Hopper to Zack Schwartz during teleconference, February 2009.

3. Develop and implement the standards and compliance program, consistent with the Health Care Remedial Plan.

4. Conduct a study to compare the results of internal peer review with the experts' peer review results. Address any discrepancies.

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

6. Adjust staffing to appropriate levels, in consultation with the medical experts and based on Chris Murray's staffing analysis.

7. Develop a complete set of health care policies that address all NCCHC Juvenile Health Care standards. Review and revise initial policies.

8. Develop and implement a structured and standardized orientation manual for facility health care staff.

9. Resolve the discrepancies, in consultation with the medical experts, between the Health Care Services Table of Organization and the Health Care Remedial Plan.

C. Mental Health Priorities

1. Improve management and treatment of self-harming youth.

   (a) Train staff on empirically-based treatment(s) on an expedited basis.

   (b) Implement the Suicide Prevention, Assessment, and Response policy system-wide (and continue evaluation and improvement of the policy as necessary).

2. Building on staff training on an empirically-based treatment(s) for self-harming youth, develop and train staff on empirically-based mental health treatments for other youth. The next priorities should be decreasing youth aggressive and disruptive behavior. Treatments that increase youth capacity to regulate emotions will address both self-harming and externalizing behaviors. Over time, develop and train staff on all the empirically-based treatment programs and methodologies that are part of the IBTM.

3. The implementation of treatment programs should be used as opportunities to better integrate clinical/treatment/program staff and facility staff to achieve fidelity to treatment model, protect clinical autonomy and create an environment supporting treatment and pro-social behavior.

4. Improve psychopharmacologic practice, including the areas of empirically supported prescribing practice, informed consent and psychiatric peer review/quality management.

   (a) Implement the new psychopharmacology policy (and evaluated it and improve it as necessary).

   (b) Appropriate peer review of prescription practices.

5. Implement policies, practices and treatments that increase family engagement and involvement in treatment.

6. Ensure access to licensed bed care for youth who need it, and an adequate quality of care.

7. Improve the quality and accuracy of mental health management data on self-injurious behavior.

8. If Ventura closes, ensure that the mental health treatment of females in DJJ custody is not compromised in their new setting.

9. In consultation with the mental health experts, adjust mental health staffing patterns as appropriate, based on population, what is being learned about mental health treatment needs and the Murray and Associates staffing study.

10. Reduce use of force and DDMS (disciplinary) sanctions in response to behavior related to mental illness. Implement use of force and DDMS policies that achieve the results required by the remedial plans.

11. Acquire or develop and mental health monitoring system in order to analyze efficacy of treatment interventions and the treatment needs of its population.

12. Analyze the efficacy of intake screening and assessment instruments.

D. Safety and Welfare Priorities

1. Develop performance indicators for high risk dormitories with the safety and welfare expert and, if necessary, implement alternative risk management strategies for youth in dormitories who are high risk.

2. Phase in behavior treatment programs (BTPs) and eliminate all special management programs (SMPs).

3. Develop plan and schedule for gender-responsive services; contract for services, convert existing facility or build new facility if unable to contract.

4. Fully implement disciplinary system that complies with the Safety and Welfare Remedial Plan (Standards and Criteria item 8.4a, which includes 12 sub-items related to discipline, including four sub-items regarding facility disciplinary coordinators, timelines for hearings, assistance to youth with disabilities, appeals for level 1 infractions, standards for prosecution referrals, earn-back of DDMS time adds, restoration of time at case conferences).

5. Fully implement a Ward Incentive Plan that complies with the Safety and Welfare Remedial Plan (Standards and Criteria item 8.4b includes promoting participation in incentive plan, expanded and standardized points for restorative justice, graduated and expanded sanctions and positive incentives, study of time adds, and plan to reduce common reasons for time adds).

6. Physical Plant Improvements and Master Planning (Standards and Criteria item 8.9 includes quarterly reports on facility conditions by superintendents to Director of Facilities, reports to Chief Deputy Secretary, local monitoring, documentation of maintenance requests. Standards and Criteria item 8.10 includes facilities master plan, operational master plan, plan for prototypical facility and designation of project coordinator for master plans).

7. Produce a detailed written description of the Integrated Behavior Treatment Model (IBTM) that is approved by the safety and welfare and mental health experts.

E. Sexual Behavior Treatment Program (SBTP) Priorities

1. Create organizational chart depicting current reporting relationships in the SBTP statewide.

2. Fill the SBTP coordinator position with a person of experience and leadership capability. The coordinator needs to have the authority to require compliance with his/her directions.

3. Develop the residential and curriculum. Once the main curriculum is developed, the outpatient curriculum will be derived from it.

4. Complete a mental health policy on confidentiality and informed consent that addresses the SBTP.

5. Adjust and implement hours spent in resource groups for youth on residential SBTP units. Specifically, split up the three hours per week requirement into two 90-minute sessions per week. Groups should meet on a schedule, at the same time every week.

6. Develop and offer an array of ten-week resource groups.

7. Adapt groups to accommodate individuals with specific needs such as monolingual Spanish speakers, youth with learning disabilities, and youth with other special issues.

8. Uniform charting of youth treatment and progress.

9. Implementation of evidence-based assessment, J-SOAP (in addition to the non-evidence-based assessment tools mandated by the state, J-SORRAT and Static-99).

10. Ensure that facility staff assigned to SBTP units are assigned based on skills and preference; staff who prefer not to work with SBTP youth should not be assigned to these units.

F. Youth with Disabilities Program Priorities[2]

1. By July 2006, the Department shall develop and maintain system that documents the mental & physical impairments of wards with disabilities and any reasonable accommodations. The Superintendent shall ensure that the following data is documented for all wards with a disability: (1) name, age, YA number; (2) location by facility, living unit, or parole office; (3) specific impairment; (4) impairments that substantially limit a major life activity: (5) impairments that substantially limit a major life activity and require accommodations; (6) specific accommodations required; (7) need for a Staff Assistant; (8) level of care designation; and (9) classification code.

2. Establish policies to assure that placement of wards with disabilities into restrictive programs is not based either directly or indirectly on a ward's physical or mental disability, or on manifestations of that disability.

3. 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. The CYA shall develop a screening tool to assess the current ward population in order to identify any developmentally disabled wards who may not have

[2] Priorities in this area are largely reflected by the items included in the key indicators section of the *Farrell* dashboard. Those audit items are included verbatim here.

been previously identified. The CYA shall complete this assessment by Dec., 2006. As part of the clinic screening and assessment process, all wards shall be screened at the reception centers, and as indicated, throughout their stay in the Department, to determine whether they have a developmental disability which may make them eligible under criteria set forth in the ADA and/or may make them eligible to receive services from a Regional Center.

4. 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, & in consultation with the Disability Expert in sensitivity, awareness, harassment. This training will be provided to all staff on an annual basis.

5. When indicators of an 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.

6. Efforts to identify wards with disabilities within youth correctional facilities shall be continuous, and shall include self-referrals, staff-referrals, facility ADA screening & assessment, & special case conferences. A ward may make a self-referral requesting an accommodation for a documented or perceived impairment through an assigned PA, Casework Specialist, or by completing the Referral for Sick Call (RSC) form.

7. 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 (SCT) form. 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.

8. The principal shall ensure that wards with disabilities enrolled in educational programs have equal access to educational programs, services, and activities.

9. 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.

10. Fill vacant facility-level WDP Coordinator positions.[3]

[3] Statements of Logan Hopper to Special Master during teleconference, March 3, 2009.

Appendix B
Status of Items with Modified Deadlines
By Zack Schwartz and Aubra Fletcher, *Farrell* Monitors
May 2009

On February 20, 2009 and March 27, , the Court adopted 's proposed modifications of certain *Farrell* deadlines.[1] Below are status updates related to those items with reset deadlines that expired in 2008, based on expert and Office of the Special Master (OSM) findings as of May 2009.[2]

A. Education: Classroom Observations (Standards and Criteria item 4.21)

The remedial plan requires that " a t least quarterly classroom observations will be conducted by school administrators and for the School Improvement Review process. The observations will be based on a rubric for Classroom Observation that will be revised to align with the California Standards for the Teaching Profession (CSTP)."[3] The revised deadline for this item is October 27, 2008.[4]

The education experts audited all DJJ facilities between October 2008 and May 2009.[5] Following each audit, the experts provided the parties and OSM with an informal report. Based on these reports, five of 's si facilities are substantially compliant with the classroom observation requirement.[6] The fourth facility, Stark, received a partial compliance rating. The experts noted:

[1] Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2.
[2] Some modified deadlines expired in late February or late March 2009. OSM will provide updates on those items as the monitors gather more information about their status.
[3] Education Remedial Plan, p. 35; *see also* Education Remedial Plan Standards and Criteria, p. 11.
[4] Order, February 20, 2009, at 2.
[5] The experts audited Chaderjian on October 20-23, 2008, O.H. Close on October 23-24, 2008, Stark on January 12-14, 2009 and May 18, 2009, Preston on February 9-11, 2009, Ventura on May 12-13, 2009, and SYCRCC on May 14-15. A comprehensive report of their findings and recommendations is forthcoming.
[6] *See* Robert ordon and Tom O'Rourke, informal report on Chader ian site isit, o ember , p. ; Robert ordon and Tom O'Rourke, informal report on O. . Close site isit, o ember , p. "The Rubric for quarterly teacher observations was provided. Observations were being conducted as scheduled. It is noted that some of the obser ations were not dated or contained incomplete dates." ; Robert ordon and Tom O'Rourke, informal report on reston site isit, ebruary , p. "The quarterly observation schedule for the first quarter 2008 was

> The rubric for quarterly teacher observations was provided [at Stark] as well as copies of Quarterly Teacher Observations. Observations are being conducted using this rubric. There is still much work to be done with teachers to monitor records management, lesson planning, grading, formative and summative assessments, classroom instruction, absence recording, as well as other areas to improve the delivery of the curriculum.[7]

B. Mental Health: Organization Charts (Standards and Criteria Items 3.1, 3.2)

The standards and criteria required DJJ to produce an organizational chart for central office consistent with the mental health remedial plan by September 1, 2006.[8] DJJ was also required to produce organizational charts for each facility, consistent with the remedial plan, by October 1, 2006.[9] The Court reset these deadlines to October 1, 2008.[10]

On February 10, 2009, DJJ filed central office and facility organizational charts with the Court.[11] The mental health experts have not yet assessed the accuracy of the facility-specific charts or their consistency with the remedial plan.[12] The experts found DJJ partially compliant with the requirement that it produce an accurate organizational chart for central office mental health staff.[13] The central office chart depicts the reporting relationships of the two chief psychologists and chief psychiatrist.[14] Although signed by the Chief Deputy Secretary on

---

provided. All teachers were observed. It was noted, however, that the principal has delegated this responsibility to his assistants. It is recommended that the principal assume some of this responsibility in order to become an integral part of the obser ation process." ; Robert ordon and Tom O'Rourke, informal report on entura site isit, May , p. "This site is commended for their thoroughness in conducting these teacher obser ations." ; Robert ordon and Tom O'Rourke, informal report on S CRCC site isit, May , p. same .

[7] Robert ordon and Tom O'Rourke, informal report on Stark site isit, anuary , p. .

[8] Mental Health Remedial Plan Standards and Criteria, item 3.1; *see also* Mental Health Remedial Plan, pp. 6-8, 12.

[9] Mental Health Remedial Plan Standards and Criteria, item 3.2; *see also* Mental Health Remedial Plan, p. 12.

[10] Order, February 20, 2009, at 2.

[11] Deft. Notice of Filing of Updated DJJ Organizational Charts, February 10, 2009.

[12] The e perts ha e noted, howe er, the pre alence of " u nclear lines of authority on mental health residential treatment units. Mental health professionals frequently report that custody staff rides roughshod over mental health recommendations for management of youth on mental health residential treatment units." ric Trupin and Terry Lee, informal report on central office site visit, February 2009, pp. 1-2.

[13] *Id.*, p. 1. The safety and welfare plan also requires a central office organizational chart, and the safety and welfare expert has rated DJJ as partially compliant. Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 3.

[14] *See* Deft. Notice of Filing of Updated DJJ Organizational Charts, February 10, 2009.

January 23, 2009, the chart does not reflect the fall 2008 creation of the Court Compliance Unit headed by Michael Brady.[15] This reorganization affected the reporting relationships and duties of mental health personnel at central office.[16]

The mental health experts are particularly concerned by organizational structure issues that pre ent 's mental health leadership from implementing their clinical judgments.[17] The experts have highlighted the role of non-clinical administrators in 's failure to pro ide effective treatment for suicidal behavior.[18] Other cited e amples of "inappropriate non-clinical influences on clinical processes" include " p rotracted administrative review of mental health policies" and " a dministrative overrides of mental health professional recommendations to step down youth from mental health residential treatment units to less restrictive settings."[19]

C. Mental Health: Psychopharmacology Policy (Standards and Criteria Item 8.1b)

The Mental Health Remedial Plan requires DJJ to develop and implement a psychopharmacology policy consistent with relevant remedial plan provisions.[20] The revised deadline for this item is December 31, 2008.[21]

DJJ is positioned to implement its new psychopharmacology policy. The Chief Deputy Secretary signed the final version of the policy on January 20, 2009.[22] The period for review by

[15] Eric Trupin and Terry Lee, informal report on central office site visit, February 2009, p. 1. A draft organizational chart for central office, which includes the Court Compliance Unit, is included with this report as an attachment to the monitors' comprehensi e safety and welfare report.
[16] *Ibid.*
[17] *See, e.g.* Eric Trupin and Terry Lee, informal report on central office site visit, February 2009, pp. 1-2 (discussed more fully below , recommending that "change the TM de elopment process to a coordinated and multidisciplinary approach with strong M in ol ement" .
[18] *Id.*, p. 1.
[19] *Ibid.*
[20] *See* Mental Health Remedial Plan, pp. 63-64. Some of those provisions overlap with provisions of the Health Services Remedial Plan. *Ibid.*
[21] Order, February 20, 2009, at 2.
[22] sychopharmocological Treatment olicy o , April , . or additional details, see the monitors' "Safety and elfare Remedial lan Audit tems Report of indings," appended to this special master's report.

the bargaining units ended on March 24, 2009.[23] DJJ has developed consent forms for psychotropic medication in consultation with various *Farrell* experts.[24] DJJ also developed a statewide, multidisciplinary training curriculum.[25] At the facilities, training for on-site instructors had been provided to 45 medical and mental health staff and 23 mental health clinicians as of February 2009.[26] These instructors will train other facility staff in the new policy and procedures.[27]

D. Safety and Welfare: Policies Master Table of Contents (Standards and Criteria Item 2.1.4a)

DJJ is required to complete a master table of contents for its policy manual.[28] The Court reset this deadline from January 15, 2007 to October 31, 2008.[29]

DJJ completed a master table of contents for its policy manual on October 22, 2008.[30] The safety and welfare expert has approved the table and rated it as substantially compliant.[31] Because the table of contents includes policies from every remedial area, the safety and welfare expert recommended that other experts review the document.[32] DJJ provided copies of the table of contents to all experts on October 22, 2008.[33]

---

[23] Eric Trupin and Terry Lee, informal report on central office site visit, February 2009, p. 52. DJJ sent a final version of the policy to the mental health experts and OSM on April 7, 2009. *See* DJJ Proof of Practice #381, April 7, 2009. Dr. Lee reviewed drafts in mid-2008 and generally approved the policy by September 5, 2008. E-mails of Terry Lee to Doug Ugarkovich, July 25 and September 5, 2008.
[24] Eric Trupin and Terry Lee, informal report on central office site visit, February 2009, p. 52; *but see* Logan Hopper, draft comprehensi e report, May , discussing disability e pert's difficulties collaborating with staff in the development of this policy).
[25] Eric Trupin and Terry Lee, informal report on central office site visit, submitted February 2009, p. 52. DJJ provided drafts of the training curriculum to the mental health experts and OSM on November 18, 2008. *See* DJJ Proof of Practice #293, November 18, 2008.
[26] Eric Trupin and Terry Lee, informal report on central office, February 2009, p. 52.
[27] *Ibid.*
[28] Safety and Welfare Remedial Plan Standards and Criteria, item 2.1.4a.
[29] Order, February 20, 2009, at 2.
[30] *See* Master Table of Contents, provided as DJJ Proof of Practice #274, October 22, 2008.
[31] Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 2.
[32] *Ibid.*
[33] *See* Master Table of Contents, provided as DJJ Proof of Practice #274, October 22, 2008.

The table of contents consists of over 100 pages and lists 's policies by sub ect area.[34] The table indicates which policies DJJ plans to consolidate, remove, revise, or develop. Over 1000 policies are marked to be reviewed or developed. Some are key to the *Farrell* reform, and others are peripheral.

The table of contents may necessarily evolve as DJJ develops its priorities and capabilities, and it may ultimately prove less important than other planning documents DJJ produces. The special master's office intends to re isit 's policy de elopment and pro ect management processes in future reports.

E. Safety and Welfare: Grievance System (Standards and Criteria Item 8.5 (selected sub-items))

The Court reset the deadline for most grievance system requirements from March 31, 2007 to November 1, 2008.[35] DJJ issued temporary departmental orders (TDOs) in October 2007 and implemented them in August 2008.[36] They will expire if they are not finalized by October 1, 2009.[37] One TDO is devoted to regular grievances, and the other outlines staff misconduct complaint procedures.[38]

n general, is in compliance with the safety and welfare plan's re uirements concerning grievances.[39] All facilities have installed lock boxes for grievances in their living units and made grievance forms available without assistance.[40] The new grievance policy limits the grievance clerks' duties to ensuring an ade uate supply of forms on the li ing unit and

[34] All statements in this paragraph are based on Master Table of Contents, provided as DJJ Proof of Practice #274, October 22, 2008.
[35] Order, February 20, 2009, at 2.
[36] *See* Sixth Report of the Special Master (January 2008), Appendix B (Beltz Report), p. 15; memorandum of Sandra Youngen to superintendents, August 1, 2008.
[37] TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[38] TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[39] *See* Barry Krisberg, revised informal report on central office site visit (summary), April 10, 2009, pp. 14-15 noting "substantial progress" in this area . The safety and welfare e pert did not assess staff training on the grievance policy or assistance to youth with disabilities during his recent audit. *See* Safety and Welfare Remedial Plan Standards and Criteria, items 8.5.11a, 8.5.11b, 8.5.13.
[40] Safety and Welfare Remedial Plan Standards and Criteria, items 8.5.1, 8.5.2; monitor observations and statements of interviewed youth during site visits at all facilities, 2008 to 2009.

educating and assisting youth in the process as necessary.[41] DJJ has adopted a standardized duty statement for facility grievance coordinators that includes the duties specified in the remedial plan.[42] As of the monitors' site isits between October 2008 and March 2009, all facility grievance coordinators were preparing monthly reports using an automated system.[43] Central office personnel review timeframes and the quality of responses on a regular basis, collect and evaluate grievance data, and assist facility staff in developing corrective action plans.[44] The safety and welfare expert has recently approved the design of a new monthly report form for use by facility grievance coordinators.[45] Statewide use of this form was scheduled to begin on April 1, 2009.[46]

Not all facilities have demonstrated compliance with the requirement that youth receive notices of receipt of submitted grievances or allegations of misconduct.[47] OSM will continue to monitor implementation of this requirement in future site visits.

Standards and criteria item 8.5.6 requires DJJ to develop a process to address abuse of the grievance system by youth. The safety and welfare expert found DJJ in partial compliance with

---

[41] Safety and Welfare Remedial Plan Standards and Criteria, item 8.5.3; monitor observations and statements of interviewed youth during site visits at all facilities, 2008 to 2009.

[42] Safety and Welfare Remedial Plan Standards and Criteria, item 8.5.9. The safety and welfare expert found DJJ in substantial compliance with this item. Barry Krisberg, informal report on central office site visit (grid), January , p. . The safety and welfare plan re uires ward grie ance coordinators to be responsible for "monitoring timeframes, reviewing and ensuring adequate responses, training staff, holding monthly meetings, training grievance clerks, preparing reports, reviewing data for trends, developing intervention strategies, and conducting inquiries into complaints alleging staff misconduct." Safety and elfare Remedial lan, p. . The ward grie ance coordinator duty statement includes these elements. *See* DJJ Proof of Practice # 85, March 31, 2007.

[43] Safety and Welfare Remedial Plan Standards and Criteria, item 8.5.4; statements of staff during facility site visits, October 2008 to March 2009. Safety and Welfare Remedial Plan Standards and Criteria, item 8.5.7a. The safety and welfare expert found DJJ in substantial compliance with this item. Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 26.

[44] Safety and Welfare Remedial Plan Standards and Criteria, items 8.5.8a-c. The safety and welfare expert found DJJ in substantial compliance with these three items. Barry Krisberg, informal report on central office site visit (grid), January 2009, pp. 26-28.

[45] Safety and Welfare Remedial Plan Standards and Criteria, item 8.5.5; Barry Krisberg, informal report on central office site visit (grid), January 2009.

[46] Statements of Tammy McGuire during SYCRCC site visit, March 2009.

[47] *See* Safety and Welfare Remedial Plan Standards and Criteria, item . . . or additional details, see the monitors' "Safety and elfare Remedial lan Audit tems Report of indings," June 2009, included in this special master's report.

this requirement.[48] He commented that the process be reviewed by the mental health and disability experts, and indicated that "some changes may still be needed to protect youth rights, not staff con enience."[49] The safety and welfare expert and disabilities expert are concerned that the process does not provide sufficient protections for youth with disabilities and mental health needs; such youth may file multiple grievances for reasons other than intentional abuse of the grievance process.[50]

F. Safety and Welfare: Time-Add Tracking (Standards and Criteria Items 8.4.8b and 8.6.4 (selected sub-items))

Standards and criteria item 8.6.4d requires DJJ to develop a system to report net time added and restored.[51] In order for DJJ to achieve substantial compliance, the safety and welfare expert must approve the system as accurate.[52] The court reset the deadline for this item from June 30, 2007 to December 7, 2008.[53]

DJJ has modified its OBITS database to track changes to parole board dates.[54] The tracking system distinguishes among disciplinary time adds, program (non-disciplinary) time adds, time restorations,[55] and "program cuts."[56] For each category, DJJ calculates the number of time adds or cuts, the number of youth that received time adds or cuts, and the number of months added or cut.[57] DJJ has produced these figures for July 2008 through September 2008 and is

[48] Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 26.
[49] *Ibid.*
[50] Statements of Barry Krisberg during central office site visit, January 14, 2009; e-mail of Logan Hopper to Barry Krisberg and Aubra Fletcher, January 21, 2009.
[51] Safety and Welfare Remedial Plan Standards and Criteria, item 8.6.4d. DJJ must audit data reliability, based on appropriate statistical measures. *Ibid.*
[52] *Ibid.*
[53] Order, March 27, 2009, at 2.
[54] *See* Attachment 1, "Time Add Tracking System," provided as DJJ Proof of Practice #303, December 5, 2008; "Time Add Tracking System ro ect lueprint," provided as DJJ Proof of Practice #338, January 28, 2008.
[55] I.e., disciplinary time adds that are reduced by half once a youth has avoided Level 3 disciplinary infractions for a period defined by policy. *See* Safety and Welfare Remedial Plan, p. 73.
[56] .e., time cuts based on a youth's incenti e le el and beha ior; these are unrelated to disciplinary time adds. *See* Safety and Welfare Remedial Plan, pp. 73-74.
[57] *See* Attachment , "Time Add Tracking System," pro ided as roof of ractice , ecember , .

tracking this data monthly.[58] The safety and welfare expert has stated that the current system does not include a wide enough range of data.[59] DJJ has responded that its system complies with the plan language requiring it to track net time added and restored.[60] DJJ and the expert appear to disagree regarding this item's relationship to requirements that DJJ analyze time adds and formulate a plan to reduce their frequency (discussed in the following paragraph). At this time, Dr. Krisberg assigns a "beginning compliance" rating to this item.[61]

tem . . b re uires Research to conduct a "formal re iew of the use of and reasons for program (non-disciplinary) time adds."[62] ithin a "reasonable time" thereafter, JJ must formulate a plan to reduce common reasons for program time adds.[63] Similarly, item 8.6.4e requires DJJ to analyze time adds issued and the reasons for them, and item 8.6.4f requires DJJ to de elop a plan "to reduce the fre uency and duration of time adds based on inadequate access to programs."[64] The Court reset the deadline for these three items to December 7, 2008.[65]

DJJ completed a study of program time adds in December 2008 and asserts that it has complied with these three requirements.[66] Based on his review of the study, the safety and welfare e pert assigned a "beginning compliance" rating to item . . b and "noncompliance" ratings to items 8.6.4e and 8.6.4f.[67] The safety and welfare expert described the time add study as " ery superficial."[68] The study is five pages in length, with one page devoted to analysis.[69] It appears that only one staff member was assigned to complete it, without assistance from 's

[58] *Id.*, p. 3.
[59] Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 31.
[60] comments on arry risberg's central office audit, April 24, 2009, p. 6.
[61] Barry Krisberg, informal report on central office site visit (grid), January 2009, p. 31.
[62] Safety and Welfare Remedial Plan Standards and Criteria, item 8.4.8b.
[63] *Ibid.*
[64] *Id.* at item 8.6.4e-f.
[65] Order, March 27, 2009, at 2.
[66] *See* Attachment , "Time Add Tracking System," pro ided as roof of ractice , ecember , ; DJJ comments on Krisberg draft report, April 24, 2009, pp. 6-7.
[67] Barry Krisberg, informal report on central office site visit (grid), January 2009, pp. 25, 31.
[68] Barry Krisberg, revised informal report on central office site visit (summary), April 10, 2009, p. 13.
[69] *See* Attachment , "Time Add Tracking System," pro ided as roof of ractice , ecember , .

research unit.[70] The staff member reviewed 164 files, representing all non-disciplinary time adds for six months of 2008.[71] The study does not indicate how the staff member analyzed the 164 files.[72] The study concludes that "the ma ority of time additions were gi en as a result of beha ioral issues and or a lack of progress in treatment" and "no time additions were gi en to youth not ha ing access to programs in facilities."[73] The study does not indicate what data support these conclusions.[74]

The safety and welfare e pert described 's study as focused on gauging staff compliance with policy rather than looking "at how alternati es and graduated sanctions could be more widely employed," indicating his interest in both disciplinary and program time adds.[75] The safety and welfare plan itself requires attention to both types of time adds:

> The Chief Deputy Secretary will establish a team of internal and external experts to develop a broader array of graduated sanctions and to propose additional positive incentives. This team will explore the possibility of further reducing projected board date extensions as a disciplinary measure in the long term.[76]

The safety and welfare expert has offered to conduct an independent analysis of the subject for DJJ.[77] DJJ intends to include him in an upcoming analysis of program time adds.[78] OSM notes that adding disciplinary time adds to the scope of this study would further DJJ's compliance with the mandate quoted above.

---

[70] Statements of staff to Barry Krisberg during safety and welfare central office audit, January 13, 2009.
[71] *Ibid*
[72] *See* Attachment , "Time Add Tracking System," pro ided as roof of ractice , ecember , , p. 3.
[73] *Ibid.*
[74] *Ibid.*
[75] Barry Krisberg, revised informal report on central office site visit (summary), April 10, 2009, p. 13.
[76] Safety and Welfare Remedial Plan, p. 71.
[77] Barry Krisberg, revised informal report on central office site visit (summary), April 10, 2009, p. 14.
[78] *Ibid.*

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

Based on Site Visits Conducted

September 5, 2007 to June 6, 2008

FARRELL MEDICAL EXPERTS

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

Contents

Introduction 3
Reference Documentation 3
Executive Summary 3
Health Care Organization, Budget, Leadership, and Staffing 7
Statewide Pharmacy Services 16
Facility Findings 18
Preston Youth Correctional Facility 18
Heman G. Stark Youth Correctional Facility 21
Ventura Youth Correctional Facility 24
Southern Youth Correctional Reception Center and Clinic 27
NA Chaderjian Youth Correctional Facility 30
OH Close Youth Correctional Facility 35
Recommendations 39
Endnotes: 39

Introduction

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

This report contains the results of the Health Care Services headquarters review as well as the executive summary for each of the facility reviews. Mental health and dental expert reports are provided separately.

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

Reference Documentation

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

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

Executive Summary

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

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

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

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

Health care staffing has increased at all facilities, and has continued even as the population has declined. The process of putting health care systems in place is initially staff intensive, but once completed, facilities can often perform well with fewer staff. Health care services has not developed, collected and analyzed health resource utilization data that would enable DJJ to adjust resources in accordance with the needs and size of the population. This is an essential component to any health care organization in order to ensure that the services provided are reasonably cost effective. Any state agency that does not provide services in a reasonably cost-effective manner hampers its own credibility and ability to carry out its mission.

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

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

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

Other services still require significant improvement. At most facilities the medical reception process was problematic in that clinicians did not consistently perform and document adequate history and physical examinations, identify medical conditions and develop appropriate treatment plans for each active medical problem. This is particularly disturbing because DJJ

adolescents and young adults are by and large a medically healthy population and the failure to adequately address the medical conditions they do have is a serious concern.

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

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

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

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

Glossary of Acronyms

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

Health Care Organization, Budget, Leadership, and Staffing

The medical experts visited DJJ Health Care Services (HCS) on June 4-5, 2008 to conduct an assessment of HCS progress with respect to implementation of the Health Care Services Remedial Plan (HCSRP). At that visit, we evaluated the status of health care using the Health Care Audit Instrument audit tool entitled "Health Care Organization, Budget, Leadership, and Staffing."

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

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

Assessment: Partial Compliance

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

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

The current table of organization is not in compliance with the remedial plan which requires that the Medical Director report to the Chief Deputy of DJJ. As noted in the First Report, the medical experts agree that the remedial plan organizational model is not the only one that can promote success of the health care program. However, the current model has not been in effect long enough for medical experts to fully evaluate its effectiveness in addressing the complexity of the issues related to health care delivery. We noted during this review period, that the Director of Nurses left the organization primarily due to perceived lack of support and resources to fulfill her duties under the Remedial Plan. It is our understanding that she repeatedly communicated her resource needs in order to accomplish her responsibilities; however these resources were not forthcoming. Although efforts were made to retain her once she announced her decision to leave, it was unfortunately too late.

The medical and dental experts reviewed the DJJ Health Care Services TO dated 5/30/08. With respect to nursing services, we noted that the Public Health Nurse (PHN)[6] did not report to the Director of Nurses. The Director of Nurses indicated that when she met with the PHN to discuss the scope of her duties, the PHN advised her that her duties were limited to TB skin testing and she would not perform additional duties. Subsequently the position was removed from her oversight. This is not consistent with the Remedial Plan that provides for the Director of Nurses to "coordinate the selection, supervision, monitoring, and evaluation of nursing staff."

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

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

Assessment: Partial Compliance

According to the Remedial Plan, headquarters clinical staff, (e.g., Medical Director, Chief Psychiatrist, Chief Dentist, and Director of Nurses etc.) provides clinical supervision of their respective counterparts in the field. The facility Chief Medical Officer (CMO) is to provide administrative supervision of all health care services staff. We noted in our first report that the CMOs did not administratively supervise dental and mental health staff.

The Medical and Dental experts reviewed a facility organizational chart template distributed to the Chief Medical Officers in May 2008.[7] The organizational chart shows that the Chief Medical Officer has line authority over administration, nursing, mental health and dental services. It does not distinguish administrative from clinical supervision. Line supervision suggests both administrative and clinical supervision. A separate table of organization shows that the health care leadership in central office does provide clinical supervision over their facility counterparts.[8] Thus there is conflict between these two tables of organization that should be corrected.

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

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

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

Assessment: Partial Compliance

The following key HCS positions are budgeted and filled:

- The Statewide Medical Director position is budgeted and is technically vacant; however, the position is filled through a contract with UCLA.
- The Chief Psychiatrist has returned from military leave.
- Pharmacy Services Manager.
- The Standards and Compliance Coordinator.
- The Clinical Record Administrator position is unfilled. However, in December 2007 DJJ posted an invitation to bid for Medical Records Director Services that resulted in a consultant being hired. In addition, a Health Program Specialist II has been hired to oversee medical records. This individual is not credentialed in medical records.
- The Director of Nurses (Nurse Consultant III) was filled at the time of our review in June 2008.[10]

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

- The Health Care Administrator (HCA) position is not a budgeted position. The HCA occupies a Correctional Health Care Administrator II position from Heman G. Stark. Staff reported that the process of establishing a budgeted position is underway.

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

Assessment: Partial Compliance

Robert Morris, MD, Professor of Pediatrics at UCLA is the Statewide Medical Director. He is on a contract position, and normally works Tuesday to Thursdays. As stated in the previous report Dr. Morris reported that he is available when he is not in the office and often works more than 40 hours per week.

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

During this review period, a statewide quality management program was implemented and facilities were in various stages of implementation during our site visits. However, a

headquarters auditing process has not been implemented as required by the remedial plan (see Question #12).

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

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

In April 2008, with intent to assist DJJ in evaluating resource needs, we requested that DJJ collect and provide us key health care data to assess resource needs. This information has not been provided to us.[11] We remain available to assist the Medical Director with development, implementation and evaluation of staff productivity and resource utilization.

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

Assessment: Partial Compliance

The Statewide Director of Nurses position was filled from May 2007 until August 2008. During her relatively brief tenure the statewide DON demonstrated impressive leadership capabilities and improved nursing services. She conducted a systematic analysis of nursing services,[12] described the strengths and weaknesses of DJJ's nursing structure and organization,[13] established statewide priorities,[14] identified needed resources, implemented training and effected strategies within her control to improve nursing services within DJJ.

She developed and implemented a Nursing Services Quality Management Plan that included an evaluation of Supervising Nurses' (SRNs) capabilities to evaluate nursing practice in their facilities; and identified educational needs of the SRNs to promote their ability to evaluate the nurses. Through this program she determined that not all SRNs were completing nursing audits within their respective facilities. Of those that were conducting audits the accuracy of the audits (as compared to her findings) ranged from 62.5% to 86% with a mean of 74%. She also noted that the SRNs as a whole were not able to identify nursing system issues evident from audit reports, and had difficulty recognizing how to effectively prioritize problems and use their time and resources effectively. She developed a corrective action plan to address the educational needs and professional development of the SRNs as well as the systems issues that were identified during the reviews.[15]

Under her direction, a nursing physical assessment curriculum was developed and implemented. We reviewed the curriculum and found that it provided useful information in performance of

general 'head to toe' assessments, EKGs and interpretation of laboratory tests. However, there was a key error in the curriculum regarding a fundamental aspect of nursing assessment and nursing documentation using the 'SOAP' format.[16] In the curriculum example of SOAP charting,[17] the note incorrectly identifies subjective data as objective data. Our facility reviews show that nurses are repeating this error in their assessments of patients, often leading to inadequate evaluations. This was discussed with the DON who concurred with our assessment. The curriculum should be corrected and nurses retrained regarding this content.

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

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

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

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

Assessment: Deferred

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

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

Assessment: Deferred

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

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

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

Assessment: Substantial Compliance

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

Assessment: Substantial Compliance

HCS staff has developed a structured, written orientation program for headquarters staff. The plan is for supervisors to provide specific training to new employees based on their specific assignment. The orientation is to be documented via a checklist that is maintained in the supervisory file.

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

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

Assessment: Partial Compliance

The Office of Health Services, in collaboration with the medical experts, has developed an initial set of policies and procedures and accompanying forms. Since our last visit, the Peer Review, Credentialing, and Organizational Structure policies have been finalized. The policies and

procedures have been disseminated to the field as Temporary Departmental Orders (TDOs). Facility staff has, for the most part, written local procedures to implement the statewide policy.

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

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

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

Assessment: Partial compliance

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

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

Assessment: Partial Compliance

Health Care Services has developed a Quality Management Plan. The plan establishes a HCS Quality Management Team (QMT) which coordinates and facilitates the performance of quality improvement activities at each facility.[18] The Standards and Compliance Coordinator (SCC) leads the HCS Quality Management Team.

The plan also provides for each facility Quality Management Committee (QMC) to monitor and evaluate 2 aspects of care from the remedial plan each quarter (using indicators from the Health Care Audit Instrument); a total of 8 per year. In addition to the two aspects of care each quarter, each facility QMC is to evaluate emergency medical response drills conducted at each facility each quarter, monthly emergency room visit reports; emergency response reviews and sentinel events reports.[19] Following the review of each aspect of care, the facility is to develop a corrective action plan for deficient areas. Because there are 18 separate facility audit tools, this frequency of review (i.e., 2 per quarter) does not ensure that all aspects of the remedial plan are reviewed annually.

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

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

The facility-based quality improvement activities are an important component to the quality management program and DJJ is to be commended for implementing this aspect of the program. However, the facility monitoring activities does not replace the Health Care Services clinical auditing process required by the remedial plan.[20] The purpose of the external audit is to conduct an independent review to validate the results of facility monitoring.

Prior to her departure in August 2008, the Statewide DON conducted external reviews using the HCS audit instrument to compare her findings with those of the SRNs.[21] Of the SRNs that were conducting audits, the DON determined that the accuracy of the audit findings ranged from 62.5% to 86% with a mean of 74%. The DON used the external auditing process to both educate the SRNs how to interpret the audit tool correctly as well as to discuss the results to her review, identify problems and assist the SRNs in developing strategies to correct the problems.

In addition, the Health Care Services audit results should be used to compare against medical experts audit findings to determine whether there is consistency and validity in audit tool interpretation and to discuss discrepancies in findings and conclusions. For example, the medical experts found significant problems with a physician's performance at Preston Youth Correctional Facility; this raised questions as to why the internal auditing/peer review process had not identified and corrected the performance issues. Also, the medical experts requested that HCS conduct an internal assessment of the HCSRP audit tool that applied to headquarters.[22] The result was a score of 100% for all areas except one.[23] These findings are not consistent with the medical expert's findings and warrant further discussion.

Finally, the remedial plan requires a comprehensive audit process using a multidisciplinary team, consisting of a physician, nurse, pharmacist, dentist and administrator.[24] A team approach enables more effective communication, identification and resolution of problems, particularly those that are interdisciplinary in nature.

Following the HCS audit, the Standards and Compliance Coordinator is responsible for coordinating the publication and distribution of audit reports; monitoring the implementation of corrective action plans. We recommend that each facility undergoes an external review audited twice annually until the system is confident in the facilities ability to self-monitor, then a minimum of annually. The medical experts offer our assistance to Health Care Services to develop this aspect of the Quality Management Program.

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

Assessment: Partial Compliance

At our last review the Clinical Records Administrator position was vacant due to recruitment difficulties. DJJ issued a Request for Bid (RFB) for a contract health records professional and in the spring of 2008 hired a Registered Health Information Administrator and Health Program

Specialist II to develop health records and a health record management program. At the time of our visit, they had developed a working plan to develop a unified health record policy and procedures manual. This involved conducting site visits to each facility to get an overview of UHR processes, inventory current health records forms and assess current health record maintenance and staffing. They also planned to review internal documentation and work processes related to health records that included: health record forms and organization; health technician desk procedures and security; access to and release of confidential health information, etc. Their goal was to complete all processes by December 31, 2008.

Statewide Pharmacy Services

Since our last visit, DJJ has hired a Statewide Pharmacy Manager who is a Pharm.D.[25] We were impressed with both his knowledge and interest in providing quality and cost-effective pharmacy services to youth.

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

Assessment: Noncompliance

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

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

Assessment: Partial compliance

The SPM has developed and implemented standardized pharmacy practices at all facilities. This was demonstrated by pharmacy audit scores that, with one exception,[26] ranged from 90-100%.

The SPM has initiated studies of pharmaceutical purchasing practices by site to determine individual facility total and psychotropic medication expenditures and provide feedback to facility and DJJ stakeholders. He also tracks pharmaceutical expenditures by type of medication and provider. For example, the total DJJ medication purchases from July-September 2007 totaled $568,002.69. Of that amount $294,756.91 (52%) was for psychotropic medications.[27]

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

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

Assessment: Deferred

The medical experts were not able to fully monitor this question at this time. We requested health care data from DJJ[28] including the number of prescriptions filled per month by facility as a basis for discussion and evaluation, but the data was not provided.

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

Assessment: Deferred

The SPM has constituted and chairs the Statewide P & T Committee that meets quarterly. Assessment was deferred pending production of meeting minutes.

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

Assessment: Deferred.

Assessment deferred pending production of minutes documenting substantive issues (e.g. pharmacy utilization, cost per youth, etc).

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

Assessment: Substantial Compliance

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

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

Assessment: Partial Compliance

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

Facility Findings

Preston Youth Correctional Facility

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

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

There are still no finalized agency, health care, or institutional tables of organization. This has led to confusion among reporting relationships at the institutional level, particularly among nursing staff and has resulted in the publication of two memoranda[29] seeking to clarify the reporting relationships.

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

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

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

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

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

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

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

Summary of Health Care Review

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

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

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

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

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

Infection Control scored 100%. Congratulations!

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

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

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

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

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

Preventive Services scored 96%. Congratulations!

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

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

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

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

Heman G. Stark Youth Correctional Facility

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

Summary of Health Care Review

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

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

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

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

nurses he received were to be dedicated to mental health even if the BCP Farrell Position spread sheet stated that a positions was designated HC (health care) instead of MH (mental health).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ventura Youth Correctional Facility

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

Summary of Health Care Review

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

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

We did not fully evaluate staffing during this visit. We did note however that there were 7 nursing vacancies for 21 budgeted positions. We toured the special counseling units Alvarado and BV. We interviewed the unit manager regarding daily activities of the youth and staff in the unit. He indicated that the youth are in school from 8:00 am-3:30 pm, Monday through Friday. A registered nurse and two psych techs provides coverage for the two units for days and evenings. As of the week prior to our visit, it was decided that the registered nurse will not conduct sick call in the housing unit because the room does not have an exam table and youths are not permitted to be in the room unescorted for security reasons. Thus the sole duties of the registered nurse are to administer medications for a total of 30 wards. On the day of our tour, there were no psych techs in the unit and we inquired as to their whereabouts. The unit manager reported that he didn't know.

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

officers do not uniformly enforce the requirement to have youth report to the medical clinic to do so. Although youth have a right to refuse care, they do not have the right to refuse direction from a correctional officer.

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

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

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

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

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

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

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

Medication Administration Process scored 77%. Nurses administering medications to youth adhered to accepted nursing practices. The medication room was neat and organized and all narcotics were accounted for. Areas requiring improvement include the development of a local policy, compliance with time requirements for administration of hour of sleep medications, and improved cooperation between nursing and custody staff during medication administration (e.g.

staff reported feeling rushed by custody because of scheduling issues which nurses perceived did not permit them to follow proper medication administration procedures and increasing risk of medication errors).

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

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

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

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

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

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

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

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

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

Southern Youth Correctional Reception Center and Clinic

The Farrell Medical Experts visited SYCRCC on January 29-31, 2008. Overall, the facility scored 72% (500 of 693 indicators). The facility population at the time of our visit was 202 youth in 5 housing units. In addition to the main clinic areas, there are two satellite nursing stations, one in the Marshall Intensive Treatment Program (ITP) and a clinic in Drake for youthful offenders. Youth housed in Drake are brought to the main medical unit on Tuesdays for medical services. The Outpatient Housing Unit (OHU) currently uses five beds for medical/mental health purposes. SYCRCC provides infirmary services for the population of Heman G. Stark YCF. We would particularly like to thank Ms. Sharon Brooks, Health Care Administrator, for the assistance she provided us during the review.

Summary of Health Care Review

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

Although there has been improved cooperation between medical and custody staff, staff reported that youth are not being consistently escorted to the medical unit, particularly when in temporary detention. Finally, although a formal staffing assessment was not conducted during this visit, we note that staff continues to be added to the facility despite the decreasing population. For example, with respect to clinical staffing, there is a Chief Medical Officer and nurse practitioner. Yet recently a full time physician was hired. Moreover, the facility has a Chief Dentist and 2 full-time dentists. At the time of our visit, the facility was interviewing candidates for a 4th dentist. In the face of the current state budget crisis, we recommend that DJJ re-evaluate staffing needs before hiring new staff.

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

problem. In our view, the history and physical examination form contributes to these problems.[30] Clinicians should also address known risk factors (obesity, tobacco, and substance abuse).

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

Nursing Sick Call scored 60%. The room where nurses conduct sick call in the main clinic is not properly equipped (no otoscope or ophthalmoscope). Youth health service requests are generally being collected and triaged in a timely manner, except for dental requests. Nurses forward all requests for dental services, including youth complaining of dental pain directly to the dentist without first seeing the youth. We found instances of requests not being triaged by a dentist in a timely manner, despite having 3 dentists at the facility. In one case, a youth complaining of pain was not seen for six days after he submitted his complaint. Areas requiring improvement include development of local policy, performance of nursing sick call in clinical areas with privacy, training of nursing staff regarding health assessment skills and nursing protocols, and a system for ongoing peer review and feedback to assist nurses in improving their assessment skills.

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

Chronic Disease Management scored 51%. Not all patients with chronic problems were on the chronic disease log, including 2 patients with thyroid disease. Other areas requiring improvement include the initial and interval history, disease assessment, and vaccinations. We also found that the providers need additional training on the treatment of asthma. Numerous patients had histories of using their inhalers on a daily basis and were not prescribed inhaled steroids. While some of these patients may not be using their inhalers correctly, and, in fact, may not require inhaled steroids, it is an indication that the providers are either not either treating appropriately or are not providing appropriate education.

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

Pharmacy Services scored 100%. Congratulations!

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

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

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

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

Health Records scored 100%. Congratulations!

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

Consultations scored 98%. Congratulations!

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

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

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

NA Chaderjian Youth Correctional Facility

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

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

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

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

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

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

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

Summary of Health Care Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmacy Services scored 100%. Congratulations!

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

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

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

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

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

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

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

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

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

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

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

OH Close Youth Correctional Facility

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

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

There are however, some fundamental structural aspects of health care services that are not in place. This includes a complete and current set of policies and procedures to which staff has been trained and a timely and comprehensive orientation program.[31] DJJ also has not developed nursing protocols and guidelines for the treatment of common conditions among adolescents and young adults that are required by the remedial plan.[32] Although there is a health care budget now under the control of the Chief Medical Officer (CMO), the budget was not available to the CMO until more than half the fiscal year had passed.

The facility population at the time of our visit was 198 youths. Currently there are 1.6 primary care providers (physician and nurse practitioner) at the facility which is a clinician to youth ratio of 1:124[33]. This appears to be more clinical coverage than is necessary to meet youth needs. There is only one exam room so on the days that both clinicians are at the facility they alternate seeing patients in the same room. Moreover, our review of clinician patient encounter logs for the months of March-May 2008 showed that for the 3 month period each provider saw an average of patients per 9.8 patients per day. The majority of these encounters were for minor conditions such as previously diagnosed acne that could be managed by nurses if nursing protocols in place and staff properly trained.

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

Summary of Health Care Review

Facility Leadership, Budget, Staffing, Orientation and Training scored 67%. Positively, all key leadership positions are filled. The Chief Medical Officer (CMO) is board-certified in a primary care field. The budget is now under the control of the CMO however this did not occur until more than half the fiscal year had passed. The facility does not have a complete set of local policies and procedures and staff has not been systematically trained regarding the policies. The medical space consists of an examination room and a small office adjacent to the exam room. The examination room is cramped and often 2 clinicians, a nurse and Medical Technical Assistant (MTA) occupy this area. There is no schedule of sanitation activities and it does not appear that the room has been thoroughly cleaned in some time.

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

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

Intrasystem Transfer scored 80%. We found that not all transferred youth were listed on the log, but a review of those records showed that the intrasystem transfer review process did occur. Of concern is that in only 1 of 5 records of youth who were taking prescription medication did the record show that continuity of medication was provided. In two cases, the findings may possibly be attributed to documentation issues (an MAR was missing and in another record the nurse did not date when the youth was given his asthma inhaler). Also, in 4 of 10 cases clinical follow-up was indicated and did not take place. In two cases youths with previously abnormal labs that warranted repeating were not noted and did not take place; one was enrolled in an obesity program for which follow-up did not occur; and one saw a psychiatrist who wanted follow-up in six weeks but this did not occur.

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

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

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

Infection Control scored 50%. This area was subject to a limited review.[34] Areas needing attention include updating the 2005 infection control manual, ensuring that exposure control and engineering controls are in place to prevent transmission of communicable diseases, and the development and implementation of sanitation schedules.

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

Headquarters

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

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

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

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

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

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

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

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

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

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

Facility

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

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

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

14. Provide training related to the chronic disease program.

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

Endnotes:

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

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

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

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

[5] See SYCRCC report.

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

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

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

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

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

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

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

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

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

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

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

[17] Page 33.

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

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

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

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

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

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

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

[25] A doctoral degree in pharmacy.

[26] Preston YCF.

[27] DJJ Pharmaceutical Purchases July-September 2007.

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

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

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

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

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

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

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

Appendix D
Safety and Welfare Remedial Plan Audit Items: Report of Findings, June 2009
Monitors Zack Schwartz and Aubra Fletcher

The Safety and Welfare Plan assigns monitoring of some requirements to the special master and her staff. In order to audit these requirements, monitors Zack Schwartz and Aubra Fletcher visited each of DJJ"s six facilities between October 2008 and March 2009.[1] On March 12, 2009, the special master and monitor Schwartz visited DJJ"s central office for a safety and welfare audit. This report is based on these visits as well as a variety of interactions with DJJ management and staff throughout the monitoring period. Report findings also draw from DJJ responses to various formal requests for documentation and from multiple "proofs of practice" provided by DJJ. Some findings are also based on site visit notes compiled by former OSM monitor Cathleen Beltz and former OSM intern Amelia Post prior to October 2008. Reliance on these sources is noted in the text and footnotes.

2.1.1: *DJJ to add/appoint a program director.* ***2.1.2:*** *DJJ to add/appoint a* Farrell *project director.*

2.1.1: This position was vacant until DJJ hired Doug McKeever as director of programs on January 2, 2008.[2]

Rating: Substantial compliance

2.1.2: Michael Brady was appointed chief of court compliance in approximately December 2008.[3] This new position encompasses the duties assigned by the remedial plans to the *Farrell* project director: coordinating statewide implementation and integration of all remedial plans.[4] Unlike the former *Farrell* project director, who reported to the directors, the chief of court compliance reports directly to the chief deputy secretary.[5]

The "*Farrell* project director" position still exists and reports to Michael Brady, but the position has a more limited role than in the past: oversight of project management for *Farrell* and *LH*-related reforms.[6] For instance, the project director is responsible for developing schedules and monitoring whether staff follow them.[7] DJJ reports that its project managers now perform several jobs previously done by Delegata (e.g., "risk and issue mitigation reporting, mitigation or

[1] O.H. Close (October 21, 2008), Chaderjian (October 22, 2008), Ventura (December 17-18, 2008), Stark (January 26-27, 2009), Preston (February 9-11, 2009), and SYCRCC (March 17-18, 2009).
[2] *Id.*; memorandum of Bernard Warner to various DJJ staff, December 20, 2007 (DJJ Proof of Practice #127, April 4, 2008). Hereinafter, DJJ"s "Proof of Practice" documents are cited as "PoP."
[3] Statements of Bernard Warner during staff training, December 4, 2008. Unless otherwise noted, cited "statements" were made to or in the presence of the special master or her staff.
[4] Statements of Michael Brady during central office site visit, March 12, 2009. Unless otherwise noted, cited site visits were conducted by the special master and/or her staff for the purpose of safety and welfare monitoring.
[5] *See* Attachment 1, draft Court Compliance organization chart, undated (provided in approximately January 2009).
[6] Statements of Michael Brady during central office site visit, March 12, 2009.
[7] *Id.*

escalation," "developing and maintaining the Portfolio Master Schedule," and "capturing lessons learned").[8]

Sandra Emert will become project director upon the departure of Dan Mehring.[9] Ms. Emert previously headed the project management office at CDCR's information technology division (Enterprise Information Systems).[10] She is expected to remain at DJJ for six months to one year.[11]

Rating: Substantial compliance

2.1.3a: *DJJ to put in place a program development and implementation team.* ***2.1.3b:*** *DJJ to put in place a temporary transition team.* ***2.1.3c:*** *DJJ to put in place a compliance team. The deadline for each of the above items is October 1, 2006.*

The safety and welfare plan requires DJJ to create three central office teams. Respectively, these teams will (a) develop and implement programs, train staff, and provide quality assurance; (b) facilitate implementation of the reform plan and cultural change; and (c) monitor compliance with the *Farrell* remedial plans.[12] Although the three teams must include a total of at least eleven members, as well as any necessary support staff (analysts and office technicians), the exact make-up of each team may vary.[13] Members of one team may be reassigned to another depending on overall needs.[14]

Since DJJ began assembling the teams in 2007, it has acted within its discretion to change or reallocate the teams' staff several times. In June 2007, DJJ provided duty statements for 18 positions that would comprise the program development and implementation team (2.1.3a).[15] Creation of the transition team (2.1.3b) was on hold at that time pending the designation of a project director.[16] By January 2008, DJJ had established three work groups in place of the transition and program development teams.[17] Meanwhile, DJJ had begun to assemble an eight-member compliance team (2.1.3c) headed by Bob Moore.[18] Since the remedial plan requirement is that at least eleven professional staff plus adequate support staff fulfill certain functions, the

[8] *See* document entitled "Project Management Office," undated (provided on March 12, 2009).
[9] Statements of Michael Brady during central office site visit, March 12, 2009.
[10] *Id.*
[11] *Id.*
[12] Safety and Welfare Remedial Plan, pp. 19, 21.
[13] *Id.*, p. 20. The program development and implementation team must include four senior clinicians and/or senior administrators with expertise in mental health services. Mental Health Remedial Plan, p. 75.
[14] Safety and Welfare Remedial Plan, p. 20.
[15] Fourth Report of the Special Master (June 2007), Appendix A (Beltz Report), p. 3; *see also* document entitled "IBTM Trainers Position Tracking as of 06/07/2007" (PoP #30, June 7, 2007). Sixteen of the positions had at that time been filled, and a seventeenth was to be offered by the end of the month.
[16] Fourth Report of the Special Master (June 2007), Appendix A (Beltz Report), p. 3.
[17] Sixth Report of the Special Master, Appendix B (Beltz report), p. 3.
[18] In December 2007 and January 2008, DJJ provided duty statements for each of the eight team positions. *See* draft duty statements for associate governmental program analyst, staff services manager II, lieutenant, office technician (PoP #81, December 7, 2007); duty statement for major position within the compliance unit (PoP #120, January 24, 2008).

special master‟s office accepted the reallocation and realignment of staff as fully within DJJ‟s discretion.[19]

In December 2008, DJJ began to establish a new Court Compliance Task Force that subsumes the functions of all three teams.[20] The Court Compliance Task Force is headed by Michael Brady (see audit item 2.1.2, above).[21] It includes three team supervisors who oversee six remedial area team leaders, as well as Bob Moore‟s compliance unit.[22] It also includes staff from IT, legal, project management, audits, communications, and the litigation coordinator.[23] Nineteen members of the team are designated as program developers.[24] In all, there are over forty members.[25] The Task Force convenes weekly to discuss progress and to problem-solve in each remedial area. Facility representatives participate in these meetings via videoconferencing equipment. Experts and OSM are also invited to participate in person or via telephone.

The compliance team, now a subset of the Task Force, originally spent significant time analyzing and responding to Office of the Inspector General (OIG) and CDCR Office of Audits and Compliance (OAC) findings and inquiries.[26] As of May 2008, the team was also in the process of developing a *Farrell* master audit schedule to coordinate facilities‟ tracking and auditing of the *Farrell* requirements.[27] The team leader reported at that time that the team would continue to work on OIG and OAC issues but planned to focus largely on *Farrell* compliance.[28]

Ratings: Substantial compliance

2.1.4a: *DJJ to install dedicated staff for policy development and policy maintenance by November 21, 2007.* ***2.1.4a:*** *Master schedule completed for updating DJJ policy by January 15, 2007.* ***2.1.4a:*** *Policies updated per schedule and TDOs issued as needed, on an ongoing basis.*

2.1.4a (dedicated staff): Central office‟s Policy, Procedures, Program, and Regulations (PPP&R) branch is devoted to policy development, maintenance, and tracking.[29] Dolores Slaton oversees the unit.[30] It includes 12 analysts and one office tech.[31] An executive policy review

[19] *Ibid.*; Fourth Report of the Special Master (June 2007), p. 2.
[20] Statements of Bernard Warner during staff training, December 4, 2008.
[21] Statements of Michael Brady during central office site visit, March 12, 2009; *see also* Attachment 1, draft Court Compliance organization chart, undated (provided in approximately January 2009).
[22] *See* Attachment 1, draft Court Compliance organization chart, undated (provided in approximately January 2009).
[23] *See id.*
[24] *See* document entitled “Program Developers,” undated (obtained from central office March 12, 2009). Program development occurs largely through DJJ‟s project management process, in which large projects are organized via the “charter process.” Statements of Delegata trainers at “Using the DJJ Reform Management Structure: A Reform Portfolio Project Training Course,” December 4, 2008. Tami McKee Sani oversees the charter process. Statements of Michael Brady during central office site visit, March 12, 2009.
[25] Statements of Michael Brady during central office site visit, March 12, 2009; *see also* Attachment 1, draft Court Compliance organization chart, undated (provided in approximately January 2009); document entitled “Program Developers,” undated (provided on March 12, 2009).
[26] Statements of staff during central office site visit, May 29, 2008.
[27] *Id.*
[28] *Id.*
[29] Statements of Dolores Slaton during central office site visit, March 12, 2009.
[30] *See* Attachment 2, PPP&R organization chart, January 26, 2009.

team examines all policies before finalization; the team includes the DJJ directors and the staff person in charge of the Integrated Behavior Treatment Model.[32] The team convenes as necessary to resolve conflicts regarding policy content.[33]

The PPP&R branch has a sufficient number of staff to develop policies and training materials. However, the monitors decline to assign a rating to this item and defer to the safety and welfare expert"s determination as to policy personnel"s knowledge of contemporary standards of care and practice in juvenile correctional agencies.[34]

Rating: Defer to expert

2.1.4a (master schedule): In its November 2008 filing, DJJ indicated that it had substantially complied with the requirement that it develop a master schedule for policy updates.[35] OSM has not seen a master schedule, only a master table of contents. The safety and welfare expert has approved the table of contents sections relevant to his remedial area.[36] Internal deadlines for policy development and implementation thus far have been designated on a rolling basis. In April 2008, the special master recommended that DJJ produce a list of policies it intends to update in the coming year.[37] OSM has since received internal deadlines for a variety of policies, and DJJ"s policy planning and development capabilities have sharply improved.[38] In June 2009, DJJ reported that its master schedule for policy updates was "currently being finalized."[39]

Rating: Partial compliance

2.1.4a (updated policies): The various policies addressed in the last year include the following.

---

[31] *Id.*
[32] Statements of Dolores Slaton and Tammy McGuire during central office site visit, March 12, 2009.
[33] *Id.*
[34] The safety and welfare plan states that policy development staff "must be knowledgeable of contemporary standards of care and practice in juvenile correctional agencies" and that policies will be "based on contemporary standards of care and practice." Safety and Welfare Remedial Plan, pp. 12, 21.
[35] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 1.
[36] *See* master table of contents for DJJ"s policy manual (PoP #274, October 22, 2008); Barry Krisberg, informal report entitled "Headquarters – Implementation of Safety and Welfare Remedial Plan," undated (received March 13, 2009), p. 2 [hereinafter "Barry Krisberg, informal report on central office site visit, 2009"].
[37] Seventh Report of the Special Master (April 2008), p. 25.
[38] OSM received various project management office-generated project schedules and charters in November 2008 and March 2009. DJJ provided the Court with revised deadlines for some policies in October 2008. *See* Deft. Notice of Filing Revised Deadlines for Select Standards & Criteria and Remedial Plans, October 22, 2008. The Court adopted these as new deadlines. *See* Order, February 20, 2009, at 2-3; Order, March 27, 2009, at 2. DJJ also submitted to the Court a list of prioritized policies for fiscal year 2008-2009 on November 21, 2008. *See* Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit CC. DJJ has incorporated policy status updates in its "dashboard" packet that is regularly submitted to the court. *See* Deft. Notice of Filing Updated Audit Criteria to Assist the Court in Monitoring DJJ"s Compliance with Remedial Plans, January 29, 2009. DJJ has refined the policy dashboard format and shared a draft with plaintiff"s counsel and OSM in February 2009. A later draft was shared with OSM on March 12, 2009. *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[39] DJJ comments on the draft of this report, June 9, 2009, p. 1; *see also* e-mail of Barry Krisberg to Aubra Fletcher, June 9, 2009.

- Grievances and staff misconduct complaints: Temporary departmental orders (TDOs) were implemented at all facilities on August 4, 2008,[40] and they expire on October 1, 2009.[41]

- Use of force (Crisis Prevention and Management): After more than one year, which included two rounds of executive review, the policy was undergoing labor review as of March 9, 2009.[42] Staff training commenced on March 17, 2009.[43] DJJ reports that it is on schedule for implementation by March 31, 2009.[44]

- Suicide Prevention, Assessment, and Response (SPAR): Work on this policy began five years ago.[45] Mental health staff received training on new SPAR procedures in November and December 2005.[46] As of nine months later, the procedures had not been implemented.[47] A new draft policy was submitted to the policy unit in July 2007,[48] and four pilots were conducted at Chaderjian in 2008.[49] DJJ modified the policy and drafted a project charter in the fall of 2008.[50] The policy was to be implemented by February 23, 2009,[51] but this internal deadline was later extended to March 10, 2009.[52] DJJ did not meet this implementation deadline. As of March 12, 2009, the policy was undergoing labor review.[53] Central office distributed the policy to facilities on March 19, 2009.[54]

- Disciplinary decision-making system: Policy revisions began in mid-2007, and a TDO was issued in the meantime. At DJJ"s request, the Court reset the deadline for implementation of this policy from March 31, 2007 to March 31, 2009.[55] The policy was finalized and distributed to facilities in April 2009.[56]

- Program credits: The policy unit received a draft policy in February 2008.[57] The revised policy was finalized and distributed to facilities on March 27, 2009.[58] Training is complete, and the policy was implemented on March 31, 2009.[59]

---

[40] Memorandum of Sandra Youngen to superintendents, August 1, 2008.
[41] TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[42] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[43] *See id.*; statements of facility staff during SYCRCC site visit, March 17, 2009.
[44] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[45] First Report of the Special Master (March 2005), p. 32 (DJJ prepared written policies and procedures that were approved by the Consent Decree mental health experts by December 2004.).
[46] Mental Health and Rehabilitation Interim Plan, ¶ 33.
[47] Third Report of the Special Master (September/November 2006), pp. 10-11.
[48] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[49] *See id.*; statements of staff during Chaderjian site visit, October 17, 2008; SPAR project schedule, undated (provided November 2008).
[50] *See* Attachment 3, "Policy Dashboard: As of 3/11/09;" Project Charter: Suicide Prevention, Assessment, and Response, November 13, 2008.
[51] *See* Attachment 3, "Policy Dashboard: As of 3/11/09;" statements of DJJ chief psychiatrist during Ventura site visit, December 3, 2008; statements of facility senior psychologists during SYCRCC site visit, January 28, 2009.
[52] Statements of Dr. Juan Carlos Arguello during central office site visit, March 12, 2009.
[53] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[54] *See* e-mail of Robert Rollins to various, March 19, 2009.
[55] *See* Order, February 20, 2009, at 2-3.
[56] DDMS policy bulletin and policy (PoP #392, April 27, 2009).
[57] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."

- Forensic evaluations (Welfare and Institutions Code § 1800): Begun in mid-2007, this policy has undergone three executive reviews in recent months, as well as two case conferences to settle disputes over language.[60] As of March 11, 2009, the policy was "in [the policy unit] preparing for [the chief deputy secretary's] signature."[61] As of the end of April 2009, the implementation date was set for June 1, 2009.[62] Central office distributed the policy to facilities on June 1, 2009,[63] and staff training was nearing completion as of early June 2009.[64]

- Outpatient housing unit (OHU): Work began in early 2008.[65] As of March 9, 2009, the policy was undergoing labor review.[66] DJJ indicates that its schedule is "on target," but no deadline is noted on dashboard policy document.[67]

- Youth classification: Begun in mid-2007, the policy unit is awaiting a draft of the policy from the program area.[68] A tentative charter for the entire classification project, including the creation of a new policy, estimated that the project would begin on March 17, 2009 and be completed in 1.5 years.[69] Although no deadline is listed on its dashboard, DJJ indicates that it is not on schedule for timely implementation of this policy.[70] DJJ has complied with the requirement to implement "interim classification" separating youth at the highest and lowest risk to harm others.[71]

- Program service day: The policy unit received a draft policy in early 2008.[72] A pilot began at Preston during the fall semester of 2008.[73] After two reviews by labor, the policy was completed and distributed to facilities for implementation at the end of March 2009.[74] Implementation of the program service day, including statewide standards, is monitored separately by the safety and welfare expert.[75] The program service day policy does not reference the required statewide standards and provides little direction to

---

[58] Memorandum of Sandra Youngen to superintendents (PoP #374, April 6, 2009).
[59] *Ibid.*
[60] Statements of DJJ mental health leadership during central office site visit (mental health), February 18, 2009; statements of Michael Brady during informal meeting, February 20, 2009; statements of Dolores Slaton and Tammy McGuire during central office visit, March 12, 2009; *see also* Attachment 3, "Policy Dashboard: As of 3/11/09."
[61] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[62] Statements of staff during Court Compliance Task Force meeting, April 30, 2009.
[63] *See* e-mail of Robert Rollins to various, June 1, 2009.
[64] Statements of staff during Court Compliance Task Force meeting, June 4, 2009.
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] Statements of Dolores Slaton during central office visit, March 12, 2009; s*ee also* Attachment 3, "Policy Dashboard: As of 3/11/09."
[69] *See* Attachment 4, draft Project Charter: Comprehensive Classification System, February 25, 2009.
[70] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[71] Fifth Report of the Special Master (October 2007), p. 19.
[72] *See* Attachment 3, "Policy Dashboard: As of 3/11/09."
[73] *Id.*
[74] *See* Attachment 5, "Program Service Day Policy" (PoP #376, April 6, 2009).
[75] Safety and Welfare Remedial Plan Standards and Criteria, items 6.2a-c, 6.6.

facilities.[76] In its comments on a draft of this report, DJJ stated that the statewide standards "were purposely excluded because we knew they would have to be revised and approved."[77] DJJ distributed a final version of the standards in May 2009.[78] DJJ"s required its facilities to develop and implement the program service day by March 31, 2009.[79] We do not understand how the program service day could be implemented in a way that conforms to the remedial plan without these standards in place.

- Psychopharmacological treatment: Begun in mid- to late-2008, this policy was finalized and distributed to facilities in March 2009.[80] DJJ has developed consent forms and a training curriculum.[81] Training for on-site instructors has been provided at the facilities to 45 medical and mental health staff and 23 mental health clinicians.[82]

- Treatment confidentiality: DJJ has developed a charter for development of this policy, which lists the start date as December 15, 2008 and the estimated duration as three months.[83] On another document, the start date is listed as January 27, 2009 and the end date as June 12, 2009.[84] OSM and the experts have not seen a draft of this policy. DJJ plans to complete a draft of the policy by June 2009.[85]

Rating: Partial compliance

2.1.4a: *As appropriate, youth are to receive information materials and/or briefing within 30 days of policy changes.*

Central office issued a memorandum to facilities in July 2007 instructing staff to notify youth of policy changes as appropriate.[86] Monitor Cathleen Beltz"s site visits to facilities in early 2008 revealed inconsistent practices, though most facilities were documenting youth notification of at least some policy changes.[87] For example, at Chaderjian, no information regarding phone access, individual achievement points, restorative justice points, or program credit was posted on dayroom bulletin boards.[88] Ms. Beltz also observed that at Stark, only one policy was publicly

[76] *See* Attachment 5, "Program Service Day Policy" (PoP #376, April 6, 2009). Draft statewide standards were produced in February 2008. *See* DJJ Program Workgroup, "Program Service Day Implementation Plan recommendations," February 20, 2008.
[77] DJJ comments on the draft of this report, June 9, 2009, p. 1.
[78] *See* Attachment 6, "Program Service Day Standards," May 11, 2009 (PoP #402, May 15, 2009).
[79] *See* Attachment 3, "Policy Dashboard: As of 3/11/09;" Attachment 5, "Program Service Day Policy" (PoP #376, April 6, 2009).
[80] Psychopharmacological Treatment Policy (PoP #381, April 7, 2009).
[81] Psychopharmacological treatment consent forms (PoP #239, September 9, 2008); draft psychopharmacological policy training materials (PoP #293, November 18, 2008).
[82] Eric Trupin and Terry Lee, informal report on central office site visit, submitted February 2009, p. 52.
[83] *See* Project Charter: Treatment Confidentiality Policy, January 20, 2009, p. 1.
[84] *See* Attachment 7, project schedule listing, e.g., chartered projects and minor projects, undated (PoP #362, March 12, 2009), p. 2.
[85] DJJ comments on the draft of this report, June 9, 2009, p. 2.
[86] Sixth Report of the Special Master, Appendix B (Beltz report), Attachment 1 (notification to youth memorandum, July 2007).
[87] Site visit notes of Cathleen Beltz, January through June 2008.
[88] Chaderjian site visit notes of Cathleen Beltz, January 2008.

displayed in Spanish.[89] Four of eight interviewed youth at Stark had heard of restorative justice points.[90] None of the eight youth had been informed about how to earn these points.[91] None of these eight youth had learned of the new phone policy from staff on their living unit; one learned of the policy while on another unit, and the other youth had learned from friends or were unaware of the change.[92]

In June 2008, the director of facilities issued a follow-up memorandum to facility superintendents, instructing them to archive "signature pages" signed by youth confirming that they were notified of each new policy.[93] The *Farrell* Compliance Team reportedly examines these binders during its facility audits.[94]

During site visits conducted between October 2008 and March 2009, staff across the state consistently described the process of announcing policy changes in large group meetings of the entire living unit.[95] Time is allowed for questions and answers, and youth sign an attendance log following the meetings.[96] O.H. Close and SYCRCC maintain these signature logs in a central location,[97] while Chaderjian's SBTP and Ventura store the logs on the living units.[98] The logs at Preston were kept in two separate offices, though this was identified and corrected during the monitors' visit.[99] At Stark, the logs were not located during the monitors' visit; an administrator stated that the signature logs were kept on the living units, and living unit staff stated that they were housed in that administrator's office.[100]

Reviewed signature logs reflect that youth are sometimes absent from large group meetings, whether due to work, family visiting, or medical reasons.[101] The logs do not normally indicate that staff later inform the absent youth of the policy change.[102] Interviewed youth indicated that they learn of some policy changes in large group meetings, but some policy and rule changes are not made known until the new rule is broken, or until a peer passes along the new information.[103]

---

[89] Stark site visit notes of Cathleen Beltz, May 2008.
[90] Statements of interviewed youth to former OSM intern Amelia Post during Stark site visit, May 2008.
[91] *Id.*
[92] *Id.*
[93] *See* memorandum of Sandra Youngen to superintendents, June 3, 2008.
[94] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[95] Statements of facility staff during site visits, October 2008 to March 2009.
[96] *Id.*
[97] The monitors reviewed signature logs at these facilities.
[98] Statements of facility administration and living unit staff during Ventura site visit, December 2008. A monitor reviewed signature logs at Chaderjian's SBTP in March 2009.
[99] Statements of Noele Richmond during Preston site visit, February 2009. A monitor reviewed signature logs housed in one staff member's office.
[100] Statements of staff during Stark site visit, January 2009.
[101] Reviewed signature logs during O.H. Close, Chaderjian, and Preston site visits, October 2008, October 2008, and February 2009, respectively.
[102] *Id.*
[103] At O.H. Close, two youth stated that no large group meetings are held and that announcements are made only regarding school schedules and incentive levels of individual youth. At Ventura, various interviewed youth confirmed that they learn of policy changes in large group meetings, and that they are given the opportunity to pose questions about the changes. At Stark, two youth on a mental health unit confirmed that large group meetings include policy announcements. A youth on Stark's SMP said that policy changes are sometimes announced and sometimes made known only through word of mouth. A youth on Stark's "incentive" unit stated that youth

With regard to posted information on living units, the monitors found inconsistent practices similar to those observed by Ms. Beltz. Posted information varies by living unit and is sometimes outdated. As a representative example, four of six dayroom bulletin boards were observed at SYCRCC: three of four units displayed posters regarding the *LH* lawsuit; three of four units posted a notice regarding a change to visiting hours as of 3/21/09; one unit had posted updated information about the grievance process; another unit still had posted grievance information from 2007; all four units posted a flyer informing youth that they are entitled to four phone calls per month; three of four had Youth Bill of Rights posters on the walls, and one of these units displayed additional information regarding SB 518/AB 1300 on its wall.[104]

Very little information is posted in Spanish at any facility. Stark provides another representative example: information on sexual assault was posted in Spanish at all five units observed. Spanish-language posters about heat exhaustion prevention were posted at three units. A poster on employee misconduct was posted in Spanish at one unit. All other information, including information on recent policy changes, was posted only in English.[105]

Interviewed youth were largely aware of the relatively new phone call policy, though implementation of this policy varies by facility, living unit, and assigned staff.[106] Most youth were familiar with new grievance procedures.[107] Many youth interviewed after December 10, 2008 were unaware of changes to the disciplinary decision-making system scheduled for implementation on that date.[108]

Orientation materials vary by facility, and were not always updated to reflect recent policy changes. For example, the orientation materials used at Stark, though reportedly revised in December 2008 and January 2009, did not reflect key changes in the grievance process and disciplinary decision-making system.[109] Central office is creating a state-wide youth orientation

---

primarily learn about policy changes through word of mouth, and another youth on this unit said that youth learn of changes only once they have broken the new rule and face discipline for it. One of the incentive unit youth provided an example of an unannounced policy change: in about November 2008, families came for visits on a Saturday and only learned after they arrived that the policy had changed and they could not visit on that day. At SYCRCC, one interviewee stated that some policy changes are announced and posted but that sometimes youth – and even staff – are not timely informed of changes. For example, he noted that the designated day for restricted visitation was changed without giving youth time to inform their families. He added that the period of time within which a youth could qualify for a different incentive level had been changed from one week to ten days, without prior announcement to youth.

[104] Monitor observations during SYCRCC site visit, March 2009.

[105] Monitor observations during Stark site visit, January 2009.

[106] Youth interviews during site visits, October 2008 to March 2009. The implementation of family contact requirements is monitored by OSM under the Mental Health Remedial Plan. *See* Mental Health Remedial Plan Standards and Criteria, audit item S&W 8.3. Comprehensive reporting on this issue will be included in a future court submission.

[107] Statements of interviewed youth during facility site visits, October 2008 to March 2009.

[108] Statements of one interviewed youth during Preston site visit, February 2009; statements of two interviewed youth during SYCRCC site visit, March 2009; *see also* Attachment 8, memorandum of Sandra Youngen to superintendents, November 25, 2008 (PoP #305, December 5, 2008) (noting implementation of changes to DDMS).

[109] New Ward Orientation: Stark, December 17, 2008; Stark orientation DVD, undated (received January 2009); statements of staff during Stark site visit, January 2009.

packet and is revising the youth rights handbook.[110] Staff at central office have begun creating useful youth handouts regarding new policies, to be distributed to youth in large groups and posted in dayrooms.[111]

Rating: Central office: SC, O.H. Close: PC, Chaderjian: NR, Ventura: SC, Stark: PC, Preston: PC, SYCRCC: PC

2.1.4b: *Clear separation between juvenile and adult training to be established. Separate DJJ training process plan and tracking system in place by June 30, 2008.*

In January 2008, OSM reported that CDCR had made good progress in separating juvenile and adult training.[112] In particular:

- CDCR had removed the provision requiring "consolidated youth and adult training" from its master plan.
- Juvenile and adult training had been moved to separate locations.
- Different trainers were conducting juvenile and adult training.
- The youth system has a number of training courses with no parallel in the adult system. The only overlap consists of a limited number of "core curriculum" classes.
- When CDCR developed curriculum for DJJ, it was done in consultation with DJJ subject matter experts.

Central office staff confirmed that these reforms remained in effect.[113] Currently, the juvenile training academy is dormant because DJJ is not hiring new staff.[114] It is reportedly ready to reopen when necessary.[115]

Juvenile and adult staff receive 56 hours of identical core curriculum at the academy, out of a total of over 600 hours.[116] Most classes concern workplace issues that are common to CDCR and DJJ (e.g., health and safety, CPR/first aid, sexual harassment, and stress).[117] A few core classes concern topics that may present special issues for juvenile correctional staff (child victimization and mandated reporting, domestic violence, and drug awareness).[118]

The goal of separating adult and juvenile training is to ensure that the content of training reflects contemporary standards of juvenile corrections. The safety and welfare plan describes a "clear

[110] Statements of Tammy McGuire during SYCRCC site visit, March 2009. The version of the handbook in use at SYCRCC, for instance, is dated May 2002.
[111] See, for example, Attachment 9, "Program Credits Handout for DJJ Youth," March 2009.
[112] Sixth Report of the Special Master (January 2008), Appendix B (Beltz report), p. 5.
[113] Statements of Vickie Skidmore during central office site visit, March 12, 2009.
[114] *Id.*
[115] *Id.*
[116] Core Curriculum Academy Lesson Plan Status as of 1/30/09; Attachment 10, memorandum of Pamela Shintaku to Sandra Youngen and Bernard Warner, March 10, 2009, p. 12.
[117] *Id.*
[118] *Id.*

separation between juvenile and adult training *content and expectations*" (italics added).[119] The plan"s authors discuss separating juvenile and adult training as part of a larger section about ensuring DJJ"s independence within CDCR.[120] The special master"s office defers to the safety and welfare and mental health care experts as to whether DJJ"s academy training reflects contemporary standards of care and practice for juvenile correctional agencies. The monitors note that curriculum changes are underway and reflect recent changes in DJJ.[121]

As part of creating its own training system, DJJ is required to track training.[122] OSM has received various DJJ training schedules and attendance logs. However, DJJ has not demonstrated that it has an automated system to track which staff need to receive which trainings. Based on the monitors" interviews and observations, training officers at each site track staff training needs in ad hoc and informal ways. OSM has asked DJJ to provide data on the percentage of staff who remain to be trained in each reform-related area, broken down by job classification.[123] Central office staff indicate that data-gathering of this type is in progress.[124]

Rating: Partial compliance

2.1.5: *A minimum of 18 trainers/quality assurance specialists to be filled/assigned by June 30, 2007.*

The 19 program developers on DJJ"s Court Compliance Task Force (described above at item 2.1.3) also act as trainers/quality assurance specialists.[125] As a result, it is difficult to differentiate between the requirement that DJJ assign18 trainers/quality assurance specialists and the requirement that it add 11 professional staff, plus support staff, to compose the teams required by item 2.1.3. The special master"s office monitors for a total of 29 staff dedicated to any of the functions in this item and item 2.1.3: program development and implementation, transition, compliance, and training/quality assurance. Given that the Task Force contains over 40 members (see item 2.1.3, above), DJJ meets this standard.

Rating: Substantial compliance

---

[119] Safety and Welfare Remedial Plan, p. 21.
[120] *Id.*, pp. 12-13. Note especially the statement that "[t]he issue, of course, is to prevent the juvenile authority from being overwhelmed by the adult authority and thereby being transformed into a smaller version of the adult system." *Id.,* p. 12.
[121] *See* Attachment 10, memorandum of Pamela Shintaku to Sandra Youngen and Bernard Warner, March 10, 2009.
[122] Safety and Welfare Remedial Plan Standards and Criteria, item 2.1.4b. The plan requires DJJ to "maintain[] records" of training "for DJJ employee certification and recertification." Safety and Welfare Remedial Plan, p. 21.
[123] *See* e-mail of Aubra Fletcher to Doug Ugarkovich, January 6, 2009; e-mail of special master to Doug Ugarkovich, February 23, 2009.
[124] Statements of Tammy McGuire during SYCRCC site visit, March 2009. In its comments to a draft of this report, DJJ reported that it maintains a training database and has a statewide procedure for tracking staff training; it also reported that the type of training data requested by OSM and various experts is now available. DJJ comments on the draft of this report, June 9, 2009, p. 2. Because statements of staff and provided documents did not reflect any such procedure during this audit round, OSM has assigned a partial compliance rating. The monitors will examine relevant documentation in future audits.
[125] E-mail of Tammy McGuire to Aubra Fletcher, May 4, 2009; document entitled "Program Developers," undated (provided March 12, 2009).

2.2.3: *DJJ to designate staff to act as facility compliance monitors and to develop internal compliance schedule for all operations by July 31, 2007.*

DJJ designated facility compliance monitors as of April 3, 2008,[126] but did not develop an internal compliance schedule until January 8, 2009.[127] In the interim, compliance monitors assisted in auditing compliance with recent legislation regarding youth-family contact, which overlapped with monitoring of remedial plan item 8.3. [128] The audit contributed to a report by CDCR"s Office of Audits and Compliance (OAC).[129] Facility compliance monitors participated in other OAC audits during 2008, as well.[130]

The 2009 internal compliance schedule issued to facility monitors lists six assessments for the calendar year:

- A follow-up youth-family contact audit in February.
- An audit of compliance with DJJ casework policy in April.
- A grievance policy compliance audit in June.
- A youth sexual misconduct audit in August.
- A SPAR policy compliance audit in October.
- An audit of compliance with DJJ safety and security policy in November.[131]

One of these audits is a follow-up audit, and two (youth sexual misconduct and safety and security) are not directly related to *Farrell* reforms. The remaining four are not sufficient to provide a meaningful review of facility compliance efforts. Though DJJ has created an audit schedule for facility compliance monitors, a partial compliance rating is assigned due to the relative lack of scheduled *Farrell*-related self-audits.

Rating: Partial compliance (all facilities)

2.2.5: *DJJ facilities to rewrite local directives and procedures as new policies are adopted, on an ongoing basis.*

In its November 21, 2008 filing, DJJ indicated that compliance with this requirement is in progress and that it does not expect to attain substantial compliance by the end of the 2008-2009 fiscal year.[132] Central office has not provided guidance to facilities regarding promulgation of

[126] *See* memorandum of Sandra Youngen to Bob Moore, April 3, 2008. Some of the original staff designations have changed, though all facilities had compliance monitors at the time of the OSM site visits.
[127] *See* Attachment 11, memorandum of Sandra Youngen to superintendents, January 8, 2009.
[128] *See* Attachment 12, memorandum of Sandra Youngen to facility staff, June 3, 2008; statements of facility compliance monitors at each facility site visit, October 2008-March 2009.
[129] *See* OAC reports on compliance with SB 518, AB 1300 and Safety and Welfare Plan item 8.3 at various facilities (PoPs# 158-164, June 30, 2008); executive summary of OAC report (PoP #221, August 21, 2008).
[130] Statements of facility compliance monitor during Stark site visit, January 2009; statements of facility compliance monitor during Preston site visit, February 2009.
[131] *See* Attachment 11, memorandum of Sandra Youngen to superintendents, January 8, 2009.
[132] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 1.

and access to local procedures.[133] During site visits, OSM found varying practices across the state.

At all sites at which the item was monitored, superintendents issue directives to staff regarding site-specific procedures.[134] For example, by way of memo, the superintendent at O.H. Close has instructed parole agents to provide parents with certain information upon a youth"s arrival at a living unit.[135] This memo also requires YCCs to contact youths" families following every case conference and directs YCCs and conflict resolution staff to meet with parents during visiting hours. This practice is unique to O.H. Close and is based on the Family Justice pilot.[136]

Preston and Ventura demonstrated an organized effort to rewrite local procedures as new policies are adopted.[137] Both maintain an electronic version of their facility"s operations manual on the facility"s intranet. The manual can therefore be updated easily and is accessible to all staff. A designated staff person is responsible for updating the manual. Staff were able to name recent revisions to the manual.[138] Staff at Preston noted that comprehensive updates are supposed to occur every three years, but are not occurring. A variety of memos and staff instructions have been issued at Preston but have apparently not been included in the operations manual.

Stark and SYCRCC are still developing systems to rewrite local procedures as new policies are adopted. Stark"s operations manual was last updated approximately six or seven years ago.[139] In January 2009, staff were reformatting the manual for user accessibility. Substantive manual updates were planned to be complete by May 2009. A staff person will be assigned to keep the manual updated in the future, and to maintain a current version of the document on the facility"s server. In the meantime, the superintendent issues local policy memos as needed, which are not stored in a centrally accessible location. These memos will be included in the facility operations manual as it is updated.

No staff person is assigned to updating the local operations manual at SYCRCC.[140] The current version is at least two years old. "Read and initial boards" are reportedly maintained on each living unit, where staff acknowledge that they have received and read directives from the superintendent. SYCRCC stores copies of the directives in the superintendent"s office.

---

[133] In its comments on a draft of this report, DJJ noted that central office has instructed each facility to "designate a point person to ensure that local directives and procedures are rewritten as new policies are adopted," and that each facility has designated a point person. DJJ comments on the draft of this report, June 9, 2009, pp. 2-3. This appears to be the extent to which central office has thus far ensured that local directives are written and accessible to facility staff.

[134] OSM did not monitor this item at Chaderjian during this round.

[135] Statements of superintendent during O.H. Close site visit, October 2008.

[136] The Family Justice pilot is related to Mental Health Remedial Plan requirements.

[137] This paragraph is based on statements of staff, particularly Ventura"s superintendent and assistant superintendent and Preston"s assistant superintendent, during site visits in December 2008 and February 2009.

[138] At Ventura, staff mentioned the introduction of the new program service day. At Preston, staff mentioned an updates in response to new legislation regarding youth-family contact and the Youth Bill of Rights, as well as the pilot BTP program.

[139] All material about Stark in this paragraph is based on statements of a program administrator during the Stark site visit in January 2009 and on DJJ"s comments to the monitors" informal Stark report, provided on April 24, 2009.

[140] All material about SYCRCC in this paragraph is based on statements of interviewed staff during OSM"s SYCRCC site visit in March 2009.

Rating: Central office: BC, O.H. Close: SC, Chaderjian: NR, Ventura: SC, Stark: PC, Preston: SC, SYCRCC: PC

2.2.6: *DJJ to update and approve job descriptions by January 31, 2007.*

The Safety and Welfare Remedial Plan requires that DJJ update job descriptions "for all living unit and management staff at the treatment team leader [level] and above, incorporating duty requirements and performance measures consistent with agency policy."[141]

In January 2008, OSM reported that DJJ had not produced updated job descriptions for staff at the TTS level and above.[142] In its November 21, 2008 filing, DJJ indicated that compliance with this requirement is in progress and that it does not expect to attain substantial compliance by the end of fiscal year 2008-2009.[143] DJJ staff reported that job descriptions would be updated once DJJ‟s treatment model was more clearly defined.[144] In March 2009, DJJ staff indicated that a project charter was being developed for the job description project,[145] though this project charter was not listed in DJJ‟s March 12, 2009 response to an OSM formal request for a list of current and planned project charters.[146] When complete, the charter will describe this project‟s dependencies on other tasks, including progress on the IBTM.[147]

Rating: Beginning compliance

2.2.7: *DJJ to produce annual reports that accurately reflect the status of reform and the state of DJJ. The first annual report is to be produced by August 30, 2007.*

In November 2008, DJJ indicated to the Court that it has not begun efforts to comply with this requirement and does not expect to achieve substantial compliance this fiscal year.[148] At his January 2009 meeting with central office staff, Dr. Krisberg stated that annual reports would be redundant at this stage, since it is unclear how they would differ from the quarterly reports DJJ currently produces.[149] DJJ subsequently proposed the modification of this requirement.[150]

Rating: Not rated

2.3.1: *DJJ to complete the "WIN Exchange" that will store important information about DJJ youth to a single server and allow DJJ facilities to share this information as youth transfer*

[141] Safety and Welfare Remedial Plan, p. 21.
[142] Sixth Report of the Special Master (January 2008), Appendix A (Beltz report), p. 6.
[143] Deft. Response to the Court‟s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 1.
[144] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[145] *Id.*
[146] PoP #362, March 12, 2009 ("Information Pertaining to Question 2").
[147] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[148] Deft. Response to the Court‟s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 1.
[149] Statements of Barry Krisberg during central office site visit, January 15, 2009.
[150] E-mail of Rachel Stern to special master, parties, and experts, April 24, 2009.

between them, by January 1, 2007.

The WIN Exchange is in use. Development of the system was completed on April 1, 2008.[151] Programmers then uploaded records to the system, combined records to avoid redundant data, and tested the system"s functions.[152] Two-way communication with DJJ facilities was activated on June 26, 2008.[153] DJJ staff can now use the server to store information about youth and to share this information as youth transfer between facilities. Senior programmer Robert Eden reported in July 2008 that the server was generally performing well.[154] At the March 2009 central office audit, staff reported no problems with the exchange of data between facilities.[155] During various site visits, staff produced records for OSM monitors from WIN on a regular basis, with minimal glitches.

Many data-reporting functions remain to be developed, some of which are in progress.[156] Modifications to WIN currently in progress include: adding the capability to track program credits contracts for particular youth, modifying the JJAC form to track time-adds in more detail (e.g., by distinguishing between program time adds and WIC-1800 cases), modifying the case conference screen tab, expanding religious services tracking, and automating mental health data.[157]

This is a one-time compliance item.

Rating: Substantial compliance (completed)

2.3.3a: *DJJ to contract for Performance-based Standards (PbS) in place by September 1, 2006.* ***2.3.3b:*** *DJJ to fill or assign a state-wide PbS coordinator position by November 1, 2006.* ***2.3.3c:*** *DJJ to fill/assign PbS site coordinators at each facility by November 1, 2006.*

2.3.3a: The PbS contract was approved by DGS in October 2006.[158] This is a one-time compliance item.

Rating: Substantial compliance (completed)

[151] DJJ Quarterly Report (July 21, 2008), p. 98.
[152] *Id.*
[153] E-mail of Bob Eden to special master, July 28, 2008.
[154] *Id*.
[155] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[156] Statements of Tammy McGuire during SYCRCC site visit, March 2009; e-mail of Tammy McGuire to Aubra Fletcher, April 1, 2009. The Mental Health Remedial Plan requires DJJ to develop certain automated data gathering and reporting capabilities, which it has not yet done. Statements of Dr. Juan Carlos Arguello during central office site visit (mental health), February 18, 2009. This will be discussed more fully in forthcoming mental health reports. The Sexual Behavior Treatment Program Remedial Plan also requires certain data storage and reporting functions, and DJJ has developed an impressive database and data reporting program, though it is not yet implemented. Presentation of Ed Chance during central office site visit (SBTP), January 30, 2009; statements of Dr. Barbara Schwartz during central office site visit (SBTP), January 30, 2009; statements of central office staff during central office site visit (SBTP), June 8, 2009.
[157] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[158] DJJ contract with PbS (PoP #1, March 13, 2007).

2.3.3b: Sue Easterwood is the state-wide PbS Coordinator. She has held the position since October 2006.[159]

Rating: Substantial compliance

2.3.3c: All facilities filled or assigned the PbS coordinator position.[160] See also items 3.5 and 3.6a, below, regarding PbS reporting practices.

Rating: Substantial compliance (all facilities)

2.4.1-5, 2.4.7-8: *DJJ must ensure that each facility has a* ***(1)*** *program manager(s) responsible for high risk, low risk and re-entry programs, as needed;* ***(2)*** *volunteer services/positive incentives coordinator (duplicate of item 6.4b);* ***(3)*** *vocational specialist;* ***(4)*** *victim services/restitution specialist;* ***(5)*** *training officer;* ***(7)*** *work assignment coordinator and* ***(8)*** *facility administrators for operations programs and business services.* ***6.3 and 6.4a, c:*** *Prior to the conversion of facilities to a rehabilitative model, DJJ must hire or assign* ***(a)*** *facility administrators of programs and program managers and* ***(c)*** *conflict resolution teams (where appropriate). Deadlines vary by facility and position. All facilities' deadlines have passed.*

These audit items require certain administrative and management positions at facilities in a generic way. The position titles need not align precisely with existing positions.

2.4.1: DJJ informed the Court in November 2008 that efforts to comply with this requirement are in progress and that it did not anticipate achieving substantial compliance by the end of this fiscal year.[161] During site visits, OSM found varying practices across the state.[162]

- O. H. Close: As of October 2008, the facility had one program manager and a program administrator vacancy in all MH programs at OHC.[163] Since that time, the facility has gained a program administrator for its SBTP.[164]

- Chaderjian: The facility"s two program administrators divide their spheres functionally, not by risk level. There is a re-entry services program administrator, but no duties have been assigned to that position.

- Ventura: The acting assistant superintendent serves as mental health program administrator until the superintendent can locate a suitable replacement.

[159] Memorandum re appointment of Sue Easterwood as PbS coordinator (PoP #2, March 13, 2007); statements of Sue Easterwood during central office site visit, March 12, 2009.
[160] Statements of facility PbS coordinators during site visits, October 2008 to March 2009.
[161] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 1.
[162] Information in this section is based on staff interviews during facility site visits, October 2008 to March 2009.
[163] Statements of staff during O.H. Close site visit, October 2008.
[164] Statements of staff during O.H. Close site visit (SBTP), March 10, 2009.

- Stark: The facility has program administrators in charge of various risk levels. One program administrator oversees the *Morrissey* and parole detainee programs. He is also the facility compliance monitor. Another program administrator oversees the high-risk programs. He also serves as the facility"s *Farrell* training coordinator. A third program administrator oversees the low- and medium-risk programs, including the substance abuse treatment program. And an acting program administrator is in charge of mental health programs.

- Preston: The superintendent"s office oversees the behavior treatment program units and one low-risk unit (Manzanita). The parole agent III oversees the intake unit. A program administrator oversees all other living units.

- SYCRCC: Two treatment team supervisors (TTS) jointly oversee the intake units. One of the two also oversees the core programs. A program administrator oversees the intensive treatment program, and another program administrator oversees the SBTP. In addition, two supervising case work specialists separately oversee each residential mental health unit (ITP and SBTP).

  Rating: Defer to expert (all facilities)

2.4.2: All facilities have hired volunteer services/positive incentives coordinators.[165] Documentation provided by these coordinators indicates that all facilities provide special events for A level youth.[166] Common activities include movie nights (O.H. Close, Stark) sports events (O.H. Close, Preston), and arts and crafts projects (O.H. Close, Stark).[167] Ventura also hosts a co-ed dinner night and a slumber party for A level females.[168] At SYCRCC the superintendent and staff take A-clearance youth off grounds for activities at least once a month. Destinations include restaurant dinners, a local golf course, and Wal-Mart.[169] This provides staff and youth the opportunity to interact socially together, and exposes youth to normalizing young adult activities that simultaneously enhance their pro-social skills.

Three facilities (O.H. Close, SYCRCC and Ventura) have created "incentive dayrooms."[170] The incentive dayrooms are generally open only to A level youth[171] and contain games and other activities. O.H. Close"s incentive dayroom stands out because of its comfortable environment, youth involvement, and gaming equipment.[172] Youth have helped to paint the walls with murals,

[165] Staff interviews during facility site visits, October 2008 to March 2009.
[166] The monitors reviewed the following documentation during or after site visits: file documenting incentive events at Chaderjian; list of A Level programs held between June 2006 and October 2008 at O.H. Close; list of incentive events at Preston, August 2008 to January 2009; Stark Youth Incentive Activity Report, December 2008; SYCRCC Incentive Activity Reports, December 2008 to February 2009.
[167] *Id.*
[168] Statements of incentive coordinator during Ventura site visit, February 2009.
[169] Statements of facility compliance monitor during SYCRCC site visit, March 2009.
[170] Observations during facility site visits, October 2008 to March 2009.
[171] At O.H. Close, B Level youth occasionally visit the incentive dayroom in order to see the benefits of achieving A-Level status. The superintendent is also contemplating one-hour visits for C Level youth who have two weeks of "good days." Statements of incentive coordinator and superintendent during O.H. Close site visit, October 2008.
[172] Observations during O.H. Close site visit, October 2008.

and decorate seasonally.[173] The dayroom was equipped with Wii video game consoles and multiple sofas and pillows.[174] Chaderjian plans to open an incentive dayroom modeled on what O.H. Close has achieved.[175]

There is some variation in other aspects of the incentive program. Some facilities provide incentive activities to B or C level youth, while others do not. For instance, SYCRCC opens sports tournaments and holiday parties to all levels.[176] Ventura, by contrast, has no special events open to youth below A level.[177] At Stark, the most common incentive activity is extra dayroom time at night.[178] Staff are instructed to provide this extra time based on a youth‟s behavior that day, rather than his formal incentive level.[179] Currently, youth in Preston‟s temporary behavior treatment program units are not permitted to participate in the incentive program.[180] They receive C Level privileges, regardless of their behavior.

Interviewed youth were generally aware of the incentives system and spoke positively of it. For example, nine youth at Stark were interviewed about incentives and were generally aware of the incentive program, their own current incentive level, and some of the differences in privileges for each level.[181] Seven of eight youth interviewed at SYCRCC characterized incentives as a motivator.[182]

Rating: Substantial compliance (all facilities)

2.4.3: No facilities have hired vocational specialists.[183] Central office staff described three bureaucratic barriers to filling the positions.[184]

- For budgeting purposes, the state considers DJJ education services and *Farrell* reforms separate programs. The state allocated money to hire vocational specialists to *Farrell* reforms, not education.

- The state budget characterized the positions as teachers, not vocational specialists. It therefore allocated the wrong amount of money for the positions.

- DJJ is facing a hiring freeze, and any new hires require a special exemption from the Department of Finance.

---

[173] *Id.*
[174] *Id.*
[175] Statements of Yvette Marc-Aurele to Aubra Fletcher during O.H. Close site visit (SBTP), March 2009.
[176] SYCRCC Incentive Activity Reports, December 2008 to February 2009.
[177] Statements of incentive coordinator during Ventura site visit, February 2009.
[178] Stark Youth Incentive Activity Report, December 2008.
[179] Statements of incentive coordinator during Stark site visit, January 2009; *see also* Attachment 13, Youth Incentive "Pyramid," March 3, 2009.
[180] Statements of superintendent and of interviewed youth during Preston site visit, February 2009.
[181] Statements of interviewed youth during Stark site visit, January 2009.
[182] Statements of interviewed youth during SYCRCC site visit, March 2009.
[183] *Id.*
[184] Statements of Rob Uno during central office site visit, March 12, 2009.

CDCR has resolved the first issue. In February 2008, the education business services manager, Rob Uno, learned about the funds budgeted to hire vocational specialists. He initially believed that it would require a budget revision to move the money. In late 2008, CDCR's Operational Support Division reallocated the funding to education.

DJJ has taken action to resolve the remaining two issues. Mr. Uno submitted requests to reclassify the positions and exempt them from the hiring freeze. Both requests are making their way through the Department of Finance. If the department does not process the requests by the end of the fiscal year, funding for the positions will not automatically roll over to the next year.

All facilities are in "beginning compliance," despite the lack of vocational specialist positions, due to the coverage of some vocational specialist duties by other staff.

Rating: Beginning compliance (all facilities)

2.4.4: Central office has created a victim services specialist position at Chaderjian, O.H. Close, Preston, and Ventura.[185] During her 2008 site visits, Cathleen Beltz found that Chaderjian was in the hiring process, and O.H. Close had filled the position.[186] As of December 2008, Ventura's parole agent III was acting in the position, and facility leadership expected to conduct interviews for the position in January 2009.[187] Preston's previous victim service/restitution specialist has been promoted to supervising case work specialist in charge of intake.[188] As of February 2009, the facility had contacted applicants to interview for the vacancy.

Central office has not officially allocated victim services specialists to SYCRCC or Stark. At SYCRCC, a retired annuitant in the parole agent III's office coordinates victim services and restitution payments/tracking.[189] At Stark, the parole agent III stated that there is a process for notifying victims of hearings and for tracking youth who owe restitution.[190]

The victim services specialist position is important to DJJ but not to the experts. In the future, OSM will defer to DJJ's self-monitoring on this issue.

Ratings: O.H. Close: SC, Chaderjian: SC, Ventura: BC, Stark: NC, Preston: BC, SYCRCC: SC

2.4.5: All facilities have full-time training officers.[191] As of the monitors' October 2008 audit at O.H. Close, the position was a secondary assignment for a TTS, with no designated clerical support.[192] O.H. Close's superintendent was attempting to reclassify the position as a lieutenant

[185] Statements of staff during facility site visits by Cathleen Beltz, Aubra Fletcher, and Zack Schwartz, 2008-2009.
[186] Statements of staff during facility site visits, 2008.
[187] Statements of staff during Ventura site visit, December 2008.
[188] Statements of staff during Preston site visit, February 2009.
[189] Statements of staff during SYCRCC site visit, March 2009.
[190] Statements of parole agent III during Stark site visit, January 2009.
[191] Statements of staff during facility site visits, October 2008 to March 2009; DJJ comments on the draft of this report, June 9, 2009, p. 3.
[192] Statements of staff during O.H. Close site visit, October 2008.

(as it is at some other facilities) because of the directive role the officer must assume with other staff.[193] DJJ reports that as of January 2009, O.H. Close had a full-time training officer.[194]

Rating: Substantial compliance (all facilities)

2.4.7: O.H. Close, Stark, SYCRCC, and Ventura have work assignment coordinators.[195] The item was not monitored at Chaderjian. Preston has no work assignment coordinator. Although the facility provides opportunities to work, interviewed staff indicated that a coordinator would make it easier for youth to find facility jobs. As it is, staff and youth learn about vacancies by word of mouth, and job applications have been lost in the past. There is no central location or youth to contact in order to learn about available facility job positions.

Rating: O.H. Close: SC, Chaderjian: NR, Ventura: SC, Stark: SC, Preston: NC, SYCRCC: SC

2.4.8: It remains unclear how the facility administrator for operations and business services function will be defined under the IBTM. Facilities currently staff this area differently.[196] Some facilities (SYCRCC, Ventura) assign the business manager responsibility for operations. Preston assigns some responsibility for operations to staff responsible for programs. We defer to the safety and welfare expert regarding this item.

Rating: Defer to expert (all facilities)

6.3 & 6.4a: The safety and welfare plan contemplates that facilities will have a single administrator of programs, reporting directly to the superintendent.[197] This is offered as an example of effective facility organization rather than a clear-cut requirement.[198] The staff member currently resembling this role is the assistant or deputy superintendent.[199] At some facilities (SYCRCC, Preston) it appears that the duties that would be assigned to the facility administrator of programs are split among staff members responsible for various risk levels. The monitors decline to assign ratings and defer to the expert.

Rating: Defer to expert (all facilities)

---

[193] *Id.*
[194] DJJ comments on the draft of this report, June 9, 2009, p. 3.
[195] Statements of staff during O.H. Close, Ventura, Stark, Preston, and SYCRCC site visits, October 2008, December 2008, January 2009, February 2009, and March 2009, respectively.
[196] Statements of staff during facility site visits, October 2008 to March 2009.
[197] Safety and Welfare Remedial Plan, p. 14 ("The following description is presented as an *example* of facility organization that conforms to the principles and concepts outlined above … DJJ facilities are organized into three component parts: operations, programs, and business service functions. Each functional area is administratively managed by a facility administrator who reports to the Superintendent.") (emphasis added).
[198] *Ibid.*
[199] Statements of staff during facility site visits, October 2008 to March 2009, particularly at Stark and Ventura.

6.4c: All facilities except SYCRCC have conflict resolution teams (CRTs).[200] CRTs consist of a combination of YCCs and parole agents, and vary in size from two to eight members.[201] Team members have been prioritized for training in motivational interviewing, safe crisis management, and conflict resolution.[202] Youth interviews at Stark,[203] Preston,[204] and O.H. Close[205] suggest that the CRTs are skillful, constructively engaged with youth, and effective in addressing conflict and violence. They played a pivotal role at Stark in the second half of 2008 to increase safety for youth and staff and lessen the influence of racial/gang "politics" and violence. As a result, youth are no longer excluded from vocational classes based solely on their race.[206]

The duties of CRT members appear to vary at different facilities. Notably, the Stark team intervenes in staff-youth and youth-youth conflicts, while the Preston team focuses on conflicts among youth.[207] The CRT duty statements drafted by central office encompass both functions: while the duty statements explicitly instruct the team to intervene in conflicts among youth, they also state that the team should "provide mentoring and modeling of desired conflict resolution skills" to staff.[208] This "mentoring and modeling" might include resolving conflicts between staff and youth.

---

[200] Statements of staff during facility site visits, October 2008 to March 2009; *see also* Fifth Report of the Special Master, Appendix B (Beltz report), pp. 10-11 and Attachments 4 and 5 (program statement and duty statements).

[201] *Id.* Team compositions are as follows: O.H. Close: two YCCs, two parole agents; Preston: four YCCs, four parole agents; Stark: two parole agents, four YCCs; Ventura: two YCCs.

[202] *Id.* For instance, all six CRT members at Stark have attended trainings in motivational interviewing, safe crisis management, and conflict resolution. Five of the seven CRT members at Preston are trained in safe crisis management, and six of seven are trained in motivational interviewing. Both members of Ventura"s CRT are certified conflict resolution trainers.

[203] Of eight youth interviewed at Stark in May 2008, six had heard of the conflict resolution team. Six knew of the team but had received no explanation of the team"s purpose or function. Five stated that because team members are staff, they did not trust them and feared consequences from other staff if they contacted the team. Of five youth asked about the CRT in January 2009, three were familiar with the team.

[204] Of five youth interviewed at Preston in February 2009, three said the CRT had prevented fights by arranging for youth to meet and discuss their conflicts. Two said that CRT members frequently spend time on living units. One youth said the CRT had never contacted him, even after fights.

[205] During a site visit to O.H. Close in October 2008, three youth were asked about the CRTs" effectiveness. Two youth indicated that the CRTs are sometimes effective but sometimes escalate matters; these youth were of the opinion that there are limits on what CRT members – as DJJ staff – can realistically achieve. In particular, they noted, CRT members" efforts address short-term problems but not underlying long-term conflicts. Another youth referred to the CRT members as problem-solvers and said that fewer "things happen" when CRT members are involved.

[206] Statements of staff during Stark site visit (mental health, education), April 29-30, 2009. The special master was shocked to find that youth racial "politics" resulted in the exclusion of African American youth from trades classes in 2005. First Report of the Special Master (March 2005), p. 21. This was still true in July 2008, but no longer in April 2009.

[207] Statements of staff during facility site visits, October 2008 to March 2009; e-mail of Elverta Mock to the special master, May 6, 2009. Staff at Preston have also found the CRT to be a good resource for preventing conflicts among youth. Statements of Elaine Stenoski during Preston site visit, February 2009. Ms. Stenoski described an incident in which staff wanted to move a youth to a new unit, but had safety concerns because of the youth"s status as a sex offender and possible gang issues. A TTS consulted the CRT about the youth"s history with other youth on the unit and received a detailed answer regarding the safety of the new unit for the youth.

[208] Fifth Report of the Special Master, Appendix B (Beltz report), Attachment 5 (duty statements).

SYCRCC lacks a conflict resolution team because it has traditionally focused on intake, rather than long-term commitments.[209] As the facility has opened several non-intake units, four staff members have been identified as potential CRT members.[210] These staff have other assignments, but are available to assist with conflict resolution if called upon.[211]

Rating: Defer to expert (all facilities)

3.3b: *DJJ to create violence reduction committees to review and evaluate incidents of violence quarterly and to develop plans to reduce violence and use of force, by January 1, 2007. (This item is also monitored by the safety and welfare expert.)*

All DJJ facilities have violence reduction committees (VRCs), which generally meet once a month.[212] All VRCs include a cross-section of management and living unit staff.[213] SYCRCC and O.H. Close also include representatives from other program areas, including mental health.[214] VRCs at three facilities (Chaderjian, O.H. Close, and Preston) include youth representatives.[215] Central office does not currently require VRCs to include youth.[216]

All VRCs review violence trend data, but most use it only minimally to inform decisions.[217] For example, only one facility (O.H. Close) uses quantitative data to set violence reduction goals and monitor progress.[218] During a VRC meeting observed at Ventura, the discussion of trend data was limited to stating the number of incidents in the past and current month, then noting if the numbers had increased or decreased.[219]

Staff and youth have identified a wide range of issues that contribute to violence. Examples include the influx of gang-entrenched youth from closed facilities (Preston), lack of activities on the living units (Chaderjian), moving youth from open dorms to closed cells (O.H. Close), and

[209] Statements of David Patterson and Tammy McGuire during SYCRCC site visit, March 2009.
[210] *Id.*
[211] *Id.*
[212] Statements of staff during facility site visits, October 2008 to March 2009. Preston"s VRC cancelled an unusual number of meetings in the last six months of 2008. Preston VRC minutes, November 2008 and January 2009.
[213] VRC minutes collected during facility site visits, October 2008 to March 2009.
[214] *Id.*
[215] Statements of staff during facility site visits, October 2008 to March 2009. O.H. Close excelled in taking detailed input from youth during meetings. *Id.*
[216] The committee chair at SYCRCC spoke to DJJ"s chief of security, who told him that the VRC was not required to include youth. SYCRCC has chosen not to put youth on its VRC due to concerns that the meetings will reveal confidential information. Statements of staff during SYCRCC site visit, March 17-18, 2008.
[217] VRC minutes collected during facility site visits, October 2008 to March 2009; Barry Krisberg, informal report on Chaderjian site visit, April 2-4, 2008; monitor"s observations of VRC meeting during Ventura site visit (December 2008).
[218] VRC minutes collected during O.H. Close site visit, October 2008. At O.H. Close, violence reduction goals are expressed as a percentage reduction in violence or other behaviors. Goals vary by living unit. E.g., one living unit had the goal of reducing physical altercations by 25%, while another had the goal of reducing inappropriate sexual behavior by 50%. *Id.*
[219] Monitor"s observations of VRC meeting during Ventura site visit (December 2008).

social dynamics such as "pressuring" and "disrespect" (O.H. Close).[220] Facilities have responded in various ways. For example, Preston requires living units to hold violence-reduction meetings between staff and youth.[221] Following a group disturbance, SYCRCC planned to introduce additional incentives for youth that avoid fighting for two weeks.[222] Other strategies that have been discussed include extra sports activities (SYCRCC, O.H. Close), dispersing gang members among living units and removing instigators from low-risk units (Preston), improving school movement to reduce fighting (Preston), and instituting additional searches for contraband (SYCRCC).[223]

Central office guidance to the VRCs has focused on reporting practices. (Committee members previously requested help in preparing quarterly reports and violence reduction plans.[224] In January 2008, most facilities were represented in a discussion of best reporting practices.[225]) VRCs have now had more than a year to experiment with different methods for reducing violence. Facilities might benefit from guidance based on a review of these strategies.

Rating: Defer to expert (all facilities)

S&W 3.4a: *DJJ to qualify 18 staff as crisis management trainers by July 1, 2007.* ***S&W 3.4b:*** *DJJ to provide crisis management training for direct care staff at Stark and Preston by November 1, 2007.* ***S&W 3.4c****: DJJ to train staff at all remaining facilities in crisis management by July 1, 2008. The latter two items are also monitored by the Safety and Welfare expert.*

3.4a: OSM previously reported that DJJ had qualified 22 staff as crisis management trainers, and trained 217 additional staff from across all facilities.[226] As of March 2009, DJJ has 24 staff qualified in crisis management training.[227]

Rating: Substantial compliance

3.4b: At Stark, most line staff have not received the JKM Safe Crisis Management training, as depicted below.[228]

Position	Total #	Trained	% Trained
Lieutenant	10	2	20%
Sergeant	17	2	12%

[220] VRC minutes collected during facility site visits, October 2008 to March 2009; Barry Krisberg, informal report on Chaderjian site visit, April 2-4, 2008.
[221] Minutes of seven Preston living units' most recent violence reduction meetings, January 2009. Stark has plans to require similar meetings. Stark Violence Reduction Plan, June 2008.
[222] Statements of staff during SYCRCC site visit, March, 2009.
[223] VRC minutes collected during facility site visits, October 2008 to March 2009.
[224] Fifth Report of the Special Master, Appendix B (Beltz report), p. 4.
[225] Attachment 14, memorandum from Jeff Plunkett, Major, Division of Juvenile Facilities, February 4, 2008.
[226] Sixth Report of the Special Master (January 2008), Appendix B (Beltz report), p. 9.
[227] Statements of Tammy McGuire and Jay Aguas during central office site visit, March 12, 2009.
[228] *See* training attendance report as of January 15, 2009: JKM Safe Crisis Management (PoP #354, February 23, 2009); Stark position listing, December 1, 2008.

SYCC	22	12	55%
YCC	190	35	18%
YCO	178	8	5%

In addition to the staff noted above, the following individuals have been trained in safe crisis management: the chief psychologist, 2 program administrators, 5 treatment team supervisors, 1 health and safety officer, 2 supervising casework specialists, 7 casework specialists, 6 parole agents, 4 psych techs, 1 clinical psychologist, 2 staff psychologists, and 2 supervising RNs.[229]

Preston"s administrators have been trained in safe crisis management, but many line staff and teachers have not been. The superintendent, assistant superintendent, principal, chief medical officer and chief dentist have been trained in crisis management, as have all program administrators and TTSs.[230] Forty-two percent of YCCs have been trained, which represents impressive progress.[231] Only 4 of 42 teachers and 7 of 67 YCOs (see below) have been trained.[232]

Position	Total #	Trained	% Trained
Casework Specialist	6	4	67%
PA I	8	7	88%
Sergeant	8	2	25%
SYCC	9	4	44%
YCC	86	36	42%
YCO	67	7	10%

Ratings: PC (both facilities)

3.4c: A January 2008 memorandum from Chief Deputy Secretary Bernard Warner states that DJJ will "prioritize [crisis management training] for staff who work with youth who are assessed as High Risk for institutional violence."[233] High priority trainees include staff assigned to DJJ conflict resolution teams, youth correctional counselors, and senior youth correctional counselors from high risk living units, as well as mental health and education staff.[234]

DJJ has made progress in training staff in crisis management, but has not trained all direct care staff. New trainees are distributed across all facilities.[235] DJJ regularly provides attendance lists indicating that training is taking place. OSM and the experts have requested that DJJ provide this data in the form of percentages of staff trained, broken down by job classification and facility.

[229] *See* training attendance report as of January 15, 2009: JKM Safe Crisis Management (PoP #354, February 23, 2009).
[230] *Id.*
[231] *See id.*; Preston staff roster February 10, 2009.
[232] *See* training attendance report as of January 15, 2009: JKM Safe Crisis Management (PoP #354, February 23, 2009); Preston staff roster February 10, 2009.
[233] Memorandum of Bernard Warner (PoP #140, May 21, 2008).
[234] Statements of staff during central office site visit, May 2008.
[235] DJJ provided the OSM with training attendance lists. The lists are not attached due to their length.

Ratings: Partial compliance (all four facilities)

3.5: *By January 1, 2007, DJJ to develop and use a database to track all incidences of violence and use of force. This item is also monitored by the Safety and Welfare expert.* ***3.6a:*** *DJJ to implement a system to record the data elements collected for PbS Safety Outcome Measures 2, 3, 4, 11, and 12 for every day of the year by November 1, 2006. Safety Outcome Measure 2 refers to injuries to youths per 100 person-days. Measure 3 refers to injuries to staff per 100 staff-days. Measure 4 refers to injuries to youths by other youths per 100 person-days. Measure 11 refers to assaults on youth per 100 person-days. Measure 12 refers to assaults on staff per 100 person-days. This item is also monitored by the safety and welfare expert.* ***3.6b:*** *By April 1, 2007, DJJ to produce quarterly reports on selected PbS data elements.*

DJJ"s Quarterly Statistical Report (QSR), formerly known as CompStat, includes figures on the number of use of force incidents each month and the safety outcomes described in item 3.6a.[236] Separate staff are responsible for gathering use of force and safety outcome measure data. To gauge the reliability of the data, a monitor interviewed PbS coordinators at all facilities except Ventura, as well as the staff who gather use of force data at Preston and SYCRCC.[237]

The data in QSR is based on records made soon after events, by staff with direct knowledge of what happened. These records include:

- Use of force (UOF) reports. UOF reports contain narrative descriptions of use of force incidents, and are primarily used to review staff compliance with policy.[238] Staff must write UOF reports any time they use force or witness its use.[239] Staff must complete the report before leaving work on the day of the incident.[240]

- Behavior reports. Behavior reports contain narrative descriptions of youth misconduct, and are primarily used in the disciplinary (DDMS) process. Staff must write behavior reports any time they observe or become aware of behavior that seems to warrant Level 2 or Level 3 DDMS charges against a youth.[241] Staff are also required to write behavior reports any time they use force against a youth, presumably because force may only be used in response to some form of youth misconduct.[242] Staff must complete behavior

[236] *See* Attachment 15, sample QSR pages. CompStat is a report format used by CDCR"s adult division. DJJ adapted CompStat to its own needs by eliminating some data items. This prompted the name change. Statements of Sue Easterwood during central office site visit, March 12, 2009.
[237] Unless otherwise noted, information in this section is drawn from those interviews.
[238] Crisis Prevention and Management Policy (PoP #388, April 20, 2009), pp. 36-39, 55-56.
[239] *Id.*, pp. 36-39. The policy"s definition of a "use of force incident" is circular ("a use of force incident involves the use of force by any DJJ employee …"). *Id.*, p. 8. The policy states that permissible means of using force "include[] but are not limited to" authoritative warnings and commands, chemical restraints, firearms, less-lethal weapons (e.g. rubber sticks, gas grenades), mechanical restraints, and physical strengths and holds." *Id.*, pp. 8, 49-51. In addition, the policy forbids certain means of using force, such as choke-holds. *Id.*, p. 21.
[240] *Id.*, p. 36.
[241] Disciplinary Decision Making System Procedures (PoP #392, April 27, 2009), pp. 4, 6.
[242] Crisis Prevention and Management Policy (PoP #388, April 20, 2009), p. 55.

reports before leaving work on the day of the incident, or within 24 hours of learning about past misconduct.[243]

- DDMS records. DDMS records state the disciplinary charge against a youth and its disposition.

- The Daily Operations Report. The Daily Operations Report contains a count of the number of various events that occur over a given day, including uses of force, fights, assaults on staff, and group disturbances.[244] Supervisors are responsible for entering this data at the end of every shift.[245] The Daily Operations Report was implemented at all facilities in March 2008. [246]

- Health services" urgent/emergent log. This log contains brief descriptions of any emergency medical situation presented to a facility"s clinic (OHU). Some PbS coordinators use it to verify whether a staff or youth was injured in an assault.

- Serious incident reports (SIRs). Policy requires facilities immediately to report "serious incidents" to the Chief Deputy Secretary.[247] The SIR policy defines "serious incident" to include a list of situations, some concrete and specific (e.g., "a secure area extraction when an extraction team is utilized") and others more vague (e.g., "an incident that has a significant impact on the operations of the facility").[248] Due to the looseness of some definitions in the policy, the statewide PbS coordinator has instructed staff not to use the SIRs for data purposes.[249]

A given incident is usually noted in multiple records. Consider a typical case: two youth have a fistfight and one hurts his eye. Staff use force to break up the fight, take the injured youth to the clinic, and file DDMS charges against one or both youth. Information on this incident would appear in a UOF report, behavior report, DDMS record, the urgent/emergent log, the Daily Operations Report, and possibly an SIR. This burdens staff with paperwork and complicates data collection.

Staff described various processes for gathering data. The processes are not always consistent between facilities. In order to tally the number of injuries to youth by other youth, for instance, the PbS analyst at Preston begins by screening DDMS records for charges 2D and 3Q (physical altercations). She then checks the number of recorded fights against the number in the Daily Operations Report. Assuming there are no discrepancies, she cross-references each DDMS record against the urgent/emergent log to determine if a youth was injured in the fight. To tally the same information, the PbS coordinator at Stark cross-references SIRs that describe fights

[243] *Id*, p. 36; Disciplinary Decision Making System Procedures (PoP #392, April 27, 2009), pp. 4, 6.
[244] *See* Attachment 16, sample Daily Operations Report.
[245] Statements of Jeff Plunkett during central office site visit, March 12, 2009.
[246] DJJ Quarterly Report, April 30, 2008, p. 73.
[247] First Report of the Special Master (March 2005), Appendix G (Serious Incident Reporting Policy), p. 1.
[248] *Ibid.*
[249] Statements of Sue Easterwood during central office site visit, March 12, 2009. Except for the urgent/emergent log and SIRs, all records described above are part of WIN.

against the urgent/emergent log. To take another example, PbS staff at different facilities sometimes screen for different DDMS charges when they look for data on assaults on youth.

Central office has provided instructions on PbS data collection to facility staff, but the instructions are not specific enough to avoid these inconsistencies.[250] The instructions for gathering data on violent incidents direct staff to refer to the "behavior report, supplemental reports, use of force report, daily operations report, SIR, [and] medical forms" to gather data on the characteristics of the incident.[251] Staff at different facilities (or at the same facility at different times) can legitimately follow these instructions using different data-gathering methods. This makes it difficult to compare data between facilities or across time.

DJJ's data regarding the number and type of UOFs are more reliable. Administrative staff must determine whether different reports relate to a single incident, what kind of force was used, and whether the incident involved a youth receiving mental health care. However, because all of these data are available in a single source – the UOF report – there is no ambiguity about where staff must look or how to cross-reference data sources.

Ratings: Defer to expert (all facilities)

3.8c: *DJJ to provide training in strategies and procedures to safely integrate gangs and racial groups by July 1, 2008. The safety and welfare expert monitors the quality of the training.*

DJJ has not begun to provide the gang/race integration training required by the remedial plan.

In its January 2008 quarterly report, DJJ indicated it had begun to research and consult with experts about gangs and confinement.[252] However, in November 2008, DJJ indicated that it had not begun efforts to comply with this remedial requirement.[253]

Following his January 13-14, 2009 central office audit, Barry Krisberg reported:

> DJJ promised to consult with a national expert in this area but the formation of an active working group to address gang issues has been given a lower priority than other *Farrell* reforms. I have met with the recently activated Headquarters gang task force and reviewed their ideas on potential gang experts. The only person on their list who I recognized as a national expert was Cheryl Maxsom of UCI. The DJJ list was dominated with names of people whose expertise is gang member identification and suppression. This approach has yielded very limited payoff in reducing gangs in either DJJ or CDCR. I suggested that DJJ look to a more multi-faceted approach that included treatment interventions, educational curriculum, and the wider use of positive peer culture approaches such as Normative Culture,

[250] *See* Attachment 17, "Outline of the Sa2-12 PbS to QSR/CompStat on Safety Issues" and "PbS Source Document Guide: Incident Report Form" (PoP # 369, March 11, 2009).
[251] *Ibid.*
[252] DJJ Quarterly Report (January 31, 2008), p. 42 ("DJJ representatives attended the Gang Consultant meeting with out of state gang experts/consultants to learn about findings of gangs and confinement.").
[253] Deft. Response to the Court's October 27, 2008 Order, November 21, 2008, Exhibit H, p. 3.

> to reduce gang behavior in DJJ. It is not clear that DJJ staff have a handle on what is driving the gang conflicts in its facilities. I have offered to work intensely with the DJJ gang reduction task group and to get them materials from around the Nation about effective evidence-based gang reduction approaches. I indicated that I would be willing to serve in the role as the National gang expert. A clear mission of the DJJ task force is to establish written policies and procedures to guide the DJJ effort to reduce the negative impact of gangs in its facilities. These written materials must be effectively delivered to all staff through well-designed training efforts. This work has just begun and I hope to encourage more steady movement forward in this arena in the near future.[254]

Central office staff held a meeting with Dr. Krisberg about this issue on April 6, 2009.[255]

Rating: Defer to expert (all facilities)

3.9a: *By July 1, 2008, DJJ to open sufficient Behavioral Treatment Programs (BTPs), in accordance with remedial plan provisions, for the projected 2008/09 demand.*

In November 2008, DJJ indicated that its development of Behavioral Treatment Programs (BTPs) is in progress but that it did not anticipate reaching substantial compliance by the end of fiscal year 2008-2009.[256]

Central office staff completed a project charter in December 2008, and in February 2009, DJJ estimated the development of the BTPs could be completed in approximately 137 days, by July 1, 2009.[257] The schedule does not include an implementation plan, but DJJ intends to open four BTP units at Stark (E, F, W, and X Companies) in August 2009.[258]

In the meantime, the Preston facility has closed its Special Management Program (SMP) and opened two treatment units currently called "BTPs."[259] Preston staff and central office personnel are reportedly sharing information in such a way that Preston"s units have become an informal pilot.[260]

---

[254] E-mail of Tammy McGuire to Aubra Fletcher, May 4, 2009.
[255] Statements of Larry Miranda during DJJ Court Compliance Task Force meeting, March 12, 2009.
[256] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 3.
[257] *See* DJJ Project Charter: Behavior Treatment Program, December 5, 2008; BTP development schedule, February 27, 2009.
[258] Statements of Tammy McGuire during central office site visit, March 12, 2009. The monitors note that DJJ staff referred to two high-risk units at the Stark facility as "temporary BTPs" in a recent Case Management Conference. Statements of Joan Loucraft during *Farrell v. Cate* Case Management Conference, February 20, 2009. Central office staff later clarified that these units are not officially BTPs, that Stark continues to operate an SMP, and that the term "temporary BTP" was employed in order to obtain teaching staff. Statements of Jim Telander and Henry Lum during central office site visit, March 12, 2009. Monitor Aubra Fletcher visited these living units on April 21, 2009, and they appear to be operated much the same as before, with little out-of-cell time and no overarching behavior treatment program concept.
[259] Statements of staff and interviewed youth during Preston site visit, February 2009.
[260] *Id.*; statements of staff during central office site visit, March 12, 2009. Staff referred to Preston"s proto-BTP units as a "sounding board for lessons learned."

In January 2009, the safety and welfare expert noted that he did not believe "DJJ has a clear program description of the BTPs, nor does it have a good handle on how many beds will be needed in these units. There is a danger that these will become SMPs with new initials or that DJJ will open more BTP beds than it needs."[261] He called for a detailed description of DJJ"s plans for the BTPs, for approval by the *Farrell* experts.[262] Dr. Krisberg subsequently reviewed DJJ"s proposed BTP design, reiterated his prior concerns, and listed 18 additional concerns about the direction DJJ is headed in designing its BTPs.[263] He reports that the team of DJJ staff working on this design are in agreement with his comments.[264]

Rating: Beginning compliance

5.4a-g: *DJJ to hire or train trainers in* ***(a)*** *DJJ Integrated Behavior Treatment Model (IBTM),* ***(b)*** *risk/needs assessment,* ***(c)*** *treatment plan development,* ***(d)*** *motivational interviewing,* ***(e)*** *normative culture,* ***(f)*** *interactive journaling, and* ***(g)*** *other formal rehabilitation/treatment programs adopted by DJJ.*

5.4a: As of this writing, DJJ is working with outside consultants to write a description of its proposed Integrated Behavioral Treatment Model (IBTM).[265] Staff training on the IBTM itself has thus not yet been developed.

Rating: Non-compliance

5.4b: DJJ has contracted with Orbis Partners to train staff in the YASI-CA risk/needs assessment tool.[266] Eight DJJ staff attended training for trainers on October 1, 2008.[267]

Rating: Defer to expert

5.4c: Orbis Partners also provides staff training in case planning.[268] DJJ reports that six staff have been trained as trainers.[269]

Rating: Defer to expert

5.4d: In December 2007, the University of California, San Diego began to provide motivational interviewing training to DJJ staff.[270] It is unknown whether any DJJ staff have been trained as trainers.

---

[261] Barry Krisberg, informal report on central office site visit (grid), 2009, p. 12.
[262] Barry Krisberg, informal report on central office site visit (summary), 2009, p. 9.
[263] *See* Attachment 18, e-mail of Barry Krisberg to various, May 7, 2009.
[264] *See id.*
[265] Statements of Michael Brady and Dr. Angela Wolf during DJJ Court Compliance Task Force meeting, April 2, 2009.
[266] Seventh Report of the Special Master (April 2008), Appendix E (Orbis contract), p. 1.
[267] Reform Related Training Data: Orbis Partners (PoP #318, December 4, 2008).
[268] Seventh Report of the Special Master (April 2008), Appendix E (Orbis contract), p. 1.
[269] DJJ comments on the draft of this report, June 9, 2009, p. 3.

Rating: Substantial compliance

5.4e: DJJ has not located a contractor to train trainers in normative culture. An initial advertisement received no bids, according to Barry Krisberg, because it was sent to non-qualified bidders.[271] For example, the North American Family Institute (NAFI), the main organization to offer normative culture training, was not aware of the advertisement.[272]

Central office staff drafted a "project charter" to guide DJJ in developing a new request for proposal (RFP).[273] Funding for this contract process expires on June 30, 2009.[274] DJJ's project schedule for the RFP process provided that DJJ begin drafting the RFP on February 10, 2009 and complete the RFP by March 13, 2009.[275] The schedule indicated that DJJ would begin the contracting process on March 16, 2009 and complete it on August 13, 2009.[276]

DJJ issued the RFP on March 27, 2009 and will accept bids through May 5, 2009.[277] The RFP calls for proposals

> to facilitate the development of norms . . . and to develop and deliver training specific to the Division of Juvenile Justice norms and practices which allow staff to establish and maintain a normative culture environment within its facilities. The result of this project will be to create a long term successful rehabilitative environment by establishing social rules and expectations centered on respect for the individual, groups, and the community at large.[278]

As of June 2009, DJJ has selected a contractor for normative culture training for trainers; the contract has not yet been signed.[279]

Rating: Beginning compliance

5.4f: DJJ has a contract with the Change Companies to provide training for trainers in interactive journaling through June 30, 2010.[280] The contract also includes assistance in the development of an Intensive Needs Interactive Journaling® Curriculum.[281] DJJ's initial interaction with the Change Companies was in 2004, when staff received some journals.[282] As of May 2008, DJJ

---

[270] Seventh Report of the Special Master (March 2008), p. 18; Reform Related Training Data: Motivational Interviewing (PoP #354, February 23, 2009).
[271] Barry Krisberg, informal report on central office site visit (grid), 2009, p. 15.
[272] Notes of former monitor Cathleen Beltz based on May 2008 site visit to central office.
[273] *See* DJJ draft Project Charter: Normative Culture Request for Proposal, January 27, 2009.
[274] *Id.*, p. 1.
[275] *See* Attachment 7, DJJ project schedule, undated, p. 2.
[276] *Id.*
[277] *See* Attachment 19, Bid #6000000077 – Normative Culture (cover page only). DJJ staff reported on May 5, 2009 that two bids had been received.
[278] *Id.*
[279] DJJ comments on the draft of this report, June 9, 2009, p. 3.
[280] DJJ Project Charter: Implement Interactive Journaling, March 2, 2009, p. 1.
[281] *Ibid.*
[282] Statements of staff during central office site visit, May 2008.

and Change Companies were planning implementation of interactive journaling in order to complement the risk/needs assessment tool developed with Orbis.[283] Also in May 2008, central office staff said they were scheduling training of all youth correctional counselors.[284] OSM has not seen this schedule.

DJJ has drafted a project charter for implementation of interactive journaling training.[285] Staff began the charter in January 2009, and it was approved by DJJ directors on March 10, 2009.[286] The charter does not include a detailed schedule, but does note that DJJ must complete the project before the Change Companies contract expires in June 2010.[287] The safety and welfare and mental health experts are concerned that all treatment materials be integrated as part of the IBTM.[288]

Rating: Beginning compliance

5.4g: The special master reported in March 2008 that staff training had begun in safe crisis management, crisis intervention and conflict resolution, aggression replacement, and understanding and preventing suicide.[289] Training in these and other areas was interrupted in July and August 2008 and early 2009 due to restrictions on travel for state employees.[290] Schedules received since that time indicate that training continues.[291]

The rating assigned to this item is "partial compliance," in light of the likelihood that while developing its IBTM, DJJ will seek to add additional programs.

Rating: Partial compliance

4.1b, 6.7: *DJJ to provide training to all direct care staff in certain areas. New or reassigned staff are to be trained within ninety days of assignment to a living unit. All supervisory and management staff are required to complete the training as required by DJJ policy. Training areas:* ***6.7a:*** *DJJ IBTM (August 15, 2009).* ***4.1b:*** *Risk/needs tool (February 1, 2009). This item is a duplicate of item 6.7b, which is monitored by the safety and welfare expert.* ***6.7c:*** *Treatment plan development (August 15, 2009).* ***6.7d:*** *Motivational interviewing (per interim training schedule).* ***6.7e:*** *Normative culture (per interim training schedule).* ***6.7f:*** *Interactive journaling (per interim training schedule).* ***6.7g:*** *Other key treatment components (August 15, 2009).*

DJJ provides OSM and the experts with training data in the form of attendance logs.[292] OSM and the medical and mental health experts have asked that DJJ provide training data that reflects

[283] *Id*.
[284] *Id.*
[285] *See* DJJ Project Charter: Implement Interactive Journaling, March 2, 2009.
[286] E-mail of Amy Seidlitz to Tammy McGuire and Joan Loucraft, March 26, 2009.
[287] *See* DJJ Project Charter: Implement Interactive Journaling, March 2, 2009, p. 2.
[288] *E.g.*, statements of Barry Krisberg, Eric Trupin, and Terry Lee during telephone conference, February 20, 2009.
[289] Seventh Report of the Special Master (March 2008), pp. 18-19.
[290] Statements of Jay Aguas during central office site visit, March 12, 2009.
[291] Training schedule as of February 2009 (PoP #354, February 23, 2009).
[292] *See, e.g.*, Training Attendance Report (PoP #354, February 23, 2009).

the percentage of staff trained in certain areas, broken down by job classification and facility.[293] It is unclear how, without this data, DJJ tracks which staff remain to be trained in which areas. Also, without data on the percentage of relevant staff still to be trained, the experts and OSM cannot fully evaluate DJJ"s compliance with training-related requirements.

6.7a: As noted above, staff training on the IBTM itself has not begun.

Rating: Non-compliance (all facilities)

4.1b: Many of DJJ"s case work specialists and parole agents have received training in the YASI-CA risk/needs assessment tool.[294] A small percentage of DJJ"s youth correctional counselors and other direct care staff have been trained in the YASI-CA.[295]

Rating: OSM defers to the safety and welfare expert (all facilities)

6.7c: In addition to its YASI-CA training, Orbis Partners is training DJJ staff in "case planning."[296] As with the YASI-CA trainings, training has thus far focused on case work specialists.[297]

Rating: OSM defers to the safety and welfare expert (all facilities)

6.7d: Motivational interviewing training began in December 2007.[298] Training for direct care staff occurs in two blocs for each staff member: a three-day class, followed by a two-day "reinforcement" training six months later.[299] Many direct care staff have completed both training sessions, and many others have completed the first.[300] DJJ intends that all staff receive motivational interviewing training by the end of 2010.[301]

Rating: Partial compliance (all facilities)

6.7e: Normative culture training has not begun.

Rating: Non-compliance (all facilities)

---

[293] *See* e-mail of Aubra Fletcher to Doug Ugarkovich, January 6, 2009; e-mail of special master to Doug Ugarkovich, February 23, 2009.
[294] For example, five of the six casework specialists working at Preston have received this training, while at Stark, six of eight casework specialists have. Training Attendance Report (PoP #354, February 23, 2009); Preston position listing, February 1, 2009; Stark position listing, December 1, 2008.
[295] For example, less than 10% of the YCCs and SYCCs at Stark and Preston have received this training. Training Attendance Report (PoP #354, February 23, 2009); Preston position listing, February 1, 2009; Stark position listing, December 1, 2008.
[296] Training description, (PoP #365, March 12, 2009), p. 5.
[297] Training patterns at Stark and Preston are almost identical to those reported for the YASI-CA training above.
[298] *See* Training Attendance Report: Motivational Interviewing (PoP #354, February 23, 2009), p. 1.
[299] Reporter"s Transcript of Proceedings, Order to Show Cause hearing, April 21, 2008, at 121:5-11.
[300] *See* Training Attendance Report: Motivational Interviewing (PoP #354, February 23, 2009), pp. 1-28.
[301] Seventh Report of the Special Master (March 2008), p. 18.

6.7f: Although interactive journals are in use on some DJJ living units, staff training in interactive journaling has not yet begun.[302]

Rating: Non-compliance (all facilities)

6.7g: As noted above, staff training began in 2008 for safe crisis management, crisis intervention and conflict resolution, aggression replacement training, understanding and preventing suicide.[303] Trainings in all of these areas continued throughout 2008, and trainings in aggression replacement therapy and safe crisis management have continued in early 2009.[304]

Orbis Partners has also begun training DJJ staff in cognitive behavioral therapy principles.[305]

Rating: Partial compliance (all facilities)

6.1a-c: *DJJ is required to convert Chaderjian to a treatment facility by April 2007.* ***6.1b*** *(begin conversion) and* ***6.1c*** *(complete conversion): Stark was due to begin conversion to a rehabilitative model January 1, 2007 and to complete the conversion by July 1, 2007. Preston was to begin conversion by July 1, 2007 and complete conversion by January 1, 2008. A fourth facility was to have completed conversion by July 2008, and a fifth was to begin the process in the same month. Items 6.1a and 6.1c are also monitored by the safety and welfare and mental health experts.*

OSM defers to the safety and welfare and mental health experts regarding compliance with these requirements.

8.1.1: *By September 20, 2008, DJJ to add all needed program space to O.H. Close, Preston, Ventura, Stark, and SYCRCC, such that no regular programs must be canceled due to lack of space. As a part of this requirement, sufficient classrooms must be located in or near BTPs in order to maintain a ratio of one teacher for every six students.*

Staff interviewed in late 2008 and early 2009 at O.H. Close, Preston, Ventura, Stark, and SYCRCC reported a lack of program space.[306] Ventura"s chief psychologist reported difficulty securing adequate space for group sessions.[307] Psychologists at Stark reported a need for space to hold groups and individual sessions, primarily for outpatient and high risk youth.[308] Living units do not house enough space, and there are problems with noise and privacy.[309] Clinicians at

[302] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 5.
[303] Seventh Report of the Special Master (March 2008), pp. 18-19.
[304] Training attendance records and training schedule for February and March 2009 (PoP #354, February 23, 2009).
[305] *Id.*
[306] Statements of facility management during O.H. Close site visit, October 2008; statements of acting superintendent during Preston site visit, February 2009; statements of chief psychologist during Ventura site visit, December 2008; statements of acting superintendent during Stark site visit, January 2009; statements of TTS during Stark site visit, April 2009; statements of two senior psychologists during SYCRCC site visit, December 2008.
[307] Statements of Geralyn Freeland during Ventura site visit, December 2008.
[308] *Id.*
[309] *Id.*

SYCRCC reported difficulty finding treatment space on the living units.[310] They must use the offices of non-clinician unit staff when these offices happen to be unoccupied, an arrangement that results in many interruptions, delays, and rescheduled sessions.[311]

SYCRCC also lacks sufficient living units to meet youth"s demands to remain in its core treatment program. The superintendent"s office frequently receives letters from youth on intake units asking not to be transferred to another facility.[312] Though one living unit is empty, funds are not available to reopen it.[313] The facility has only one low-risk unit, with the result that youth on the high-risk unit who perform well are rewarded only with a slot on the low-risk wait list.[314]

DJJ is drafting a fifteen-year facilities master plan based on population projections, and plans to use either modular or living units for program space.[315] The division has $9.3 million in funding for modulars – of which it must still request authority to spend $6 million, a process that takes about two months – and $2.5 million for major repairs. The division has earmarked money for BTPs to receive program, classroom, and office space. It is unclear whether the funds match its needs, given that DJJ is unsure how many BTPs it will open.

Central office is waiting for decisions on facility closures before allocating funds for modulars or major repairs to specific sites. Ten modular buildings were expected to arrive at O.H. Close in the fall of 2008, but this plan was "on hold" as of October 2008.[316] Staff at Stark indicated that the facility has been awaiting promised modular buildings for about two years.[317]

Some work to remedy program space needs is underway. Chaderjian has received new modular buildings, which were not yet in use as of mid-May 2009.[318] Ventura is building new classrooms for post-secondary educational classes.[319] New classrooms on living units are under construction at Stark.[320] O.H. Close has received permission to resume work on the extension of its residential SBTP, which was nothing more than a foundation slab as of October 2008.[321]

An ongoing project at SYCRCC sheds light on the numerous barriers to meeting space needs; these barriers appear to arise at the facility, central office, and CDCR levels. In 2005, SYCRCC

[310] Statements of two senior psychologists during SYCRCC site visit (mental health), December 2008.
[311] *Id.*
[312] Statements of staff during SYCRCC site visit, March 2009.
[313] *Id.*; monitor observations during SYCRCC site visit, March 2009.
[314] Statements of staff and interviewed youth during SYCRCC site visit, March 2009.
[315] Information in this paragraph is based on statements of Mark Blaser to Barry Krisberg during central office site visit, January 14, 2009. Staff expect to have a final version of this plan by the end of this fiscal year. Statements of staff during Court Compliance Task Force meeting, May 21, 2009.
[316] *Id.*
[317] Statements of staff during Stark site visit, January 2009.
[318] Statements of Michael Minor during Chaderjian site visit, October 2008; statements of Mark Blaser to Barry Krisberg during central office site visit, January 14, 2009; statements of Margaret Wall during Court Compliance Task Force meeting, May 14, 2009.
[319] Statements of staff during Court Compliance Task Force meeting, May 14, 2009.
[320] Statements of Elverta Mock during Stark site visit, January 2009; statements of TTS George Castellanos during Stark site visit, April 2009; monitor observations during Stark site visit, April 2009.
[321] Statements of facility management during O.H. Close site visit, October 2008; statements of central office staff to Barbara Schwartz during central office site visit, June 8, 2009.

began work on a new building intended to hold mental health staff offices, as well as SBTP and mental health treatment space.[322] By May 2008, the building was complete, except for the installation of computer data lines in the offices.[323] The data lines have not been installed in the past year, and the building remains vacant.[324] Group sessions are not being held in the building either, because climb-proofing of the nearby fence has not been completed.[325] The installation of data lines and climb-proofing are the only needs that have prevented staff from using the building for anything other than staff trainings.[326]

Facility staff explained that when the construction planning began, the need for data lines was not included in the "project scope."[327] This omission and the failure to correct it promptly apparently accounts for a great deal of the delay in opening the building.[328] Also, CYA merged with CDCR around the time this project began.[329] CDCR personnel became involved in the project, and there was high turnover among the project coordinators. SYCRCC staff had difficulty obtaining clear and consistent information, but at one point were told that the project scope could not be changed because construction had already begun. Funding problems also arose, and the project was behind schedule. Once construction was complete, the building was "signed off on" as complete despite the lack of data lines – because the data lines were never included in the project scope.

Program staff at the facility have reportedly struggled to have the problem addressed,[330] and obstacles continue to arise.[331] Unable to obtain a prompt response from central office or CDCR, SYCRCC's network manager and its acting chief of plant operations identified measures to address the lack of data lines.[332] CDCR's Information Technology (IT) department learned of the facility's plans and wanted to be part of the decision-making, which has further delayed the process.[333] Apparently, IT opposes the use of wireless routers due to privacy and security concerns,[334] but others have told facility staff that wireless networking is even more secure than wired connections.[335]

To install data lines, the facility network manager recently determined that the necessary materials would cost $500.[336] However, the only engineer at SYCRCC qualified to install the equipment is currently the acting chief of plant operations and reportedly does not have time to

[322] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[323] *Id.*; statements of Ted Bonds during SYCRCC site visit (SBTP), May 2009.
[324] Statements of various facility and central office staff during SYCRCC site visit (SBTP), May 2009.
[325] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[326] *Id.*
[327] *Id.*
[328] *Id.*
[329] All information in this paragraph is based on statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[330] *Id.*; statements of senior psychologists during SYCRCC site visit (mental health), December 2008.
[331] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[332] *Id.*
[333] *Id.*; statements of Ted Bonds during SYCRCC site visit (SBTP), May 2009.
[334] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[335] *Id.*
[336] All information in this and the following two paragraphs is based on statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.

perform the installation. As a result, the facility must determine the price of outside labor, then contract for that labor. The network manager estimates the labor cost to be $2,000. He is required to obtain three quotes and as of early May 2009 had only received two. Once all quotes are obtained, facility staff must write a formal justification for the expense, since the funds requested are general funds. It is unclear why this is necessary, since *Farrell* funds remain available, and the adequacy of office and program space is a requirement of three remedial plans (SBTP, Mental Health, and Safety and Welfare).

As for the climb-proofing of the nearby fence, it is 75% complete, according to the program manager. Despite its near completion, facility staff indicated that they lack the equipment necessary to finish the job. Maintenance will reportedly coordinate with another CDCR office to loan them the equipment. The program manager stated that it might be possible to obtain the superintendent"s authorization and begin escorting youth to the building in the meantime.

SBTP personnel at central office are alerted to the problem and will be working with DJJ"s director of facilities to remedy it by the end of August 2009.[337] In the meantime, SBTP and other mental health staff use inadequate office spaces and inadequate rooms for group sessions.[338] The SBTP group session room is reportedly too small and has poor air circulation.[339] All the while, brand new office and group space has been standing, unoccupied, a few feet away for the past year. This process highlights an inability to solve problems efficiently and also reflects the age and physical condition of some DJJ facilities. SYCRCC was built in 1954.[340] Newer facilities, such as Chaderjian, have had less difficulty generating computer access in recently constructed buildings because they were "wired for fiber," unlike SYCRCC.[341]

Rating: O.H. Close: PC, Ventura: PC, Stark: PC, Preston: NR, SYCRCC: PC

8.1.1: *By September 30, 2008, DJJ to add all needed office space to the same five facilities, so that all living unit staff requiring offices have space in or adjacent to the living unit.*

In its November 21, 2008 filing, DJJ noted that compliance with this requirement is in progress.[342] OSM monitors interviewed staff at each facility regarding office space needs.

O. H. Close facility management reported that staff space, like program space, is severely lacking.[343] For its part, Chaderjian acquired many new mental health staff in 2008, which exacerbated its office space shortage.[344] Additional space was to become available by September

[337] Statements of Erin Peel during SYCRCC site visit (SBTP), May 2009; statements of Erin Peel during Court Compliance Task Force meeting, May 21, 2009.
[338] *Id.*; statements of senior psychologists during SYCRCC site visit (mental health), December 2008.
[339] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[340] Statements of Norma Fong-Mori during SYCRCC site visit (SBTP), May 2009.
[341] *Id.*
[342] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 4.
[343] Statements of facility management during O.H. Close site visit, October 2008.
[344] Statements of staff during Chaderjian site visit (mental health), October 2008.

11, 2008, but this was delayed.[345] The modulars arrived later, and a final walk-through was to occur during the last week of October 2008, following the monitors' visit.[346]

Also, among Chaderjian's resource deficiencies, as identified by the quality management committee report, is the need to install telephone lines to health care staff offices.[347] Rats have chewed the phone lines inside the walls of at least some of the MH staff office spaces, and because there is limited cell phone reception in the facility, communication among staff falters.[348] Modular buildings arrived at Chaderjian after the monitors' visit, but as of mid-May 2009, these were not yet operational.[349]

Ventura also requires additional phone lines; some staff reportedly share voice mail and/or phones.[350] As of December 2008, the superintendent had submitted budget change requests for additional phone lines. He had also requested modulars for psychologists, treatment teams, and education. Central office had not authorized the modulars as of that time due to uncertainty over Ventura's closure.

At Stark, staff offices are located primarily off the living units.[351] Two of the three units have office buildings behind them.[352] Limited office space is available in the living units themselves.[353] Preston's acting superintendent reported no problems with office space.[354] The monitors observed staff offices located on the living units to which they are assigned.

Mental health staff at SYCRCC indicated that additional office space on the living units was needed.[355] See description of the still-pending office building, above.

Rating: O.H. Close: PC, Ventura: PC, Stark: PC, Preston: SC, SYCRCC: PC

6.6: *DJJ to approve a program service day schedule for all BTPs. The schedules must ensure structured activity based on evidence-based principles for at least forty percent of waking hours. Initially, deadlines varied by facility. At DJJ's request, the court has reset the deadline for all sites to March 31, 2009.*

The remedial plan requires that each Behavioral Treatment Program (BTP) have a program service day schedule that "maximize[s] out of room time and ensure[s] structured activity based on evidence-based principles for 40 to 70 percent of waking hours."[356]

---

[345] *Id.*
[346] *Id.*
[347] *Id.*
[348] *Id.*
[349] Statements of Margaret Wall during Court Compliance Task Force meeting, May 14, 2009.
[350] Information in this paragraph is based on statements of David Finley during Ventura site visit, December 2008.
[351] Statements of staff during Stark site visit, January 2009.
[352] *Id.*
[353] *Id.*
[354] Statements of Timothy Mahoney during Preston site visit, February 2009.
[355] Statements of mental health staff during SYCRCC site visit, December 2008.
[356] Safety and Welfare Remedial Plan, p. 57.

DJJ has not implemented BTPs in any facility, though an informal pilot is taking place on two of Preston"s living units.[357] BTP development is discussed in more detail at item 3.9a.

Prior to the development of the BTP project charter, a central office program workgroup drafted recommendations for the program.[358] These recommendations include a draft program service day schedule.[359] This schedule is in use at Preston"s "interim BTPs."[360] Central office staff indicated in March 2009 that BTPs will ultimately use the same program service day schedules as core living units.[361]

DJJ plans to open BTPs at Stark in about August 2009, though modifications to the program will continue to be made after they are opened.[362]

Rating: Central office: BC, O.H. Close: NA, Chaderjian: NA, Ventura: NA, Stark: NA, Preston: NR, SYCRCC: NA

7.1: *DJJ to issue request for letters of interest for contract services for programs for young women.* ***7.4:*** *DJJ to request legislative authority and funding for contract services, and issue RFP. The deadline for both requirements is July 1, 2006.*

7.1: As OSM has previously reported, DJJ issued requests for Letters of Interest in April 2006.[363] This is a one-time compliance item.

Rating: Substantial compliance (completed)

7.4: DJJ issued a new Request for Proposal (RFP) for contract services in January 2009.[364] Proposals are due by May 15, 2009, and DJJ will announce the selected bidder by June 15, 2009.[365]

DJJ sent an announcement regarding the RFP to 116 addresses and provided this list to OSM.[366] Forty-two organizations have viewed the RFP online, including seven from outside California.[367] Two others requested paper versions of the RFP, which DJJ provided.[368] There will be no

[357] Statements of central office staff during various meetings, November 4, 2009; statements of staff during Preston site visit, February 2009.
[358] *See* draft Behavior Treatment Program Operations Guide, August 7, 2008.
[359] *See* Attachment 20, excerpt from draft Behavior Treatment Program Operations Guide (Sample BTP Facility Schedule), August 7, 2008, pp. 9-11.
[360] Statements of Henry Lum and Jim Telander during central office site visit, March 12, 2009
[361] *Id.*
[362] *Id.*
[363] *See* Fifth Report of the Special Master (October 2007), Appendix B (Beltz Report), p. 12.
[364] Statements of Pam Erskine during central office site visit, March 12, 2009.
[365] *Id.*; document entitled "Tentative Timeline for Female RFP," undated (provided March 12, 2009).
[366] *See* e-mail of Pam Erskine to Michael Brady and Tammy McGuire, March 4, 2009.
[367] *See* e-mail of Eric Zimmerman to Pam Erskine, March 12, 2009.
[368] *Id.*

mandatory conference for bidders; instead, DJJ will hold an optional question-and-answer session, in which out-of-state bidders may participate by phone.[369]

DJJ"s mental health team leader believes that the funding for the RFP (7.9 million dollars per year) is appropriate for the acute care needs of the women at Ventura.[370] The RFP recommends that providers house the girls in groups larger than 15 to obtain some economy of scale.[371]

Budget staff have ensured that ongoing legislative authority is in place for this RFP.[372]

Rating: Substantial compliance

8.1.2: *DJJ to fill or assign community/court liaison positions by December 1, 2006. These staff will perform functions as outlined in the Safety and Welfare Remedial Plan.*

OSM rated DJJ as substantially compliant with this requirement in October 2007; DJJ had filled its four allotted community/court liaison positions.[373] Central office staff indicated in March 2009 that it currently employs five liaisons and has one vacancy.[374] The sixth liaison retired at the end of December 2008, and the decision about whether to fill the vacancy is on hold until DJJ"s staffing analysis is released.[375] DJJ provided OSM with a December 31, 2008 list of its current community/court liaisons.

Rating: Substantial compliance

8.2.4: *By July 1, 2008, pending funding (which DJJ must request), DJJ will provide orientation at county detention facilities.*

DJJ began providing orientations at county detention facilities in May 2008.[376] To date, staff have provided 19 orientations.[377] During the first three months of 2009, DJJ conducted orientations in five counties (Santa Barbara, San Bernardino, Orange, San Diego, and

[369] Statements of Pam Erskine during central office site visit, March 12, 2009.
[370] *Id.* In the first nine months of 2008, nine women were referred from Ventura to a DMH hospital or the Stark CTC, sometimes multiple times. Trackable Mental Health Placement List Through 9-30-2008. There were a total of 25 referrals. *Ibid.* The RFP directs the contractor to "complete service agreements with off-site providers for mental health services requiring acute care including hospitalization." Request for Proposal, Secure Residential Placement and Treatment Services for Female Youthful Offenders, January 2009, p. 28.
[371] Statements of Pam Erskine during central office site visit, March 12, 2009.
[372] Statements of Tammy McGuire during central office site visit, March 12, 2009; letter of Van Kamberian to Barry Krisberg, April 24, 2009, p. 4.
[373] Fifth Report of the Special Master (October 2007), Appendix B (Beltz Report), p. 13.
[374] Statements of Eleanor Silva during central office site visit, March 12, 2009.
[375] *Id.*
[376] *Id.*
[377] *Id.* In May 2008, DJJ provided former monitor Cathleen Beltz with a schedule of juvenile hall orientations for that month, and orientations were held in Los Angeles, Stanislaus, San Mateo, Alameda, and Fresno counties.

Sacramento).[378] Community/court liaisons conduct the orientations and train probation staff to answer youth‟s questions about DJJ.[379]

The orientation covers a variety topics, including intake, medical and mental health services, the youth incentive program, DDMS and grievance procedures, and work opportunities.[380] The emphasis is on describing rules and procedures at DJJ. Descriptions of policies are up to date. Youth in county facilities also receive informational sheets regarding the intake process, the current gang intervention program, the Office of Victim and Survivor Rights and Services, mental health treatment programs, the substance abuse treatment program, and the sexual behavior treatment program (SBTP).[381]

The safety and welfare plan requires that the content of orientation materials provided at county facilities "help alleviate youth[s‟] fears and dispel the myths about DJJ." OSM defers to the safety and welfare expert as to existing materials‟ compliance with this provision.

Rating: Partial compliance

8.3.1: *Intake process to include documentation of family interviews and assessment. The written report at intake must document contacts and interviews with parents, close relatives, and community service providers during the intake process for each youth. The reports include measures to assess family background, strengths, and functioning. Deadline is July 1, 2007. This item is also monitored by the mental health experts.* ***8.3.2a:*** *By November 1, 2006, DJJ is required to facilitate family phone contact within 24 hours of youth arrival.* ***8.3.2b:*** *By December 1, 2006, DJJ is required to facilitate ongoing family phone contact.* ***8.3.3:*** *By March 1, 2007, DJJ must arrange for family visiting days at least four times per year. These items are monitored solely by the mental health experts who have requested that the OSM gather information for them.*

OSM monitors compliance with these requirements as a part of its monitoring in the mental health remedial area.[382] Mental health monitoring is still underway, and the monitors will submit their findings in a later report.

8.4.2a: *Disciplinary fact-finding hearings to be held within fourteen days, except as provided for in policy (e.g., youth out to court).* ***8.4.2b:*** *Disciplinary disposition hearings to be held within seven days, except as provided for in policy. The deadline for both items was initially March 31, 2007. At DJJ's request, the court has reset both deadlines to March 31, 2009.*

[378] *See* Attachment 21, DJJ Intake and Court Services, Juvenile Hall Orientation Log, January to March 2009.
[379] Statements of Eleanor Silva during central office site visit, March 12, 2009.
[380] *See* Attachment 22, DJJ, New Commitment Orientation (Power Point slides), undated (provided March 12, 2009).
[381] See Attachment 23, orientation handouts, undated (provided March 12, 2009). The SBTP info sheet is being updated to reflect program changes. E-mail of Erin Peel to Dr. Barbara Schwartz and Aubra Fletcher, March 27, 2009.
[382] *See* Mental Health Remedial Plan Standards and Criteria, item S&W 8.3.

8.4.2a: Pending the completion of the revised Disciplinary Decision-Making System policy, DJJ"s director of facilities instructed staff to abide by this remedial plan requirement effective December 10, 2008.[383]

Though the monitors visited O.H. Close prior to the issuance of that instruction, the facility"s DDMS fact-finder was already striving to conform to the remedial plan deadlines.[384] Staff interviewed at facilities after December 10, 2008 were aware of the recent changes and were working to meet the new timeframes, utilizing WIN as a tracking tool.[385]

DJJ is developing an automated process by which central office staff and any outside monitors may monitor compliance with the seven- and fourteen-day time frames.[386] There was no such process during the monitoring periods covered by this report.[387] Facility staff are manually tracking fact-finding and disposition deadlines.[388]

Rating: O.H. Close: PC, Chaderjian: NC, Ventura: SC, Stark: SC, Preston: PC, SYCRCC: PC

8.4.2b: See discussion regarding 8.4.2a, above.

Rating: O.H. Close: SC, Chaderjian: NC, Ventura: SC, Stark: SC, Preston: PC, SYCRCC: PC

8.4.6b: *Eligibility to restore time added is to be reviewed at youth case conferences. The deadline was initially March 31, 2007. At DJJ's request, the court has reset the deadline to March 31, 2009.*

This requirement is based on the following description in the Safety and Welfare Remedial Plan:

> Under state law, if a youth"s Projected Board Date is extended as a result of misconduct, he or she may earn back half of the time received for the last offense by remaining free of serious misconduct for a specified period of time. Some offenses are excluded from this "earn back" provision.[389]

During site visits, the monitors noted inconsistent practices. For example, O.H. Close, Ventura, and Stark staff provided documentation reflecting that case conference staff review earn-back eligibility. At Preston, the parole agent III and a parole agent I stated that earn-back eligibility is not reviewed at case conferences and is reviewed by treatment team supervisors at a youth"s request. Another parole agent I at Preston stated that he does review eligibility at case conferences.

[383] *See* Attachment 8, memorandum of Sandra Youngen to superintendents, November 25, 2008.
[384] Statements of DDMS Fact Finder during O.H. Close site visit, October 2008.
[385] Statements of staff during Ventura, Stark, Preston, and SYCRCC site visits, December 2008, January 2009, February 2009, and March 2009, respectively.
[386] E-mail of Tammy McGuire to Aubra Fletcher, April 1, 2009.
[387] Statements of central office and facility staff during SYCRCC site visit, March 2009.
[388] Statements of staff during facility site visits, 2008 to 2009.
[389] Safety and Welfare Remedial Plan, p. 62.

Prior to this audit round, changes to WIN had been made in order to facilitate eligibility reviews. The relevant WIN screen was changed to indicate eligibility for restoration of disciplinary time, but staff at some facilities noticed that this WIN feature was not reliably calculating how much time youth could have restored.

Central office staff stated in March 2009 that a new WIN tab would soon replace this feature, to remind staff to review eligibility at each case conference. Central office has not yet developed a comprehensive way to automate eligibility tracking.

DJJ needs to provide a clear reminder to facility staff serving on case conference committees that earn-back eligibility must be reviewed. The January 14, 2009 Disciplinary Decision Making System (DDMS) policy requires staff to review eligibility for restoration of DDMS time at each case conference, if not sooner.[390] This policy had not been implemented as of the end of the monitors' audit round.[391] The January 26, 2009 program credits policy may be read to require staff to review eligibility to restore earn-back time at each case conference, though this requirement is not explicit.[392] This policy was also scheduled for implementation on March 31, 2009, also after the monitors completed their round of site visits.[393]

Prior to March 31, 2009, facilities' practices varied. OSM defers assigning a rating to this item until its next audit round, during which it will monitor implementation of the new policy.

Rating: Deferred (all facilities)

8.6.3a: *DJJ's earn-back policy is to be revised to allow restoration of added time after six months.* ***8.6.3b:*** *DJJ policy is to be revised to require that restored months are rounded up rather than down. The deadline for both requirements is March 31, 2007.*

8.6.3a: The DDMS policy has been revised so that 50 percent of disciplinary time adds may be earned back following six months – rather than one year – of good behavior. However, this policy change is not retroactive. A youth who engaged in misconduct on February 28, 2009 cannot restore half of his time add until one year has passed, but a youth who committed the same misconduct the following day need only wait six months.[394] Youth may easily infer from this technicality that the system is arbitrary and therefore illegitimate; youth perceptions of arbitrariness and illegitimacy may in turn undermine the effectiveness of both positive and negative sanctions.

[390] *See* Disciplinary Decision-Making System policy (PoP #392, April 27, 2009), p. 21.
[391] *See* memorandum of Sandra Youngen and Doug McKeever to superintendents, et al., March 27, 2009.
[392] DJJ youth have three ways to advance their parole consideration dates: by earning program credits, by complying with (new) DDMS behavior contracts, and via time-add earn-backs based on lack of disciplinary sanctions over a specified period of time (to be reduced to six months, per requirement 8.6.3a, discussed below). The new program credit policy focuses on the first two options, which are distinct from the earn-backs referenced in this remedial requirement. *See generally* Program Credits Policy (PoP #374, April 6, 2009).
[393] *See id.*; memorandum of Sandra Youngen to superintendents, et al., March 27, 2009 (PoP #374, April 6, 2009).
[394] *See* Disciplinary Decision-Making System policy (PoP #392, April 27, 2009), p. 21.

Facility staff were trained on the new policy in February 2009.[395] DJJ intended to implement the new policy on March 31, 2009 and reports that it was implemented in early April 2009, after this audit round was complete.[396]

OSM assigns a beginning compliance rating in part because of the lack of retroactivity in the policy and in part because the policy had not been implemented as of the end of this audit round. The monitors will audit implementation during the next audit round.

Rating: Beginning compliance

8.6.3b: The revised DDMS policy requires that restored months be rounded up.[397] As noted above, staff have been trained, and implementation was scheduled for March 31, 2009.

Facility practices prior to March 31, 2009 varied. Ratings are deferred until the next audit round, when OSM will monitor implementation of the new policy.

Rating: Deferred

8.5.1: *All facilities will make grievance forms available to youth without assistance in all units.* ***8.5.2:*** *All facilities will install a lock box for grievances in all living units.* ***8.5.3:*** *In each facility, the grievance clerk will ensure an adequate supply of forms and will educate and assist grievants in the process. The deadline for the above measures was initially March 31, 2007. At DJJ's request, the court has reset the deadline for these requirements to November 1, 2008.*

OSM reported in January 2008 that DJJ had issued Temporary Departmental Orders (TDOs) regarding youth grievances and staff misconduct complaints, "effective" October 1, 2007.[398] The TDOs were not implemented until August 4, 2008,[399] and they expire on October 1, 2009.[400]

In June 2008, 1,370 staff were trained in the new grievance and staff misconduct complaint procedures, including facility youth grievance coordinators.[401] Youth notification and grievance clerk training began in July[402] and has been completed.[403]

In late 2008 and early 2009, the *Farrell* compliance team audited facilities' compliance with the requirements of these TDOs.[404] OSM is awaiting these reports.

---

[395] Statements of Tammy McGuire during central office site visit, March 12, 2009.
[396] *E.g.*, DJJ comments on the draft of this report, June 9, 2009, p. 3. Confusion about the implementation date ensued, and some staff thought it had been changed to April 4, 2009. Statements of central office staff during *Farrell* task force meeting, April 2, 2009. The implementation of changes in WIN's DDMS functions did not occur until April 6, 2009. Statements of Bob Eden during *Farrell* task force meeting, April 2, 2009.
[397] Disciplinary Decision-Making System policy (PoP #392, April 27, 2009), p. 21.
[398] *See* Sixth Report of the Special Master (January 2008), Appendix B (Beltz Report), p. 15.
[399] Memorandum of Sandra Youngen to superintendents, (PoP #209, August 11, 2008).
[400] TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[401] DJJ Quarterly Report (July 2008), p. 98; grievance training sign-in sheets (PoP #167, June 30, 2008).
[402] DJJ Quarterly Report (July 2008), p. 98.
[403] Statements of staff and youth during facility site visits, 2008-2009; *see also* Attachment 24, Youth Grievance System Handout for DJJ Youth, July 2008.

8.5.1: Pursuant to the TDOs, facility staff must ensure that grievance forms are available to all youth without assistance from staff or grievance clerks.[405] This has been implemented at all facilities.[406]

Rating: Substantial compliance (all facilities)

8.5.2: The TDOs require that lock boxes be available on all living units.[407] All living units observed by the monitors throughout the state are equipped with functioning lock boxes.[408]

Rating: Substantial compliance (all facilities)

8.5.3: The grievance clerk duty statement makes clear that clerks are no longer responsible to issue, record, or submit grievances, but clerks must ensure that sufficient forms are available and must educate and assist grievants.[409] This has been implemented at all facilities.[410]

Though the grievance clerk duty statement is uniform throughout the state, the differing nature of living units and individual clerks yields varying levels of clerk involvement in youth grievance- and complaint-filing. Two clerks at Chaderjian, for example, were extremely active in fielding youth questions regarding their rights, the content of policies, and the grievability of various issues.[411] These youth minimize frivolous grievance filing while also helping others to shape their complaints in order to maximize desired outcomes.[412]

Rating: Substantial compliance (all facilities)

8.5.4: *A notice of receipt of grievance or allegation of misconduct will be provided to all grievants.* ***8.5.5a:*** *Each facility grievance coordinator will prepare monthly reports. The deadline for the above measures was initially March 31, 2007. At DJJ's request, the court has reset the deadline for these requirements to November 1, 2008.*

---

[404] Statements of *Farrell* compliance staff during Chaderjian and SYCRCC site visits, October 2008 and March 2009, respectively; *see also* O.H. Close Youth Correctional Facility Youth Grievance/Staff Misconduct Complaint Compliance Assessment, (PoP #321, January 13, 2009).
[405] *See* Memorandum of Sandra Youngen to superintendents, (PoP #209, August 11, 2008); TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[406] Monitor observations and statements of interviewed youth during facility site visits, 2008 to 2009.
[407] *See* Attachment 25, Youth Grievance Clerk Duty Statement, undated; Memorandum of Sandra Youngen to superintendents, (PoP #209, August 11, 2008); TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[408] Monitor observations during facility site visits, 2008 to 2009.
[409] *See* Memorandum of Sandra Youngen to superintendents, (PoP #209, August 11, 2008); TDO # 07-92 (Youth Grievance), October 1, 2007; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007.
[410] Monitor observations and statements of interviewed youth during facility site visits, 2008 to 2009.
[411] Statements of interviewed staff and youth during Chaderjian site visit, October 2008.
[412] *Id.*

8.5.4: The grievance and staff misconduct TDOs require facility grievance coordinators to notify youth of the receipt and acceptance of a grievance.[413] The staff misconduct complaint TDO specifies that this must be done within five calendar days.[414]

Staff interviews regarding receipt notices yielded unclear and inconsistent responses. Grievance coordinators at O.H. Close, Chaderjian, and Ventura stated that WIN generates receipt letters that are then provided to youth.[415] The grievance coordinator at Stark stated that WIN does not generate any such receipt letter.[416] Grievance coordinators at Preston and SYCRCC indicated that the receipt notice is simply a copy of the youth"s original grievance or complaint with a tracking number at the top.[417]

Rating: Substantial compliance (all facilities except Stark, where the item was not rated)

8.5.5a: Prior to the implementation of the new procedures, some facilities were preparing monthly grievance reports and forwarding them to central office.[418] As of the monitors" site visits between October 2008 and March 2009, all facility grievance coordinators were preparing monthly reports.[419]

The safety and welfare expert has recently approved the design of a new monthly report form to be completed by facility grievance coordinators.[420] Statewide use of this form was to begin on April 1, 2009.[421]

Rating: Substantial compliance (all facilities)

8.6.4a: *By March 31, 2007, DJJ is to simplify the description of the Ward Incentive Program (WIP) and create and distribute posters, flyers, and handouts to promote understanding and participation in the Program.*

DJJ has developed a "Youth Incentive Pyramid" flyer, and the most recent revision was completed on March 3, 3009.[422] Central office has reportedly sent two laminated posters of the "pyramid" to each facility and plans to produce more.[423] The pyramid is to be posted in all living units and the visiting hall.[424]

---

[413] TDO # 07-92 (Youth Grievance), October 1, 2007, p. 12; TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007, p. 9.
[414] TDO # 07-93 (Staff Misconduct Complaint), October 1, 2007, p. 9.
[415] Statements of facility grievance coordinators during O.H. Close, Chaderjian, and Ventura site visits, October 2008, October 2008, and December 2008, respectively.
[416] Statements of facility grievance coordinator during Stark site visit, January 2009.
[417] Statements of facility grievance coordinators during Preston and SYCRCC site visits, February 2009 and March 2009, respectively.
[418] Barry Krisberg, informal reports on O.H. Close, SYCRCC, Ventura, Preston, and Chaderjian site visits, 2008.
[419] Statements of staff during facility site visits, October 2008 to March 2009.
[420] Barry Krisberg, informal report on central office site visit (grid), 2009.
[421] Statements of Tammy McGuire during SYCRCC site visit, March 2009.
[422] *Id.*; *see also* Attachment 13, Youth Incentive Program "Pyramid," March 3, 2009.
[423] Statements of Alicia Ginn during central office site visit, March 12, 2009.
[424] *Ibid.*

Central office staff are developing a pamphlet regarding the youth incentive program, which will be available in facility visiting halls.[425]

As of the monitors" 2008-2009 site visits, youth incentive program information posted on living units has been inconsistent. The version of the pyramid that was current as of each site visit was not consistently posted on dayroom walls, and some dayrooms displayed no incentive information at all. Youth and staff interviews revealed inconsistencies and, on the part of youth, confusion regarding the relevant time frames in which youth can change incentive levels.

Rating: Partial compliance

8.6.4b: *DJJ to revise its policy to allow youth full program credit if youth not responsible for non-participation in assigned/required programs. The deadline was initially March 31, 2007. At DJJ's request, the court has reset the deadline to March 31, 2009.*

DJJ"s revised program credits policy states that "[w]hen failure to complete a treatment or training program is no fault of the youth, PBD extensions shall not be recommended and full program credits shall be awarded."[426] The policy was distributed to facilities in late March 2009.[427]

This item will be considered in substantial compliance when there is evidence that facilities are following the revised policy. Central office staff recently examined time adds for the period between July 2008 through September 2008.[428] They concluded that no time adds were imposed based on inadequate access to programs and that "behavioral issues and/or a lack of progress in treatment was a primary reason for non-disciplinary time adds."[429] The evidence and analysis to support these conclusions was not retained, and the monitors are unable to credit the conclusions.

OSM reported in January 2008 that youth were not consistently receiving full program credit when evaluated for parole, despite the recommendations of DJJ treatment teams and the Youth Authority Administrative Committee.[430] Since that time, authority to impose non-disciplinary time adds was transferred from the parole board to the Juvenile Justice Administrative Committee (JJAC, formerly YAAC).[431]

Rating: Deferred

8.6.4c: *By March 31, 2007, DJJ must develop standards for awarding program credits for youth participation in restorative justice projects.*

[425] *Ibid.*
[426] Program Credits Policy (PoP #374, April 6, 2009), p. 3.
[427] *See* item 2.1.4a, above.
[428] Time Add Tracking System (PoP #303, December 5, 2008), p. 2.
[429] *Ibid.*
[430] *See* Sixth Report of the Special Master (January 2008), Appendix B (Beltz Report), p. 16.
[431] Statements of Alicia Ginn during central office site visit, March 12, 2009.

The remedial plan requires DJJ to develop standards for restorative justice program credits – i.e., credits that move a youth's parole board date closer – to be awarded above and beyond the available incentive program credits.[432] Non-discretionary standards for restorative justice program credits must be developed, based on types of restorative justice activities and/or the activities' duration.[433] DJJ's recently completed program credit policy does not comply with this requirement.[434]

DJJ has developed standards for restorative justice *points*. Incentive points are used to "purchase" certain privileges, such as additional family phone calls.[435] Effective June 1, 2007, facilities were instructed to award points to youth who had participated in designated restorative justice activities.[436] (For unexplained reasons, youth could not receive points for achievements that occurred prior to June 1, 2007.) The directive designated the following as restorative justice point opportunties:

1. Earning a high school diploma: 10 points;
2. Earning a GED: 5 points;
3. Attaining a GPA of 3.0 or higher in a semester with at least three classes: 4 points;
4. Earning a certificate in certain behavioral management programs: 4 months;
5. "Heroic or major institutional safety contribution[s]:" 2 points;
6. Active membership in the student council or youth advisory committee for a semester: 2 points;
7. Serving as a peer counselor or mentor over a 60-day period: 2 points;
8. Completing an institutional community service project: 2 points.[437]

Site visits during late 2008 revealed poor implementation. OSM staff visited O.H. Close in October 2008 and noted some confusion. Staff could not explain why only some of the restorative justice points listed above were awardable in WIN and some were not.[438] Chaderjian

[432] Program credits translate into decreased length of stay at DJJ. Per DJJ policy, A-Level youth may receive up to 15 program credits per month, which means a 15-day advancement of the youth's parole consideration date. Safety and Welfare Remedial Plan, p. 73. B-Level youth may receive up to 9 program credits per month, and C-Level youth may receive six credits per month. *Id.*; DJJ Program Credits Policy, January 26, 2009. The plan requires DJJ to award program credits in addition to the 9- or 15-credit maximum each month for participation in restorative justice activities. *See* Safety and Welfare Remedial Plan, pp. 73-74.

[433] Safety and Welfare Remedial Plan, pp. 73-74 ("For example, working x hours on a restorative justice project might be worth one program credit, participating in blood drive might be worth several credits, etc.").

[434] *See* Program Credits Policy (PoP #374, April 6, 2009), pp. 4-5; DJJ comments on the draft of this report, June 9, 2009, p. 5 ("No program credits are earned above and beyond for the restorative justice program.")

[435] The plan is ambiguous as to whether restorative justice *points* should also be awarded, as it refers to both program credits and incentive points in an action plan section entitled "DJJ will increase offsets to time adds through increased use of positive reinforcement for good behavior." *See* Safety and Welfare Remedial Plan, p. 73.

[436] *See* Attachment 26, memorandum of Sandra Youngen to superintendents and ward incentive coordinators, May 23, 2007.

[437] *Id.* OSM notes that this memo represents the removal of three items from DJJ's prior list of restorative justice point opportunities. *See* memorandum of Ed Wilder to superintendents and ward incentive coordinators, November 2, 2006.

[438] Statements of staff during O.H. Close site visit, October 2008. OSM staff later noted that the May 2007 memorandum itself explains that only the first three listed options are in WIN, and the remaining five options can only be awarded by submitting a request form to the superintendent. *See* Attachment 26, memorandum of Sandra Youngen to superintendents and ward incentive coordinators, May 23, 2007. The memo does not make clear how

administrators, also interviewed in October 2008, were unsure whether point standards had been developed for restorative justice projects.[439]

Central office issued a clarifying e-mail to all superintendents and youth incentive coordinators on October 29, 2008. The e-mail explained that the first five listed point opportunities are not restorative justice point options.[440] Instead, these points are for "Individual Achievements," and the last *three* options are for restorative justice activities.[441]

Subsequent site visits showed varying levels of staff understanding and youth awareness of restorative justice points. During the monitors' December 2008 visit to Ventura, the youth incentive coordinator clearly articulated the point system and referred to the October 2008 e-mail.[442] By contrast, a parole agent I interviewed at Preston in February 2009 stated that when points are awarded at case conferences, all "positive activities" are considered, though he was unaware of any points for "restorative justice" activities or accomplishments.[443]

Records reviewed at Preston in February 2009 also showed that the directives were not being implemented fully. A monitor reviewed six youths' records of incentive point awards and deductions for 2008, after the first directive went into effect. A total of 28 instances of restorative justice or individual achievement activities were noted. In 20 instances, points were awarded consistent with DJJ's point award system. In the remaining eight instances, or 29% of those reviewed, no points were awarded.[444]

Though some youth are receiving these points, many remain unaware of restorative justice point opportunities.[445] Even at SYCRCC, where restorative justice opportunities abound and staff were well-informed of the point system, some youth were unaware of the relationship between these activities and the incentive point program.[446] Ten youth, from four living units, were interviewed about restorative justice point opportunities in March 2009; three of the interviewees indicated some awareness of the policy.[447] The remaining seven were unaware of restorative justice points, even when the concept was explained in alternative ways to them.[448]

---

these "manually" awarded points are entered into WIN or how they can be spent by youth. *Id.* In response to OSM's informal site visit reports, central office staff are reportedly meeting with IT support regarding the apparent inconsistency between the restorative justice points in the recent memo and awarded points listed in WIN. Statements of central office staff during SYCRCC site visit, March 2009.

[439] Statements of staff during Chaderjian site visit, October 2008.

[440] E-mail of Rosemary Crisostomo to superintendents, incentive coordinators, and others, October 29, 2008.

[441] *Id.*

[442] Statements of staff during Ventura site visit, December 2008.

[443] Statements of staff during Preston site visit, February 2009.

[444] Two additional records were received, but excluded from the review above because they contained ambiguous data. Both recorded the same restorative justice activity multiple times on a single day, each time noting that the youth received no restorative justice points. It was unclear whether the youth had actually completed the activity multiple times or if the repeats were caused by a computer glitch.

[445] Statements of various interviewed youth during facility site visits, October 2008 to March 2009. In response to a draft of this report, DJJ stated that it "intends to continue defining the standards, thereby expanding awareness." DJJ comments on the draft of this report, June 9, 2009, p. 5.

[446] Statements of staff and interviewed youth during SYCRCC site visit, March 2009.

[447] One youth knew he could earn points for educational achievements, but said that otherwise points depend on "how you run your program." Another youth on the same unit had logged about 70 hours of activities such as Kids at Risk and facility clean-ups. The third youth, from a different unit, was aware of these opportunities and stated

Central office staff recently examined WIN data depicting restorative justice point awards.[449] Staff found that many youth receive points for obtaining certificates and participating in community service, but few points are awarded for other areas. DJJ attributes the poor implementation to communication problems among facility staff; for instance, school personnel may be unaware that youth should receive points for student council participation, and therefore do not inform relevant staff. The problem also seems to be a lack of communication to youth, who participate in the case conferences during which points are awarded. It makes little sense to incorporate restorative justice activities in an *incentive* system without raising youth awareness about the positive sanctions that would result from their participation. Staff cannot incentivize youth without informing youth.

Almost two years after authorizing restorative justice points, central office intends to produce a handout explaining the concept to youth. Central office also now plans to solicit information from facility staff to learn what types of restorative justice activities are already occurring.

Rating: Non-compliance[450]

8.7.1a: *DJJ is to ensure that Education Services operates the facilities' law libraries by August 20, 2007.* ***8.7.1c:*** *Education Services is to control the law libraries budget and manage purchases by June 30, 2010 (deadline reset from August 30, 2007).* ***8.7.3:*** *Needed law library materials must be purchased annually by August 30, 2007.* ***8.7.1b:*** *Education Services is to track law library needs and conduct annual audits indicating that materials are up-to-date or ordered by June 30, 2010 (deadline reset from August 30, 2007).* ***8.7.5:*** *DJJ is to replace print libraries with electronic or internet materials by June 30, 2010 (deadline reset from August 30, 2007).*

8.7.1a: The remedial plan described the law library problem thus: "Law libraries are managed by two branches of DJJ: Education handles operations, and Institutions and Camps administers the budget. This creates a lack of coordination."[451]

This has not changed. In fact, it does not appear that law libraries have been managed at all, as described in the discussion of the next few compliance items, especially item 8.7.1b.

Rating: Non-compliance

---

that participation in these activities was required to attain A-Level status. He mentioned a "charity dinner" that took place the month before, in which youth donated $10 for restaurant food to be provided to a charity of their choice. He also referred to the Kids At Risk program.

[448] Statements of interviewed youth during SYCRCC site visit, March 2009.

[449] Information in this and the following paragraph is based on statements of Alicia Ginn during central office site visit, March 12, 2009.

[450] OSM previously designated a "PC" rating for this item; that rating was based upon a reading of the plan requirement as limited to the development of restorative justice points. *See* Sixth Report of the Special Master (January 2008), Appendix B (Beltz Report), pp. 16-17. As discussed above, the plan requires DJJ to develop restorative justice program credits in addition to regular incentive credits, which DJJ has not done. The plan's language is ambiguous with regard to the requirement of incentive *points*. OSM therefore amends its prior rating to "non-compliance."

[451] Safety and Welfare Remedial Plan, p. 66.

8.7.1c: Education Services does not have control of the law library budget.[452] On June 11, 2008, DJJ sent a request to the CDCR Budget Management Branch for a permanent budget allotment transfer effective FY 2008/09.[453] DJJ expected the budget transfer to occur by August 2008.[454] The transfer did not take place,[455] and in November 2008, DJJ indicated that it did not expect to attain substantial compliance this fiscal year.[456]

According to the Education Services business manager, the Department of Finance requires a budget revision in order to make a permanent budget allotment transfer.[457] Reportedly the Department of Finance will not attempt a budget revision for such a small-dollar item. To obtain the transfer, DJJ would have to prepare a "policy budget change proposal," which involves examining every problem in the budget. In the meantime, Education Services has received a one-year authorization from CDCR's budget office to spend the funds for law libraries. Without a permanent budget reallotment, Education Services must request this authorization every year. Although its current authorization allows Education Services staff to decide what law library materials to purchase this fiscal year, Education Services still lacks permanent control of the law library budget.

It is unclear why DJJ was able to transfer funds to the education budget for the creation of vocational specialist positions (see item 2.4.3, above) but cannot do the same for law library funding.

Rating: Partial compliance (Note that the revised deadline has not yet passed.)

8.7.3: The most recent law library purchases were made in May 2007.[458] DJJ contracted for a variety of codes, reporters, secondary legal sources, and accompanying updates.[459] At some facilities, the print resources acquired in 2007 languished in boxes for months before being shelved.[460] The update subscriptions then expired in December 2007,[461] though at least one

[452] Statements of staff during central office site visit, May 2008; Attachment 27, memorandum of Jim Cripe to Doug Ugarkovich, November 13, 2008 ("No funds (budget) have been transferred from Facilities to Education Services to date (note: education funds cannot be used to purchase Law Library materials) . . . ."); statements of staff during central office site visit, March 12, 2009.
[453] *See* Attachment 28, memorandum of Lisa Goodwill to Jan Krueger, June 11, 2008.
[454] Document entitled "Solution Status," November 2008 (PoP #265, November 19, 2008), p. 3 ("A request to transfer funds from the Facility Index budget into the Education Services budget has been submitted to CDCR. The budget transfer is planned to be accomplished by August 2008.").
[455] Statements of Rob Uno during central office site visit, March 12, 2009.
[456] Deft. Response to the Court's October 27, 2008 Order, November 21, 2008, Exhibit H, p. 8.
[457] Information in this paragraph is based on statements of Rob Uno during central office site visit, March 12, 2009.
[458] *See* Attachment 29, State of California Purchase Order #61613, May 23, 2007; Attachment 30, State of California Purchase Order #61614, May 23, 2007 (DJJ Proof of Practice #154, June 18, 2008).
[459] *See* Attachment 29, State of California Purchase Order #61613, May 23, 2007; Attachment 30, State of California Purchase Order #61614, May 23, 2007 (DJJ Proof of Practice #154, June 18, 2008).
[460] In February 2008, Chaderjian's acting librarian reported that books received in late 2007 had not yet been unpacked. Former monitor Cathleen Beltz observed roughly 30 boxes from Thompson-West, including books from the initial May 2007 order (referenced above) and subscription updates. The acting librarian stated that there was insufficient space to shelve all the legal publications, but he believed there to be a plan to make space for them in the future. Ms. Beltz observed the same problem in Preston in February 2008. Due to insufficient shelf space,

vendor continued to send updated materials to the facility law libraries by mistake.[462] Library staff were later instructed to de-shelve the materials and return them to the vendor(s).[463]

Across the state, the monitors noted a lack of current know-your-rights-type guides directed at incarcerated juveniles in California. DJJ does not centrally purchase "street law" resources, and facility library staff make these purchases on their own when funds are available.[464] The safety and welfare expert has recommended that DJJ obtain current, appropriate street law resources.[465] Currently, few such resources are on the library shelves, and many of them are out of date.[466] For example, a Nolo Press immigration law guide on the shelf at Preston was published in 1994.[467] SYCRCC also had 1996 edition of a book entitled "How to Get a Green Card."[468] Reliance on either of these manuals could be significantly detrimental to an immigrant's status in the U.S., due to sweeping immigration law changes that followed their publication.

In November 2008, DJJ stated that it did not expect to achieve substantial compliance with this requirement during fiscal year 2008-2009.[469] However, the monitors have been told that the transition to electronic law libraries is well ahead of schedule, and this process entails the procurement of updated law library resources.[470]

Rating: Beginning compliance

8.7.1b: The remedial plan requires Education Services to "conduct annual audits of access and materials compliance."[471] Education Services has not audited facility law libraries to date and has provided no documentation that law library needs are being tracked.[472] DJJ staff report that annual audits will begin following the transition to electronic law libraries.[473]

---

shipments remained in boxes stacked in a back room. The principal stated that there was a plan to build additional shelves but was unsure when the project would be completed.

[461] Deft. Response to the Court's October 27, 2008 Order, November 21, 2008, Exhibit J, p. 1. However, the vendor contracts suggest that DJJ should have continued to receive subscription updates through March 2008. *See* Attachment 29, State of California Purchase Order #61613, May 23, 2007; Attachment 30, State of California Purchase Order #61614, May 23, 2007 (PoP#154, June 18, 2008).

[462] Statements of law library staff during Stark and Preston site visits, January and February 2009, respectively; statements of Jim Cripe to Barry Krisberg during central office site visit, January 14, 2009.

[463] Statements of law library staff during Stark and Preston site visits, January and February 2009, respectively; statements of Jim Cripe to Barry Krisberg during central office site visit, January 14, 2009.

[464] Statements of staff during Chaderjian, Ventura, and Stark site visits, October 2008, December 2008, and January 2009, respectively.

[465] Statements of Barry Krisberg during central office site visit, January 14, 2009.

[466] The basis for this statement is discussed with regard to item 8.7.1b, below.

[467] The book was removed from the shelf once the significance of its age was pointed out to the acting librarian.

[468] SYCRCC's librarian did not remove the volume from the shelves during the monitor's visit.

[469] Deft. Response to the Court's October 27, 2008 Order, November 21, 2008, Exhibit H, p. 8.

[470] Statements of Tammy McGuire and facility librarian during SYCRCC site visit, March 2009.

[471] Safety and Welfare Remedial Plan, p. 75.

[472] Statements of staff during central office site visits, May 2008 and March 12, 2009.

[473] Statements of staff during central office site visit, March 12, 2009. The central office staff member in charge of libraries is working with the head of *Farrell* compliance to develop an audit strategy. Statements of Jim Cripe during central office site visit, March 12, 2009.

The monitors‟ own information-gathering suggests that central office should immediately take steps to meet the mandate that facilities make legal resources available to youth. DJJ should not wait until the electronic law libraries are in place to address the systems issues that have yielded the current state of DJJ‟s law libraries and youth access to them. Central office should assess not only procurement needs in each facility‟s library, such as street law resources, but also barriers to youth access. These barriers include delayed and incorrect shelving of print materials, staff members‟ lack of training and qualifications, restricted library visitation, a tedious law library request process, and youth unawareness of law libraries and how to access them.

DJJ provided library staff with law library training in March 2009. The special master‟s office has not yet had a chance to assess the impact of that training. Before March 2009, most if not all staff responsible for the law libraries were insufficiently trained or experienced to assist youth with law library materials.[474] As of the monitors‟ site visits, only two of DJJ‟s facility librarians are formally trained and credentialed librarians.[475]

Also, many DJJ youth have no direct access whatsoever to the law libraries.[476] Youth in high-risk units and in restricted living settings are often not allowed to visit the libraries at all. For example, two of four interviewed youth at Stark had attempted to use the law library but were not permitted to do so, one because he was "high-risk."[477] A youth on Chaderjian‟s SMP unit, though he was the unit‟s "resident ward" and not on SMP status, was not allowed to visit the law library as of October 2008.[478] As of January 2009, many youth at Stark could not visit the school area at all, including youth on residential mental health units who were not classified as high-

[474] For instance, as of Cathleen Beltz‟s January 2008 visit to Chaderjian, the facility had no permanent librarian, and its temporary librarian, hired in February 2008, had not received law library training. Statements of acting librarian during Chaderjian site visit, January 2008. In fact, the acting librarian was not "eligible for" the training because he was a temporary employee. *Id.* Nothing had changed as of October 2008. Statements of acting librarian during Chaderjian site visit, October 2008. As of February 2008, Preston‟s library was staffed by a substitute teacher temporarily assigned to the librarian position, and she had not completed law library training. Statements of staff during Preston site visit, February 2008. A year later, nothing had changed. Statements of staff during Preston site visit, February 2009. The certified teacher-librarian at O.H. Close has attended law librarian training, but this training did not thoroughly cover the operation of law libraries. Statements of staff during O.H. Close site visit, June 2008. The Safety and Welfare expert also reported training deficiencies in the librarians at SYCRCC and Ventura. Barry Krisberg, informal reports on SYCRCC and Ventura site visits, 2008.

[475] Statements of staff during various site visits, 2008 to 2009. Central office reported that DJJ is experiencing difficulty in obtaining trained law librarians. Statements of staff during central office site visit, 2008. OSM notes, however, that some of this difficulty may be preventable. For instance, Preston‟s librarian position remained vacant for over six months, at least in part due to the unnecessary classification of the position as a "teacher librarian," which narrowed the potential pool of candidates. Statements of staff during Preston site visit, February 2009; *see also* Tom O‟Rourke and Robert Gordon, Preston informal report, February 2009, p. 3 ("Based on the remedial plan . . . , each high school shall have a minimum complement of credentialed staff, including a senior librarian or a teacher librarian at each site. There is a need to fill this position . . . . The site principal, with the approval of the DJJ education director, should be given the responsibility and ability to reclassify the positions to provide enough courses in each academic area based on the unique needs at the site."), 4 (noting the position‟s six-month vacancy). This position was filled as of May 20, 2009, though OSM does not yet have information about Preston‟s newly hired librarian‟s credentials. Statements of Preston school principal during Court Compliance Task Force meeting, May 21, 2009.

[476] The lack of youth access was particularly extreme during former monitor Cathleen Beltz‟s site visits in early 2008. Her notes reflect that law libraries at Preston and Ventura were not operational at the time of her visits.

[477] Statements of interviewed youth to former OSM intern Amelia Post during Stark site visit, May 2008.

[478] Statements of interviewed youth, Chaderjian site visit, October 2008.

risk.[479] Though efforts have been made to increase youth access to the school area, as of April 2009, many youth were still not allowed in the school area, and many others were afraid of the school area because facility leadership had not adequately addressed safety and security concerns there.[480] Youth in SYCRCC's high-risk unit are also not permitted to visit the facility's library.[481]

Youth who are allowed to visit the libraries still face barriers to access. First, at least some youth are unaware that the law libraries exist.[482] Second, two facilities' libraries do not shelve all print legal resources in a publicly accessible place.[483] Third, library staff lack the training needed to assist youth in their research, as described above. Fourth, DJJ's recently developed system for providing youth with library access is unnecessarily complicated. The following steps are required: 1) the youth must obtain a Law Library Request Form from living unit staff; 2) s/he must complete the form and specify what information is needed from the law library; 3) the form must be sent to library staff via the institutional mail system; 4) library staff then schedule an appointment in WIN and mail the request form back to the youth; 5) on the day of the library appointment, the youth must request and receive a library pass from living unit staff; 6) the youth must then present the pass to his or her regular classroom instructor; and 7) that instructor ensures that "arrangements are made" for the youth to access the library.[484] It is unclear why so many steps are necessary and why youth must miss class to visit the law library. Furthermore, the central office memo setting forth this process does not direct staff to make adjustments for youth with disabilities and/or mental health issues.[485]

Central office first sent the Law Library Request Form to superintendents and principals on July 22, 2008, with a memo directing facility staff to discuss the availability of the form with all youth by August 8, 2008.[486] As mentioned above, some youth are still unaware that the law libraries exist. Other youth do not know how to access it.[487]

---

[479] Robert Gordon and Tom O'Rourke, Stark informal report, January 2009; OSM monitor observations during Stark site visit (education), January 2009; statements of interviewed youth on one unit during Stark site visit, January 2009.

[480] Barry Krisberg, informal report on Stark site visit, 2009, p. 1.

[481] Statements of interviewed youth during SYCRCC site visit, March 2009.

[482] Five of seven youth interviewed at O.H. Close in 2008 were unaware of the existence of a law library at the facility. Statements of interviewed youth to former OSM intern Terry Schuster during O.H. Close site visit, June 2008; statements of interviewed youth during O.H. Close site visit, October 2008.

[483] Many of Chaderjian's (out of date) legal materials are shelved two-deep in a back room to which youth have no direct access. OSM monitor observations during Chaderjian site visit, October 2008. At Preston, numerous law library books and subscription updates had not yet been shelved as of February 2009. OSM monitor observations and statements of staff during Preston site visit, February 2009.

[484] *See* Attachment 31, memorandum of Jim Cripe to principals, October 8, 2008. The process is slightly different for youth who are prohibited from physically visiting the library; they must submit the request form in the same way, and the library staff is to send the youth copies of any gathered research. Statements of staff and youth during Chaderjian site visit, October 2008.

[485] *See* Attachment 31, memorandum of Jim Cripe to principals, October 8, 2008.

[486] *See* memorandum of Sandra Youngen and Doug McKeever to superintendents and principals, July 22, 2008.

[487] For instance, a youth at Chaderjian stated that he had never accessed the law library but that he "think[s] you can." Statements of interviewed youth during Chaderjian site visit, October 2008. An interviewee on SYCRCC's high-risk unit stated that he was unaware of any process by which to access the library through unit staff. Statements of interviewed youth during SYCRCC site visit, March 2009.

Some youth who were restricted from the library reported problems with the law library request system. A young man at Stark stated that he frequently received no response from his inquiries to the library.[488] A youth at Chaderjian stated in October 2008 that he was enrolled in a college-level distance learning class in business law, and its curriculum required him to refer to a legal dictionary. The librarian reportedly would not provide him with a necessary legal dictionary, presumably because the book is considered a reference work that does not circulate. The youth could not visit the library personally because of his restricted program status. He provided the librarian with the URL for an online legal glossary and asked that it be printed out for him. The librarian reportedly replied that this was not his job. The youth stated that he consequently had to drop the course.

In addition, it appears that in practice youth cannot directly access legal materials, even when physically visiting the libraries. It is generally library staff who research youths" questions and provide them with print-outs of the results.[489]

Youth access problems could be improved by compliance with DJJ"s own Education Services Branch Manual, which requires that students and staff be involved in planning library collections, services, and programs.[490] The OSM is unaware of any student involvement in library planning, though Stark"s library staff have reported periodic training of youth to assist their peers with the law library.[491]

Rating: Non-compliance (Note that the revised deadline has not yet passed.)

8.7.5: In May 2008, central office staff informed former monitor Cathleen Beltz that the transition from print libraries to electronic or internet materials had not begun and that DJJ would most likely use CDROM materials rather than internet subscriptions.[492] Staff stated that the earliest possible order date was in the fall of 2008.[493]

In early November 2008, DJJ provided OSM with a project schedule for its conversion to electronic law libraries.[494] The schedule allots 654 days to the conversion process, beginning July 1, 2008 and ending December 31, 2010, the date of DJJ"s proposed revised deadline.[495] Perhaps most notable is the allocation of 270 days to develop the contract for electronic law libraries.[496] To learn why DJJ expected the procurement of Lexis-Nexis or WestLaw[497] contracts and software (or internet subscriptions) to take nine months, OSM sent DJJ counsel an email

[488] Statements of interviewed youth to former OSM intern Amelia Post during Stark site visit, May 2008.
[489] Statements of staff during Chaderjian, Stark, and Preston site visits, October 2008, January 2009, and February 2009, respectively.
[490] Excerpts from the Education Services Branch Manual, (PoP #279, November 5, 2008).
[491] Statements of staff during Stark site visit, May 2008. In January 2009, OSM staff visited the library and interacted with a very impressive youth who had until recently been a library assistant.
[492] Statements of staff during central office site visit, May 2008.
[493] *Id.*
[494] This schedule was submitted to the Court on November 21, 2008. *See* Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit J, p. 3.
[495] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit J, p. 3.
[496] *Id.*, p. 4.
[497] These two vendors are the only providers of comprehensive, electronic legal research resources in the U.S.

containing this and other inquiries on November 17, 2008.[498] Despite OSM's repeated follow-up attempts, DJJ has never explained its need to devote so much time to the conversion process in general or the contracting process in particular.

In practice, the contract process has unfolded as follows. DJJ staff first met with Lexis and Westlaw in July 2008.[499] DJJ then spent time approaching other entities that do not provide electronic law library services, to satisfy a state requirement that agencies obtain three bidders for certain state contracts.[500] These efforts yielded no new bidders, because no other entities provide the needed service.[501] In January 2009, a central office manager said that he hoped DJJ would be permitted to award a contract without having three bidders.[502] In March 2009, DJJ informed OSM that it had submitted a purchase order for WestLaw law library materials on DVD.[503]

DJJ has cited three other barriers to the conversion to electronic law libraries: 1) the need to clarify what legal materials DJJ is required by law to include in its law libraries; 2) transfer of the law library budget to Education Services; and 3) potential information technology issues.[504]

As to the first obstacle, on November 3, 2008 DJJ asked its legal department to review what law library materials it must make available to youth.[505] Legal staff responded in early January 2009 that the law does not impose any specific requirements.[506]

Regarding the budget, DJJ requested a permanent transfer of the law library budget to Education Services effective fiscal year 2008-2009.[507] The transfer did not occur, though Education Services has received a one-year authorization from CDCR's budget office to spend the funds for law libraries.[508] DJJ staff report that the budget issue created an 18-month delay.[509]

---

[498] Attachment to e-mail of Aubra Fletcher to Rachel Stern, November 17, 2008, p. 2 ("My overarching question is why it should take 654 days to purchase, install, and train on what I assume is ready-made legal research software/databases. I also have questions about subparts of this schedule, such as why it would take 270 days to develop a contract for something that seems to entail basically the selection of a software package and placing a purchase order? . . . . Why, for instance, are four weeks allotted to receiving the contractor's signature and required documents . . . ?").

[499] Document entitled "Solution Status," November 2008 (PoP #265, November 19, 2008), p. 4 ("Education staff met with representatives from LexisNexis on July 7, 2008, and with Westlaw on July 8, 2008 . . . . By July 20, 2008, both LexisNexis and Westlaw submitted quotes . . . .").

[500] Statements of Jim Cripe to Barry Krisberg during central office site visit, January 14, 2009. OSM notes that the state makes reasonable exceptions to the three-bidder requirement.

[501] *Id.*

[502] *Id.*

[503] Statements of Rob Uno during central office site visit, March 12, 2009. DJJ has ordered the items on the "*Gilmore* list," except for Shepard's. See discussion below.

[504] Deft. Response to the Court's October 27, 2008 Order, November 21, 2008, Exhibit J, pp. 1-2.

[505] *Id.*, Exhibit J, p. 1 ("On 11/3/2008 the DJJ requested an updated review of Gilmore [v. Lynch] listing by Legal to verify whether it will suffice for a law library for youth or if additional materials are needed."); statements of staff to Barry Krisberg during central office site visit, January 14, 2009.

[506] Statements of staff to Barry Krisberg during central office site visit, January 14, 2009.

[507] *See* Attachment 28, memorandum of Lisa Goodwill to Jan Krueger, June 11, 2008; *see also* discussion related to audit item 8.7.1a, above.

[508] Statements of Rob Uno during central office site visit, March 12, 2009.

[509] *Id.*

In January 2009, central office staff described the information technology concerns as the need to assess whether DJJ youth are legally permitted to have internet access and the accompanying need to limit this access to law library resources only.[510] In March 2009, central office staff informed OSM that it planned to purchase electronic resources on disc rather than via an internet subscription.[511] It is unknown why DJJ did not select this option in the first place. However, other IT issues persist. DJJ has submitted requisitions for necessary computing equipment and is awaiting response.[512] As of mid-March 2009, central office expected the equipment and the WestLaw materials by April 2009.[513]

DJJ plans to equip the electronic law library with WestLaw DVDs,[514] and implementation is scheduled for the end of June 2009.[515] The resources available will be limited to the *Gilmore* list, which includes a variety of state and federal codes, digests, reporters, and secondary sources.[516] OSM will consult the safety and welfare expert as to whether the secondary sources on the list should include more in the way of juvenile-specific information.[517]

Also, though the *Gilmore* list includes Shepard"s, DJJ does not plan to include a Shepardizing feature in its law libraries on the grounds that DJJ youth are not likely to utilize it.[518] Access to up-to-date legal information is the purpose of the law libraries and must be provided to all youth, and a law library should allow researchers to ensure that information is current. As the safety and welfare expert has recommended, DJJ should provide law library training to youth,[519] and this training should address youth willingness and ability to investigate the current validity of legal information discovered on WestLaw.

As discussed above, DJJ should also promptly designate and purchase appropriate "street law" resources for its law libraries statewide.

Rating: Non-compliance (all facilities)

---

[510] Statements of Jim Cripe to Barry Krisberg during central office site visit, January 14, 2009.
[511] Statements of Rob Uno during central office site visit, March 12, 2009.
[512] *Id.*
[513] *Id.*
[514] Statements of central office staff during central office site visit, January 14, 2009.
[515] Statements of staff during Court Compliance Task Force meeting, June 4, 2009. Some facilities have received the DVDs, and computers are expected sometime in June 2009. Statements of staff during Court Compliance Task Force meetings, May 14, 2009 and June 4, 2009.
[516] *Id.*; *see also* Gilmore v. Lynch, 319 F. Supp. 105, 107-109 (N.D. Cal. 1970). The Gilmore list is set forth in CDCR"s Operations Manual. *See* Attachment 32, Department of Corrections and Rehabilitation Operations Manual § 101120.11 (2007). OSM notes that it is unable to locate the listed item "California Criminal Law Procedures and Practices" on WestLaw.
[517] CDCR regulations include Witkin"s California Criminal Law, which does not include information regarding juvenile courts. *See* Attachment 32, Department of Corrections and Rehabilitation Operations Manual § 101120.11 (2007). Witkin"s Summary of California Law, by contrast, contains a section regarding juvenile delinquency proceedings in California, at Chapter VIII. California Jurisprudence, which is on the *Gilmore* list, contains information regarding juvenile court proceedings. *See generally* 27A Cal. Jur. 3d. DJJ should consider adding the Witkin resource as well.
[518] Statements of Jim Cripe during central office site visit, March 12, 2009; *see also* Attachment 32, Department of Corrections and Rehabilitation Operations Manual § 101120.11 (2007).
[519] *See* Barry Krisberg, informal report on central office site visit, 2009, p. 15.

8.8.2a: *By June 30, 2007, DJJ must designate a religious coordinator to oversee mandated programs, policy, manual revisions, and training.* ***S&W 8.8.2b-d:*** *The religious coordinator is to monitor facilities for* ***(b)*** *provision of services/programs for various faiths,* ***(c)*** *youth access to services/programs/materials, and* ***(d)*** *documentation of services/programs in an automated tracking system.*

8.8.2a: OSM previously reported that in 2006 DJJ assigned religious coordinator functions, among other functions, to the program administrator for special programs, Gregory Brewer.[520] This is a secondary assignment.[521] In January 2008, DJJ provided a duty statement for the religious programs coordinator.[522] The duty statement includes all tasks assigned to the coordinator by the safety and welfare plan.[523] Mr. Brewer continues to serve as DJJ's religious coordinator, now as a retired annuitant.[524]

Rating: Substantial compliance

8.8.2b: Mr. Brewer reports that he has been tracking unmet needs for religious services/programs via the WIN Exchange since November 30, 2008.[525] The facility chaplains send him a weekly schedule, and he checks WIN records to determine whether the documented services align with the weekly schedule. WIN does not generate a report of any kind to facilitate this process; Mr. Brewer checks WIN records manually.

As a separate matter, central office staff who oversee the grievance process track religious grievances separately from other grievances.[526] The safety and welfare expert has recommended that the grievance data be routinely shared with the religious coordinator.[527] Currently, the coordinator sees only some of the religious grievances.[528]

---

[520] *See* Sixth Report of the Special Master, Appendix B (Beltz Report), p. 18.
[521] Memorandum of Ed Wilder to superintendents, August 10, 2006.
[522] *See* Attachment 33, duty statement for Religious Programs Coordinator, January 24, 2008.
[523] *See id.* The remedial plan requires that the religious coordinator 1) oversee "uniform enforcement of legally mandated religious programming to youths in all DJJ facilities," 2) "be responsible for oversight of religious policy, manual revisions, and chaplain training," and 3) "monitor all facilities through WIN and field visits to ensure that:

- Religious services/programs are provided for various faith groups.
- All youth have access to religious services/programs and materials.
- There is proper documentation of services/programs in WIN.
- State, Federal (Faith Based Initiative), and other grants are pursued.
- The Department is represented at various interdepartmental meetings, professional chaplain organizations, and conferences such as the State Advisory Council on Institutional Religion (SACIR), Association of Chaplains in State Services (ACESS) and Bureau of Prisons (BOP).
- An Internship Program for DJJ's chaplaincy is developed."

Safety and Welfare Remedial Plan, pp. 75-76.
[524] Statements of Gregory Brewer during central office site visit, March 12, 2009.
[525] *Id.*
[526] Statements of staff to Barry Krisberg during central office site visit, January 14, 2009.
[527] Statements of Barry Krisberg during central office site visit, January 14, 2009.
[528] Statements of staff to Barry Krisberg during central office site visit, January 14, 2009.

The remedial plan requires the religious coordinator to monitor the provision of services, both via WIN records and by conducting field visits.[529] OSM has received no documentation or other indication that Mr. Brewer conducts field visits to monitor provision of services.[530]

All DJJ facilities have a full-time Catholic chaplain and a full-time Protestant chaplain.[531] Native American spiritual leaders serve as part-time staff at each facility except for Preston, whose full-time Native leader was soon to leave as of February 2009.[532] Muslim leaders serve as part-time staff at Stark, SYCRCC, and Ventura.[533] O.H. Close and Chaderjian had lost their on-staff Muslim leader as of October 2008.[534] Preston had recently lost its volunteer Muslim leader as of February 2009.[535]

Leaders of other faiths and traditions are brought in as volunteers. For example, O.H. Close has a volunteer rabbi, Mormon elder, and Jehovah's Witness elder.[536] As of October 2008, the facility was screening a Wiccan volunteer candidate.[537] Protestant, Catholic, and other traditions' laypersons volunteer to meet with youth in many of DJJ's facilities. These visits are in addition to regularly scheduled religious programs. Ventura appears to have the broadest community base of religious (and other) volunteers.[538]

Facility leadership at times experience difficulty locating volunteers for youth with certain faith traditions. Staff at O.H. Close described their obstacles in bringing on a volunteer Buddhist monk, and Chaderjian staff mentioned difficulties locating a volunteer Mormon elder.[539] Youth at Chaderjian, O.H. Close, and Preston mentioned that no programs are offered for Rastafarian youth, and it was not apparent that staff had sought Rastafarian leaders.[540]

Rating: Partial compliance

8.8.2c: It does not appear that the religious coordinator conducts field visits to monitor access to programs.[541] He does track access in WIN by noting whether services/programs provided are listed as "alternative services," or services provided to youth who are restricted from leaving

[529] Safety and Welfare Remedial Plan, pp. 75-76.
[530] *See e.g.*, statements of Gregory Brewer during central office site visit, March 12, 2009; e-mail of Tammy McGuire to Aubra Fletcher, May 4, 2009.
[531] Statements of staff during facility site visits 2008 to 2009.
[532] *Id.*
[533] *Id.*
[534] Statements of Yvette Marc-Aurele during O.H. Close site visit, October 2008.
[535] Statements of Timothy Mahoney during Preston site visit, February 2009.
[536] Statements of Yvette Marc-Aurele during O.H. Close site visit, October 2008.
[537] Statements of Yvette Marc-Aurele and Lynn Cummings during O.H. Close site visit, October 2008.
[538] In December 2008, OSM monitors heard and observed repeated evidence of this in interviews with facility leadership, with youth, and with community volunteer Rosalinda Vint, who coordinates much of the community involvement with Ventura youth. OSM monitors also observed youth meeting with their religious volunteers during the week, and had the opportunity to interact with some of these volunteers and various youth during Ventura's Kiwanis club luncheon.
[539] Statements of staff during O.H. Close and Chaderjian site visits, October 2008.
[540] Statements of youth and staff during Chaderjian, O.H. Close, and Preston site visits, October 2008, October 2008, and February 2009, respectively.
[541] Statements of Gregory Brewer during central office site visit, March 12, 2009; e-mail of Tammy McGuire to Aubra Fletcher, May 4, 2009.

their living unit where possible.[542] The chaplain/spiritual leader visits the youth on his or her living unit. According to the religious coordinator, chaplains and spiritual leaders spend a great deal of their time conducting these visits, because so many youth are in restricted settings.[543]

For example, youth in Stark's SMP are not allowed to attend religious programs with other youth, and reportedly only Protestant services are offered on the unit.[544] And as of recently, other "high-risk" youth at Stark also cannot leave their living units to attend religious programs.[545] As of January 25, 2009, Stark housed 84 youth on its high-risk units, plus 25 youth on its SMP.[546] A quarter of the youth at Stark are not permitted to attend regular religious programming.[547] This arrangement poses a particular problem for Native American youth, whose programs involve hot stones and incense-burning and are necessarily held outdoors. According to one staff member and one interviewed youth, the facility's Native American spiritual leader has discontinued his visits to living units in protest of the recent rule prohibiting all "high-risk" youth from attending regular religious programs.[548]

DJJ is revising its policy for religious services.[549] The current draft eliminates a provision allowing gang information coordinators to recommend that certain youth not attend a particular religious service based on security concerns.[550] The draft also seems to allow youth to attend group religious services (as opposed to group religious programs) even if the youth is on temporary detention, in a BTP, on administrative lockdown, or disallowed from attending school/work for security reasons.[551]

The current and draft policies require each youth to designate her or his religious affiliation on a Religious Identification Form.[552] Youth are permitted to attend one religious service per week,

---

[542] Statements of Gregory Brewer during central office site visit, March 12, 2009. Alternative services also refer to provision of religious programs to a youth who cannot attend regular programs for a reason beyond her or his control. *Id.*

[543] *Id.*

[544] Statements of staff and youth during Stark site visit, January 2009. Youth on Preston's recently opened "interim BTPs" are also not allowed to attend off-unit religious services/programs, but receive chaplain/spiritual leader visits. Statements of staff and youth during Preston site visit, February 2009.

[545] *Id.*

[546] Administrative Summary: HGSYCF [Stark], January 25, 2009.

[547] Stark housed 423 youth as of the same date. *See id.* One interviewed youth stated that until sometime in 2008, religious staff did not visit the SMP at all.

[548] Statements of staff and youth during Stark site visit, January 2009. The Native American spiritual leader was away from the facility for training during OSM's site visit.

[549] Statements of Gregory Brewer during central office site visit, March 12, 2009; DJJ, Religious Services to Youth [draft policy], December 16, 2008.

[550] Statements of Gregory Brewer during central office site visit, March 12, 2009; CYA, Religious Services to Wards [policy], August 2003, § 6311; DJJ, Religious Services to Youth [draft policy], December 16, 2008, p. 5.

[551] *See* DJJ, Religious Services to Youth [draft policy], December 16, 2008, p. 9. The draft includes a typographical error; it states: "Youth(s) may not be prohibited from attending a group religious service for one or more of the following reasons." The word "not" is a typo that has since been corrected. E-mail of Tammy McGuire to Aubra Fletcher, May 4, 2009.

[552] CYA, Religious Services to Wards [policy], August 2003, § 6309; DJJ, Religious Services to Youth [draft policy], December 16, 2008, p. 4.

regardless of their designated faith groups.[553] Youth must also be allowed to explore other faith groups by attending programs or activities of other traditions.[554]

OSM's final site visit during this audit round was at SYCRCC, where youth interviews suggested that staff restrict youth from exploring other faith groups. One interviewed youth stated that youth cannot, for example, attend Protestant services one week, Catholic another, and Native American another.[555] If a youth wishes to begin attending a different faith's activities, he must ask staff, who then ask the youth's chaplain.[556] The youth may then attend only that tradition's activities.[557] Another youth on the same living unit reported that some staff "make an issue" about youth wanting to go to different faiths' activities because they do not trust the youth not to sign up for a different religious service in order to fight with people there.[558] He added that staff are suspicious when a Latino youth wishes to attend Protestant services and when African American youth want to attend Catholic services.[559]

Additional problems were noted at SYCRCC. Like other facilities, SYCRCC maintains religious services sign-up sheets on the dayroom bulletin boards. Youth must sign up by Wednesday in order to attend a weekend service. At SYCRCC, only Protestant and Catholic church sign-up forms were observed posted on the living units. Youth interviews reflected that many young men were unaware that non-Christian services/programs are offered at the facility.

Three youth were interviewed on the facility's core low-risk unit. One youth was unaware that the facility had a Native American spiritual leader or any activities/services.[560] He was aware of Muslim services, but said that youth could only access them through the librarian.[561] Another youth on the same unit had attended Muslim programs at SYCRCC in the past and stated that youth can ask any staff member to contact the Muslim chaplain.[562] The third interviewee was unaware that Muslim or Native American programs were offered at SYCRCC.[563]

Two of the youth who were interviewed on the high-risk unit stated that sign-up sheets are posted every week for Muslim, Catholic, and Protestant services.[564] One of these youth was unaware of any Native American spiritual activities.[565]

---

[553] CYA, Religious Services to Wards [policy], August 2003, § 6309; DJJ, Religious Services to Youth [draft policy], December 16, 2008, p. 4. OSM is unclear as to why youth may only attend one religious service per week, but OSM defers to the safety and welfare expert regarding the policy's content.
[554] CYA, Religious Services to Wards [policy], August 2003, § 6309; DJJ, Religious Services to Youth [draft policy], December 16, 2008, p. 4.
[555] Statements of one interviewed youth during SYCRCC site visit, March 2009.
[556] *Id.*
[557] *Id.*
[558] Interview with one youth during SYCRCC site visit, March 2009.
[559] *Id.* OSM notes that the Safety and Welfare Remedial Plan decried this same conduct, found in a March 2005 audit; in listing "Problems with the Current System," the plan stated that "[s]ome staff are 'suspect' of a youth's religious belief." Safety and Welfare Remedial Plan, p. 66.
[560] Statements of interviewed youth during SYCRCC site visit, March 2009.
[561] *Id.* OSM notes that youth on the high-risk unit stated that they have no access to the facility's library.
[562] Statements of interviewed youth during SYCRCC site visit, March 2009. This youth also reported having seen sign-up lists for Native American programs, though during the monitors' visit, none were observed.
[563] Statements of interviewed youth during SYCRCC site visit, March 2009.
[564] *Id.*

As noted above, youth at three facilities stated that no Rastafarian programs are offered, and staff did not appear to have made efforts to obtain Rastafarian volunteers.[566] One youth at Chaderjian remarked that a friend of his identified as a Satanist but was long denied access to his bible.[567] His bible was reportedly later mailed to him, but the Protestant chaplain excised portions he deemed inappropriate.[568]

In November 2008, DJJ reported to the court that it was in substantial compliance with this requirement.[569] OSM assigns a PC rating, based on the access problems identified above and on the lack of religious coordinator field visits. OSM is hopeful that the religious coordinator will conduct regular visits in the future in order to identify and address problems of access and deviation from DJJ policy.

Rating: Partial compliance

8.8.2d: OSM previously reported that DJJ tracks religious services in WIN at all facilities.[570] DJJ has since brought the WIN Exchange online, and central office staff can now review WIN records remotely. WIN does not generate a report of any kind, and monitoring of the WIN entries must be done manually.[571] The WIN tracking record for religious services lists the youth who signed up for the service and whether each youth attended.[572] For youth who did not attend, the form provides a space for staff to note the reason and whether and when an alternative service was rendered.[573] On a sample form provided to OSM, three of six youth did not attend a particular service, but no reason for their absences was noted and no alternative service was rendered.[574] OSM recommends that DJJ staff make better use of WIN forms in order that appropriate managers may identify potential obstacles to youth access.

Rating: Substantial compliance

8.8.2e-g: *The religious coordinator is also responsible for* ***(e)*** *pursuit of state and federal grants,* ***(f)*** *DJJ representation at meetings and conferences, and* ***(g)*** *development of chaplaincy internship program.*

8.8.2e: Central office staff report that an extensive search for grant opportunities has been conducted, and no state or federal grants appropriate for DJJ"s needs have been identified.[575]

---

[565] *Id.*
[566] Statements of youth and staff during Chaderjian, O.H. Close, and Preston site visits, October 2008, October 2008, and February 2009, respectively.
[567] Statements of youth and grievance coordinator during Chaderjian site visit, October 2008.
[568] *Id.*
[569] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 9.
[570] Sixth Report of the Special Master (January 2008), Appendix B (Beltz report), p. 19.
[571] Statements of Gregory Brewer during central office site visit, March 12, 2009.
[572] *See* Attachment 34, Religious Services/Programs Sign Up and Attendance Roster, January 2003.
[573] *See id.*
[574] *See id.*
[575] Statements of staff during central office site visits, February 2008 and January 2009. DJJ also provided OSM with e-mail messages among central office staff, dated March 10, 2008, indicating that all available state and federal

Staff also stated in early 2008 that DJJ‟s large volunteer base is sufficient to provide all necessary religious services.[576] (The monitor noted however, that chaplains at Chaderjian and Preston stated that they do not always have time to provide all scheduled "alternative services" for youth who cannot attend chapel or other group services.[577]) The chaplains suggested a potential solution not involving grant funding and were optimistic that the implementation of a chaplaincy internship program might help maintain and coordinate the facility's large volunteer base, fill in for chaplains on leave or vacation, and provide timely faith services to more youth.[578]

DJJ reported in early 2008 that it was considering requesting removal of this requirement from the remedial plan and the standards and criteria.[579] However, DJJ indicated in November 2008 that it does not intend to modify this remedial requirement, that its compliance efforts are "[i]n [p]rogress," and that it does not anticipate attaining substantial compliance this fiscal year.[580] Again in January 2009, DJJ staff indicated that they wish to remove the requirement.[581]

The safety and welfare expert indicated in January 2009 that DJJ staff are correct in their assessment of the unavailability of grant opportunities for DJJ.[582] OSM thus declines to rate DJJ‟s compliance at this time.

Rating: Not rated

8.8.2f: The remedial plan requires the religious coordinator to attend conferences at the State Advisory Council on Institutional Religion [SACIR] and Association of Chaplains in State Services [ACCSS] and/or other state conferences as appropriate.[583]

OSM previously described documented participation of DJJ chaplain and staff attendance at various conferences and meetings in 2007.[584] DJJ continued to provide documentation of DJJ Chaplains‟ Advisory Standing Committee meetings through the beginning of 2008.[585]

According to documentation provided in 2009, the religious coordinator is involved with SACIR and attended a January 2009 ACCSS training program.[586]

Rating: Substantial compliance

---

grants are for community-based programs and not state agencies. E-mail of Gregory Brewer to Doug Ugarkovich, March 10, 2008.

[576] Statements of staff during central office site visit, February 2008.

[577] Statements of staff during Chaderjian and Preston site visits, January and February 2008, respectively.

[578] *Id.*

[579] Statements of staff during central office site visits, February 2008 and January 2009.

[580] Deft. Response to the Court‟s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 9.

[581] Statements of Gregory Brewer to Barry Krisberg during central office site visit, January 14, 2009.

[582] Statements of Barry Krisberg during central office site visit, January 14, 2009.

[583] Safety and Welfare Remedial Plan, p. 76.

[584] *See* Sixth Report of the Special Master, Appendix B (Beltz Report), p. 19.

[585] Minutes of Chaplains‟ Advisory Standing Committee meeting, (PoP #99, February 21, 2008).

[586] E-mail of SACIR Subcommittee member to Gregory Brewer and fellow subcommittee members, February 10, 2009; ACCSS Annual Training Program agenda, January 2009.

8.8.2g: DJJ still does not have a state-wide chaplaincy internship program and has made no progress on this item since February 2008, when it was discussed at the DJJ Chaplains" Advisory Committee.[587] Meeting minutes provided by DJJ indicate that those present agreed that an optional internship program would be useful.[588] Meeting attendees also agreed that further discussion of eligibility requirements and the potential role of interns was needed.

Though DJJ indicated in November 2008 that it did not intend to seek modification of this remedial requirement,[589] DJJ has since proposed a revision of this requirement.[590] DJJ"s proposed modification is based on a stated lack of need for chaplaincy interns.[591] Because OSM received the proposed modification after the monitors completed their audit round, this is not verified. OSM thus assigns a non-compliance rating but notes that DJJ may otherwise be meeting the need for services that would otherwise be provided by chaplaincy interns.

Rating: Non-compliance

8.10.4: *By September 1, 2006, DJJ to designate a project coordinator for master plans.* ***8.10.3:*** *By July 1, 2007, DJJ is required to develop a proposal for a new facility that is consistent with the goals of the Remedial Plan.*

8.10.4: DJJ designated a part-time master plan project coordinator on September 1, 2006, but the position became vacant in February 2007.[592]

In December 2007, DJJ designated Eleanor Silva as the project coordinator for master plans, though this is not her primary assignment.[593] In this role, Ms. Silva participated as staff on the State Commission on Juvenile Justice, which recently sunset after issuance of its Operational Master Plan for the state"s entire juvenile justice system.[594]

In November 2008, DJJ formally designated Ms. Silva as the project coordinator for DJJ"s operational master plan, and Mark Blaser as project coordinator for DJJ"s facility master plan.[595]

---

[587] Minutes of Chaplains" Advisory Standing Committee meeting, (PoP #99, February 21, 2008); statements of staff during central office site visit, May 2008; statements of Gregory Brewer to Barry Krisberg during central office site visit, January 14, 2009. Staff at Ventura informed former monitor Cathleen Beltz of the facility"s chaplaincy internship program; Ventura receives two new interns twice a year. Statements of staff during Ventura site visit, 2008.

[588] Minutes of Chaplains" Advisory Standing Committee meeting, (PoP #99, February 21, 2008). Presumably an optional program would not treat the internship as a hiring requirement.

[589] *Id.*

[590] See e-mail of Rachel Stern to Donna Brorby, et al., April 24, 2009.

[591] *See id.* DJJ reports that the need giving rise to this remedial requirement is currently satisfied by the large number of religious volunteers providing services to youth in DJJ facilities.

[592] Fourth Report of the Special Master (June 2007), Appendix A (Beltz Report), p. 8.

[593] Statements of Eleanor Silva during central office site visit, March 12, 2009.

[594] See W&IC §§ 1798.5, 1960.5; *see also* State Commission on Juvenile Justice, Operational Master Plan, January 2009, *available at* http://www.cdcr.ca.gov/Divisions_Boards/State_Commission_on_Juvenile_Justice/docs/JJOMP_Final_Report.pdf.

[595] *See* memorandum of Sandra Youngen to Bernard Warner, November 17, 2008. Ms. Silva and Mr. Blaser had functioned in these roles "for some time" prior to the issuance of this memo. *Id.*

The safety and welfare expert monitors DJJ"s compliance with requirements related to the development of a facilities master plan and an operational master plan.[596]

Rating: Defer to the expert.

8.10.3: The remedial plan requires DJJ to modify its initial prototypical design in accordance with DJJ"s facilities master plan.[597] The facilities master plan, in turn, must first be developed in coordination with the juvenile justice master plan.[598]

The juvenile justice master plan was issued in January 2009,[599] though DJJ had already begun developing a facilities master plan.[600] And although the facilities master plan is not yet complete, DJJ developed a proposal for a prototypical facility in 2008.[601] The resulting proposal was not fiscally viable.[602] In October 2008, DJJ reported that it was seeking ways to make the prototype more affordable."[603] DJJ staff provided the same report in January 2009.[604] In February, DJJ said that the "value-engineering" process would be completed by the beginning of April 2009.[605]

DJJ has indicated that it does not anticipate achieving substantial compliance by the end of this fiscal year.[606]

Rating: Beginning compliance

[596] *See* Safety and Welfare Remedial Plan Standards and Criteria, items 8.10.1, 8.10.2.
[597] Safety and Welfare Remedial Plan, p. 69.
[598] *Ibid.*
[599] *See* State Commission on Juvenile Justice, Operational Master Plan, January 2009, *available at* http://www.cdcr.ca.gov/Divisions_Boards/State_Commission_on_Juvenile_Justice/docs/JJOMP_Final_Report.pdf.
[600] In approximately January 2009, DJJ provided Dr. Krisberg with its June 2008 draft facilities master plan, for his review. Memorandum of Barry Krisberg to special master, March 2, 2009, p. 15.
[601] In January 2008, OSM reported that DJJ was in the "design phase" of its prototypical facility proposal. *See* Sixth Report of the Special Master (January 2008), Appendix B (Beltz Report), p. 20. By October 2008, the prototype proposal had been drafted. Statements of DJJ staff during teleconference with OSM and experts, October 28, 2008.
[602] Statements of DJJ staff during teleconference with OSM and experts, October 28, 2008; memorandum of Barry Krisberg to special master, March 2, 2009, p. 15.
[603] Statements of DJJ staff during teleconference with OSM and experts, October 28, 2008.
[604] In January 2009, DJJ reported that the prototype was being "value-engineered." Statements of Mark Blaser to Dr. Krisberg during central office site visit, January 15, 2009; *see also* memorandum of Barry Krisberg to special master, March 2, 2009, p. 15.
[605] Statements of Bernard Warner during teleconference, February 5, 2009.
[606] Deft. Response to the Court"s October 27, 2008 Order, November 21, 2008, Exhibit H, p. 9.

OSM Monitor Findings: Safety and Welfare 2008-2009

ACTION ITEM	Section/Item		Central Office	OHC	N.A.C	VYCF	HGS	PYCF	SR	Audit Method / Standard
2.1 ADD CENTRAL OFFICE RESOURCES										
Add/appoint Program Director	2.1	1	SC							Position filled / assigned
Add/appoint Farrell Project Director	2.1	2	SC							Position filled / assigned
Program development & implementation team	2.1	3a	SC							Teams in place
Temporary transition team	2.1	3b	SC							
Compliance team	2.1	3c	SC							
Dedicated staff for policy development / maintenance	2.1	4a	NR							
Master schedule completed for updating DJJ policy	2.1	4a	PC							Schedule in place
Policies updated per schedule. TDOs as needed	2.1	4a	PC							Farrell related policies updated per schedule
Youth informed of changes as appropriate	2.1	4a	SC	PC	NR	SC	PC	PC	PC	Information materials and/or briefing provided within 30 days of change
Clear separation between juvenile and adult training	2.1	4b	PC							Separate DJJ training process plan and tracking system in place
Trainers/quality assurance specialists (minimum 18)	2.1	5	SC							Positions filled / assigned
2.2 CLARIFY LINES OF AUTHORITY / CREATE SYSTEM FOR AUDITING AND CORRECTIVE ACTION										
Designate facility compliance monitors and schedule	2.2	3		PC	PC	PC	PC	PC	PC	Monitors appointed and scheduled developed
Rewrite local directives & procedures as new policy is adopted	2.2	5	BC	SC	NR	SC	PC	SC	PC	Local directives and procedures in place (on going process)
Update job descriptions	2.2	6	BC							Official job descriptions approved
Produce annual reports	2.2	7	NR							Annual reports produced. Reports accurately reflect status of reform and state of DJJ
2.3 IMPROVE MIS CAPABILITY										
Complete WIN exchange	2.3	1	SC							Exchange operational
Contract for Performance-based Standards	2.3	3a	SC							Contract in place
Establish state-wide PbS Coordinator	2.3	3b	SC							Position filled / assigned
Establish PbS site Coordinators at each facility	2.3	3c		SC	SC	SC	SC	SC	SC	Positions filled / assigned
2.4 ADD RESOURCES AT EACH FACILITY										
Program Manager(s)	2.4	1		NR	NR	NR	NR	NR	NR	Positions filled / assigned
Volunteer Services / Positive Incentives Coordinator	2.4	2		SC	SC	SC	SC	SC	SC	
Vocational Specialists	2.4	3		BC	BC	BC	BC	BC	BC	
Victim Services/Restitution Specialists	2.4	4		SC	SC	BC	NC	BC	SC	
Training Officer	2.4	5		SC	SC	SC	SC	SC	SC	
Work Assignment Coordinator	2.4	7		SC	NR	SC	SC	NC	SC	Positions filled / assigned
Facility Administrators for operations and business services	2.4	8		NR	NR	NR	NR	NR	NR	
Facility Administrator of programs	6	3		NR	NR	NR	NR	NR	NR	
2.5 RESEARCH										
Assist with annual reports	2.5	1b	NR							Reports accurately reflect status of reform and state of DJJ
3.0 REDUCE VIOLENCE AND FEAR										
Create Violence Reduction Committees at each facility	3	3b		NR	NR	NR	NR	NR	NR	Violence Reduction Committees review, map and evaluate all incidents of violence quarterly. Violence Reduction Plans are submitted to the DJJ Chief of Security for review, monitoring and sharing of results. The effect of violence reduction plans is measured at the living unit and facility level.
Qualify 18 staff in crisis management training	3	4a	SC							Trainers qualified
Crisis management training for direct care staff at two facilities	3	4b	PC				PC	PC		Direct care staff are trained. New staff are trained within 90 days of assignment to a living unit.
Crisis management training for remaining direct care staff	3	4c		PC	PC	PC			PC	Direct care staff are trained. New staff are trained within 90 days of assignment to a living unit
Develop and use databases to track violence and use of force	3	5	NR	NR	NR	NR	NR	NR	NR	System developed in consultation with S&W expert, plaintiff's counsel and Special Master that includes all PbS data elements relating to violence, injuries to youth and staff, and use of force. System is in place and operational. DJJ audits data reliability and data is determined to be reliable per appropriate statistical measures. Starting in July 2007 and subject to the S&W expert's approval, DJJ develops annual targets and action plans for each facility for reduction of violence, injuries, and use of force. Quarterly reports provided to S&W expert, plaintiff's counsel and Special Master for all facilities and all data elements. Report format approved by S&W expert.

OSM Monitor Findings: Safety and Welfare 2008-2009

ACTION ITEM	Section	Item	Central Office	OHC	N.A.C	VYCF	HGS	PYCF	SR	Audit Method / Standard
Record PbS safety outcome measures 2-4, 11, 12 for every day of year. (Injuries to youth per 100 days youth confinement, injuries to staff per 100 days staff employment, injuries to youth by other youth per 100 days youth confinement, assaults on youth per 100 days youth confinement, assaults on staff per 100 days youth confinement)	3	6a		NR	NR	NR	NR	NR	NR	INCLUDED UNDER 3.5
Quarterly reports on selected PbS data elements	3	6b	NR							INCLUDED UNDER 3.5
Provide gang/race integration training to appropriate staff	3	8c		NR	NR	NR	NR	NR	NR	Expert reviews quality of training
Open sufficient BTPs for projected 2008/09 demand	3	9a	BC							BTPs are operational and staffed and sized according to the Remedial Plan
4.0 IDENTIFY REHABILITATION TREATMENT MODEL										
Provide training in use of risk/needs tool	4	1b		NR	NR	NR	NR	NR	NR	Duplicate of 6.7b
5.0 LAY THE FOUNDATION FOR TREATMENT REFORM										
DJJ Integrated Behavior Treatment Model	5	4a	NC							Trainer(s) hired/retained or existing staff trained as trainers
Risk / Needs Assessment	5	4b	NR							
Treatment Plan Development	5	4c	NR							
Motivational Interviewing	5	4d	SC							
Normative Culture	5	4e	BC							
Interactive Journaling	5	4f	BC							
Other programs adopted by DJJ	5	4g	PC							
6.0 CONVERT FACILITIES TO REHABILITATIVE MODEL										
Convert Chaderjian to special treatment facility	6	1a			NR					All living units at Chaderjian, with the exception of parole detainee and reception units, are staffed and operated as special treatment units.
Convert first facility to rehabilitative model	6	1b		NR		NR	NR	NR	NR	All youth are in living units no larger than those specified in the Remedial Plan. All living units are staffed according to the staffing standards outlined in the Pan.
Complete conversion of facilities to rehabilitative model	6	1c		NR		NR	NR	NR	NR	Youth are in living units no larger than those specified in the Plan. Living units are staffed at levels equal to, or greater than, staffing standards specified in the Plan or as mutually agreed to by the parties. Program delivered consistent with program design.
All needed program space added	8.1	1		PC		PC	PC	NR	PC	Sufficient space exists so that no regular programs have to be canceled due to lack of space. There are sufficient classrooms in or near all BTPs to maintain a ratio of 1 teacher for every 6 students.
All needed staff space added	8.1	1		PC		PC	PC	SC	PC	Sufficient office space exists so that all living unit staff requiring offices have space in, or adjacent to, the living unit.
Program Service Day schedule for BTPs	6	6	BC	NA		NA	NA	NR	NA	Schedule ensures structured activity based on evidence-based principles for at least 40% of waking hours. BTPs operating in accordance with approved schedule.
Conflict resolution teams where appropriate	6	4	NR	NR	NR	NR	NR	NR	NR	Team members appointed and training scheduled
Complete training	6	7								
DJJ Integrated Behavior Treatment Model	6	7a		NC	NC	NC	NC	NC	NC	DJJ policy specifies training requirements for all staff. Direct care staff are trained in all aspects of the treatment model within 90 days of assignment to a living unit. All supervisory and management staff complete training on the treatment model as required by DJJ policy.
Treatment plan development	6	7c		NR	NR	NR	NR	NR	NR	
Motivational Interviewing	6	7d		PC	PC	PC	PC	PC	PC	
Normative Culture	6	7e		NC	NC	NC	NC	NC	NC	
Interactive Journaling	6	7f		NC	NC	NC	NC	NC	NC	
Other key treatment components	6	7g		PC	PC	PC	PC	PC	PC	
7.0 SYSTEM REFORM FOR FEMALES										
Issue request for Letters of Interest for contract services	7	1	SC							COMPLETED
Request legislative authority and funding for contract services	7	4	SC							RFP issued
8.1 ACCEPTANCE/REJECTION CRITERIA										
Designate Community/Court Liaison staff	8.1	2	SC							Position filled / assigned
8.2 ORIENTATION										
Provide DJJ orientation at detention facilities (pending funding)	8.2	4	PC							Accurate and useful information about DJJ is provided to new commitments before they leave detention. This does not relieve DJJ of the requirement to provide information to youth on new/revised policies per 2.1 4a
8.3 FAMILY INVOLVEMENT										
Community assessment reports at commitment	8.3	1	NR							Monitored by MH Remedial Plan experts
Family phone contact facilitated w/in 24 hrs of commitment	8.3	2a	NR							
Ongoing family phone contact facilitated	8.3	2b		NR	NR	NR	NR	NR	NR	

OSM Monitor Findings: Safety and Welfare 2008-2009

ACTION ITEM	Section/Item		Central Office	OHC	N.A.C	VYCF	HGS	PYCF	SR	Audit Method / Standard
Family visiting days organized	8.3	3		NR	NR	NR	NR	NR	NR	
8.4a DISCIPLINARY SYSTEM										
Disciplinary fact finding hearings held within 14 days	8.4	2a		PC	NC	SC	SC	PC	PC	Except as provided for in policy (e.g. youth out to court), fact finding hearings held within specified time.
Disciplinary disposition hearings held within 7 days	8.4	2b		SC	NC	SC	SC	PC	PC	Except as provided for in policy (e.g. youth out to court), disposition hearings held within specified time.
Eligibility to restore time reviewed at case conferences	8.4	6b		NR	NR	SC	NR	BC	NR	Spot check of case conference notes indicates that, where applicable, eligibility to restore time is reviewed.
8.5 GRIEVANCE SYSTEM										
Forms available without assistance in all units	8.5	1		SC	SC	SC	SC	SC	SC	Forms available in each living unit
Lock box for grievances in all living units	8.5	2		SC	SC	SC	SC	SC	SC	Lock boxes in all living units
Grievance clerk ensures adequate supply of forms; educates/assists in process	8.5	3		SC	SC	SC	SC	SC	SC	Job description of grievance clerk standardized and limited per this Plan
Notice of receipt of grievance or allegation of misconduct	8.5	4		SC	SC	SC	NR	SC	SC	Documentation shows that all youth are notified of receipt of grievances and allegations of staff misconduct.
Facility grievance coordinator prepares monthly reports	8.5	5a		SC	SC	SC	SC	SC	SC	Monthly reports produced. Reports summarize prior month and show longer-term trends and highlight areas for possible corrective action
8.6 TIME ADDS										
Earn-back policy revised to allow restoration after 6 months	8.6	3a	BC							Policy revised
Restored months rounded up	8.6	3b		NR	NR	NR	NR	NR	NR	Policy revised
Description of Ward Incentive Program simplified	8.6	4a	PC							Monitored with 8.4 7a
Full program credit if youth not responsible for non-participation	8.6	4b	NR	NR	NR	NR	NR	NR	NR	Policy revised
Point standards developed for restorative justice projects	8.6	4c	NC							Standards in place. Interview of youth indicate awareness of policy
8.7 ACCESS TO COURTS AND LAW LIBRARY										
Education Services operates law libraries	8.7	1a	NC							Budget, procurement, and operations assigned to Education Services. Written annual audits produced.
Education Services tracks needs and conducts annual audits	8.7	1b	NC							
Education Services controls budget and manages purchases	8.7	1c	PC							
Needed law library materials purchased annually	8.7	3	BC							Annual audits by Education Services indicates materials up-to-date or ordered
Print libraries replaced with electronic or internet materials	8.7	5		NC	NC	NC	NC	NC	NC	Electronic or internet law libraries at all facilities.
8.8 ACCESS TO RELIGIOUS PROGRAMS AND FUNCTIONS										
Religious Coordinator oversees mandated programs, policy, manual revisions, and training	8.8	2a	SC							Job description conforms to requirements of Remedial Plan. Position filled / assigned
Religious Coordinator monitors facilities for:										
Provision of services/programs for various faiths	8.8	2b	PC							Written documentation of monitoring produced upon request. Sufficient resources available to provide religious services to youth as required by law.
Youth access to services/programs/materials	8.8	2c	PC							
Documentation of services/programs in an automated tracking system	8.8	2d	SC							
Religious Coordinator responsible for:										
Pursuit of state and Federal grants	8.8	2e	NR							Grant applications submitted as appropriate
DJJ representation at meetings and conferences	8.8	2f	SC							Coordinator attends conferences of the State Advisory Council on Institutional Religion and Association of Chaplains in State Services and/or other state conferences as appropriate
Development of chaplaincy Internship Program	8.8	2g	NC							Internship program in place
8.10 MASTER PLANNING										
Proposal for prototypical facility	8.1	3	BC							Proposal for new facility developed that is consistent with the goals of the Remedial Plan
Designate project coordinator for master plans	8.10	4	NR							Position filled / assigned

Appendix E
Facsimile of Email sent by Donna Brorby, March 3, 2009

From: Donna Brorby

To: William Kwong; Michael Brady

CC: Rachel Stern; Sara Norman; Don Specter; Barry Krisberg; Barbara Schwartz, Ph.D.; Eric Trupin; Terry G Lee; Aubra Fletcher; Zack Schwartz

Subject: IBTM -- experts' high level issues

DJJ and the safety and welfare, mental health and sexual behavior treatment experts have had a number of discussions of the IBTM. It is not clear whether DJJ will agree to do what the experts' think is necessary to succeed in the development and implementation of a reasonable treatment model and system. This is to summarize the highest level issues as I said I would for you. I have worked closely with the experts in order to accurately represent their views. This distillation also is consistent with notes of the YASI and IBTM discussions August 2008 - February 2009. As I have said, I think that we need to determine whether DJJ fundamentally agrees or disagrees with the experts. If it agrees, will DJJ move forward accordingly? If there is a fundamental disagreement, we should have that resolved by the court.

1. In the series of conversations between DJJ, Orbis and the mental health experts that concluded October 15, 2008, it became clear that DJJ did not intend to adapt the integrated treatment model from Washington state's juvenile corrections system. The mental health, sexual behavior treatment and safety and welfare experts all previously had thought that DJJ was going to adapt the Washington model. The mental health experts strongly recommended the Washington model and they continued to believe that it would be easier for DJJ to adapt the Washington model than to proceed with the development of the model that DJJ was working on with Orbis Associates. They thought that DJJ could copy Washington to a large extent, based on extant documentation, where the approach it was taking required the creation of something new. But, they also accepted the DJJ risk/needs assessment and case planning approach to treatment (with a set of appropriate programs that evidence did or might show were effective) as an equally reasonable approach, if it were executed properly. They and DJJ agreed that all treatment interventions and all elements of DJJ's system and program (WIP, UOF, DDMS, anti-gang strategy, etc.) would have to be woven together into a whole. The safety and welfare expert did not participate in all of the calls but he said that he would defer to the mental health experts on issues related to the treatment model and programs.

2. In the opinion of the experts, DJJ has not articulated a plan to integrate all treatment interventions and all elements of DJJ's system and program into a whole "IBTM." It has

said that all of its treatment interventions will be cognitive behavioral and will have a common language. It also has noted that it is training its staff in the cognitive behavioral approach and the common language of the programs that DJJ uses or will use. This does not satisfy the experts. First, staff training is not enough. DJJ must direct staff in how, when and where they are supposed to use their training, by policies and/or program guides and supervision. For example, DJJ doubtless intends to discourage some behaviors that it anticipates youth will engage in and to encourage other behaviors. That will require consistency in how staff respond to those behaviors, whenever and wherever they occur. In order to get staff to respond consistently, DJJ needs to tell them how they are expected to respond. It needs to give them a coherent framework for understanding how to respond to and guide youth. Second, DJJ has not addressed how its basic systems and programs are integrated into the IBTM, e.g., DDMS, Youth Incentive Program, school, Change Company journals, etc. DJJ needs to integrate all treatment interventions and elements of its system and program in a whole IBTM that staff understand. Also, the integration is necessary if DJJ is to mold and control facility environments and the positive and negative incentives that affect youth behavior. Facility environments, including youth and staff behavior, will create/affect positive and negative incentives that will affect youth behavior. They are the setting/context within which DJJ will deliver treatment interventions. DJJ has to have a strategy/plan for controlling them. The concept of an IBTM includes such a strategy/plan. DJJ has not yet articulated such a strategy/plan.

3. The point of difference between the experts and DJJ may have been illustrated in the discussion of normative peer culture during the February 5, 2009 expert/DJJ IBTM conference call. Bernie Warner said that normative peer culture provides tools to and develops skills in youth and staff that promote youth function in the DJJ institutional environment at the highest possible level. It develops coping skills and life skills and promotes a "normal" environment. He said the IBTM, by way of contrast, targets the risk to re-offend and reduces delinquency. He said this as if there might be an overall treatment program or philosophy that was entirely separate from and unaffected by the institutional environment and as if the institutional environment is irrelevant to the risk to re-offend. The experts strongly believe that the treatment programs and everything else in the environment are part of one whole. DJJ needs to fit them into a coherent paradigm.

4. The experts and DJJ agree that DJJ is trying to do something particularly challenging in trying to "fix the bus while driving it." In the ordinary reform, the model would be designed before implementation commenced. The pressure of the Farrell lawsuit requires DJJ to implement reforms while continuing to design its treatment model and before adequate facilities are in place. DJJ probably sees itself as doing the best it can, working with Orbis to develop the California YASI and identify promising cognitive behavioral programs and training staff in cognitive behavioral and other techniques for managing and molding youth. It plans to pull all the pieces together into a coherent whole in the future. The experts believe that DJJ is headed for a cliff, driving the bus without the context of an IBTM plan. They do see that DJJ is trying very hard to succeed in its reform. They do not think that all the effort can be either efficacious or efficient without an overall plan that encompasses all of DJJ and its staff and its programs and activities.

This is the same position they took on October 15, see paragraph 1 above.

5. The safety and welfare plan requires a written description of the IBTM and the experts believe that it is essential for DJJ to develop that description immediately. They envision a description at the level of detail of the 120+ page description of Washington JRA's ITM. They will offer their advice to DJJ as DJJ develops the description. (Dr. Krisberg offers the services of a skilled and experienced NCCD staffer to put DJJ's model into a draft writing for it.) They hope to be able to approve what DJJ develops. If they cannot, the OSM and parties will determine what to do about that.

6. The experts believe that DJJ would increase its likelihood of success if it identified an existing documented (replicable) model and adapted it for DJJ rather than creating its own model.

7. The experts believe that DJJ needs to have a solid plan for a piloting and evaluating the IBTM that is developed and executed by research staff. This has to be developed now as a part of the model.

8. The experts and DJJ have agreed that DJJ's IBTM must encompass family engagement and involvement and be linked and consistent with transition and re-entry services and strategies.

Appendix F

Excerpt from Barry Krisberg, revised informal report on January 2009 central office site visit (summary), submitted April 10, 2009

4.0 And 5.0 Identify Rehabilitation and Treatment Model: Lay the Foundation for Reform

Absolutely central to the DJJ reforms is the development and implementation of a model treatment model or Integrated Behavior Treatment Model (IBTM). This model should fundamentally alter how DJJ operates, improve outcomes for youth, and provide the underlying framework for all policies and programs.

DJJ has successfully contracted with a Canadian for-profit company, Orbis Partners, to develop a risk needs assessment tool, offer case management training to staff, and to help introduce "evidence-based" treatment programs into DJJ. This contract does not appear to cover all of the areas involved in implementing the IBTM. DJJ has consulted with the Farrell Experts in the development of the IBTM, although the consultation with the S&W Expert has been limited and less than satisfactory in terms of full engagement and responsiveness to my concerns.

The IBTM is currently an undeveloped and very generic approach. It is my view that DJJ has not assigned the proper staff to develop the IBTM and the Division may lack the in-house expertise to conceptualize and articulate the IBTM. The contract with Orbis Partners, while providing needed services, does not appear sufficient to assist DJJ in developing and launching a comprehensive IBTM. The lack of progress in this area is concerning and seems to be frustrating many of the Farrell Experts. To date, several top DJJ managers have responded by my observations and those of other Farrell Experts with defensiveness and resistance. On its current path, I believe that DJJ will be out-of-compliance with the Farrell requirements for the foreseeable future.

There are many problems in the DJJ approach to the IBTM. Most basic is that there is only a very sketchy description of the IBTM. The S&W Remedial plan contemplated a detailed and thorough description of the program and model, similar to documents shared with us from Washington State. According to DJJ top management, the IBTM is no longer a specific program but an overall philosophy of operations. I do not know what this means!

DJJ has not reached out to national experts from the most progressive juvenile corrections systems such as MO, MA, or CO for specific help in formulating the IBTM. It is my opinion that Orbis Partners can only provide some guidance in this area . in part because the firm's track record is mostly in probation or reentry and appears to have far more limited experience with institutionalized, serious and violent juvenile offenders. But, even if Orbis Partners had a wider skill set, the DJJ desperately needs to develop staff and management expertise in model treatment approaches.

A second concern is that DJJ promised to mount a pilot test of the IBTM at two facilities this year. This is not occurring and instead DJJ is "piloting different parts of the IBTM in different places". This is a no substitute for a carefully implemented pilot that is accompanied by careful

research and evaluation. The IBTM is a very complex undertaking and a pilot would help DJJ understand the critical ingredients to success and the barriers to proper implementation. DJJ has repeatedly been unable to articulate an answer to a simple, but fundamental question: How will things be changing for the youth when the IBTM is fully operation?

At this stage, the development of the ITBM does not appear to be data-driven. Neither the CA YASI nor other DJJ data sources seem accessible to planners working on the components and central parts of the IBTM. Despite over 3000 hours of staff time devoted to administering the CA YASI, there are seemingly no data apart from individual youth reports that can be used to guide DJJ planning for the IBTM. Further, I see little evidence that DJJ possesses an actual implementation timeline for the IBTM. Issues of staffing, facility needs, budget requirements, and other core issues seem unresolved. DJJ managers seem intent on rolling out a new approach and training their staff in parts of it, but there seems a lack of strategic vision. Training is being offered to staff, but we don't know if it is the right training, or being delivered to the right number of staff in the proper positions. At its base the DJJ performance in the IBTM looks like the proverbial " ire, Ready, Aim" approach.

DJJ should be required to produce a detailed written description of the IBTM that should be approved by the Farrell Experts. Once approved the IBTM should be reflected in a well developed implementation plan that contains timelines, milestones, budget requirements and capital needs. There should be an IBTM Logic Model similar to the one developed by the Expert Panel for CDCR Adult Rehabilitation Programs. DJJ should not be permitted to abandon its commitment to a carefully evaluated pilot test of the IBTM.

DJJ has contracted for substantial training of its staff on several of the components of the IBTM. The OSM is monitoring the delivery of this training. One big area in which critical training has been delayed is in the area of Normative Culture. While more training is a positive step forward, there is little evidence of a DJJ strategic approach to training as it relates to the full implementation of the IBTM. To my knowledge there is not a current written DJJ training plan. Further, the DJJ training should be connected with strategies to institutionalize the treatment reforms via ongoing management, supervisor coaching, and personnel reviews. The DJJ has supplied rosters of training sessions and some anecdotal evidence that the staff enjoy the training (most staff do!), but there is little objective evidence that the desired competencies underlying the training are actually being enhanced.

DJJ also reported that it has not completed the adjusted staffing positions to add the treatment team leaders, case managers, and other team members that are envisioned in the S&W team. DJJ reports that it has not yet approved and fully adopted the job descriptions related to the model treatment aspects of the S&W Remedial Plan.

DJJ committed to implementing a statewide service day for its core treatment unit. There has been a pilot of the program service day at Preston. DJJ is still analyzing the results of the pilot. Full implementation of a statewide service day is still planned in the future. No such program service days have been piloted for the BTPs since these program units have not been implemented yet.

Michael Brady has now invited Dr. Angela Wolf, a community psychologist who is very knowledgeable about juvenile justice nationwide, to work with a team of DJJ staff to improve progress in the definition and documentation of the LBTM. Mr. Brady has also reached out to staff from Washington State to provide information about that model. I am also collecting descriptions of model approaches from Missouri and other states to share with DJJ staff.